Evaluation of the USAID/Cambodia PEPFAR HIV/AIDS Flagship Project

November 2016
This publication was produced at the request of the United States Agency for International Development. It was prepared independently by David Lowe, David Hales, Katya Burns, Billy Pick, Michael Cassell, Mao Bunsoth, and Chea Bunnary.
Cover Photo by Mr. Cheav Aphyra, HIV/AIDS Flagship Project | KHANA, HIV Finger Prick Testing by SMART girl lay counselor, Siem Reap, Cambodia.
EVALUATION OF THE USAID/CAMBODIA PEPFAR HIV/AIDS FLAGSHIP PROJECT

November 2016
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ABSTRACT


Evaluation questions: Questions related to the effectiveness of project innovations in detecting new cases of HIV among key populations (KPs); effectiveness of technical assistance in improving case management, antiretroviral therapy (ART) initiation, adherence, and retention in HIV treatment; and the capacity of implementers to use data in monitoring and planning services.

Methods: Collection of qualitative data from interviews and focus groups with project implementers, KP clients and stakeholders; analysis of project indicator data; secondary data analysis; and document review.

Key findings and conclusions: Community HIV testing of KPs by outreach workers (OW) was successfully scaled up (58,285 tests to June 2016). The very low HIV case detection yield of 0.44% was associated with a lack of data on KP sub-groups with high-risk behaviors and limited reach by OWs to high-risk KP segments, and a poorly functioning OW system. Innovations to increase KP reach and yield were either delayed, over-engineered, or not scaled up. There was no evidence of development of a culture of innovation at the field level. Active case management for People Living with HIV (PLHIV) was successfully scaled up, resulting in 100% of newly diagnosed HIV cases among KPs (227) being enrolled in ART. Loss to follow-up declined from 38% in Year 1 to 4% in Year 4. Ninety-six percent of those on ART achieved viral load suppression. Cost efficiencies could be achieved by differentiated care for stable and non-stable PLHIV. The capacity of most NGO implementing partners to analyze data, draw lessons learned, and apply those lessons was limited.
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<tr>
<td>ACON</td>
<td>AIDS Council of New South Wales</td>
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<tr>
<td>AHC</td>
<td>Angkor Hospital for Children</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>AUA</td>
<td>ARV User’s Association</td>
</tr>
<tr>
<td>BC</td>
<td>Bandahn Chaktamouk</td>
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<tr>
<td>B-CoC</td>
<td>Boosted Continuum of Care</td>
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<tr>
<td>B-CoPCT</td>
<td>Boosted Continuum of Prevention to Care and Treatment</td>
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<td>B-IACM</td>
<td>Boosted Integrated Active Case Management</td>
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<tr>
<td>B-LR</td>
<td>Boosted Linked Response</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Surveillance Survey</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CDHS</td>
<td>Cambodia Demographic and Health Survey</td>
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<tr>
<td>CMAs</td>
<td>Case Management Assistants</td>
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<tr>
<td>CMC</td>
<td>Case Management Coordinator</td>
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<tr>
<td>CMP</td>
<td>Case Management Provider</td>
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<tr>
<td>CMS</td>
<td>Case Management Supporter</td>
</tr>
<tr>
<td>CNPUD</td>
<td>Cambodian Network of People Who Use Drugs</td>
</tr>
<tr>
<td>CoE</td>
<td>Center of Excellence</td>
</tr>
<tr>
<td>COP</td>
<td>Country Operational Plan</td>
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<tr>
<td>CoPCT</td>
<td>Continuum of Prevention to Care and Treatment</td>
</tr>
<tr>
<td>CPN+</td>
<td>Cambodian PLHIV Network</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>CSV</td>
<td>Community Support Volunteer</td>
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<tr>
<td>DIC</td>
<td>Drop-in Center</td>
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<td>DQA</td>
<td>Data quality assurance</td>
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<tr>
<td>DSD</td>
<td>Direct service delivery</td>
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<tr>
<td>EW</td>
<td>Entertainment worker</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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GBV  Gender-based violence
GF   Global Fund
GIS  Geographic Information System
GoC  Group of Champions
HIEP HIV Innovate and Evaluate Project
HIV  Human immunodeficiency virus
IACM-PNTT Integrated Active Case Management-Partner Notification, Tracing and HIV Testing
IBBS Integrated Biological and Behavioral Surveys
IP   Implementing partner
IRIR Identify, Reach, Intensify and Retain
KHANA Khmer HIV/AIDS NGO Alliance
KP   Key populations (at risk for HIV)
LGBT Lesbian, gay, bisexual, and transgender
LTFU Loss to follow up
MOU Memorandum of Understanding
MSM Men who have sex with men
NCHADS National Center for HIV/AIDS, Dermatology and STD
NECHR National Ethics Committee for Health Research
NGO Non-governmental organization
OD   Operational District
OID  Organizational and institutional development
OW   Outreach worker
PDI+ Peer-driven intervention
PEPFAR US President’s Emergency Plan for AIDS Relief
PHSC Protection of Human Subjects Committee
PLHIV People living with HIV
PMP  Performance Monitoring Plan
PMTCT Prevention of mother-to-child transmission
PSI/PSK Population Services International/Population Services Khmer
PWID People who inject drugs
RDS  Respondent-driven sampling
RTS  Risk-tracing snowball
SCC  Salvation Center Cambodia
SI   Strategic information
SOGI Sexual orientation and gender identity
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>SOP</td>
<td>Standard operating procedures</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually transmitted disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TA</td>
<td>Technical assistance</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender people</td>
</tr>
<tr>
<td>TH</td>
<td>Technical hub</td>
</tr>
<tr>
<td>UIC</td>
<td>Unique Identification Code</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USG</td>
<td>United States Government</td>
</tr>
<tr>
<td>VCCT</td>
<td>Voluntary counseling and testing</td>
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<tr>
<td>VL</td>
<td>Viral load</td>
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<td>WHO</td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

EVALUATION PURPOSE
This endline evaluation of the PEPFAR USAID/Cambodia HIV/AIDS Flagship Project was designed to serve three purposes: (1) to assess the project’s performance and the extent to which it has been able to meet its intended objectives; (2) to document lessons learned and best practices; and (3) to make recommendations to inform and improve future program directions and effectiveness. Evaluation questions:

1. Which of Flagship’s HIV prevention innovations and services for key populations (KPs) (entertainment workers [EWs], men who have sex with men [MSM], transgender people [TG], and people who inject drugs [PWID]) are high-impact and efficient in detecting new cases of HIV, increasing access to condoms, and increasing uptake and yield of HIV testing among underserved and neglected groups (EWs, MSM, TG, and PWID)?

2. How effective was Flagship’s technical assistance (TA) in improving the quality and integration of HIV/AIDS care and treatment services and the Integrated Active Case Management approach (tracking referrals from the community to health facilities, monitoring the care and treatment cascade, enrollment on antiretroviral therapy [ART], adherence and viral suppression, and reducing lost-to-follow up cases)?

3. How effective was the project at scaling up proven innovative HIV prevention, care, and treatment interventions? How have the studies/evaluations conducted by HIV Innovate and Evaluate Project been used to determine which innovations should be replicated to improve the Flagship project?

4. How effective was the consortium’s approach to sustainability and organizational development, including strengthening the financial management, program management, and technical implementation capacity of the government, local nongovernmental organizations (NGOs), and networks of key populations (EWs, MSM, TG, PWID), and people living with HIV (PLHIV) at the national, provincial, and community levels?

5. How has the project built local capacity to understand and effectively use service delivery data to plan and monitor progress of the HIV cascade and the continuum of prevention, care, and treatment services?

EVALUATION DESIGN, METHODS, AND LIMITATIONS
This performance evaluation undertook a wide range of interviews with the Flagship Project’s consortium partners and implementers, key stakeholders, and focus group discussions with KP project beneficiaries. This was supplemented by review of the project’s performance indicator data, including secondary analysis and document review. All data were triangulated during analysis.

This was a performance evaluation that primarily relied on qualitative data. The evaluation relied on existing project data to assess the impact of Flagship innovations and services. There were limitations on the extent to which a performance evaluation could measure the efficiency of prevention interventions, although qualitative-based findings have been made.

PROJECT BACKGROUND
The five-year (2012–2017), $30 million USAID HIV/AIDS Flagship Project is implemented by a consortium of KHANA (prime) and FHI 360 and Populations Services International/Khmer (PSI/PSK). Flagship’s goal is “to enhance the impact, reduce costs, and improve the effectiveness of the national response through technical innovation and improvements in quality and capacity to deliver sustainable
HIV services.” The project’s four main areas of work are to foster local capacity in (1) designing technical innovations to enhance the impact of targeted HIV prevention for KPs, (2) improving the quality and integration of HIV care and treatment services, (3) strengthening the use of strategic information, and (4) strengthening local organizational and institutional capacity.

Flagship’s main sites are Phnom Penh, Siem Reap, and Kampong Cham, where it supports civil society organizations (CSOs) and ART Clinics working across the continuum of prevention to care and treatment (CoPCT). Flagship also provides TA to CSOs working in Global Fund (GF) sites in three provinces to replicate Flagship innovations and achieve scale-up. The project is aligned with the work of Cambodia’s National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Disease (NCHADS). Cambodia’s achievements in HIV control have positioned it to be the first lower-middle-income country capable of virtually eliminating HIV transmission by 2025. To realize this aim, considerable work is still to be done.

**FINDINGS AND CONCLUSIONS**

**Question 1: Prevention and HIV case detection innovations**

The signature achievement of the Flagship project has been the massive scale-up of community-based finger-prick HIV testing administered by outreach workers (OWs). Through June 2016, Flagship’s implementing partners had administered 58,285 finger-prick HIV tests to KPs. However, the yield has been extremely low at 0.44 percent. Reasons for the low yield are the lack of data to guide targeting of KP subgroups with high-risk behaviors and an outreach model with limited reach to some KP segments. In light of the low yield, which was apparent in Year 1, Flagship should have moved to adjust its approach. Introduction of the peer-driven intervention (PDI+) for HIV case detection in Year 4 was a positive step but was delayed. Problems with how Flagship adapted PDI+ for Cambodia demonstrate a lack of familiarity with proven approaches in other settings, the time taken to adapt those approaches, and perhaps an inclination to over-engineer the approach.

The roles, responsibilities, and expectations of OWs, the linchpin for prevention activities, have increased significantly. Their low pay has made it difficult to recruit suitable personnel and turnover rates are very high. The model is no longer functional. There has been no action to address this longstanding problem. There is an urgent need to redesign the role of OWs to focus on a cross-cutting, community-based initiative on case detection and support for prevention, testing, and treatment that is tightly focused on the KPs at greatest risk.

Risk-tracing snowballing (RTS), using peer seeds and waves of referrals, has been piloted over a number of phases at two Flagship-supported clinics, with a yield of new HIV diagnoses ranging from 3.1 – 4.7 percent. Despite its superior yield, RTS has not been scaled up at other facilities.

The validity of Flagship’s pilot tablet-based screening tool to assess HIV risks is questionable in the light of the extremely low yield from HIV testing. The tool is another example of a slow and over-engineered approach to development, improvement, and rollout of an intervention. Collection of case profile data to improve HIV case detection commenced only in Year 4. The data collected are not currently being used at either site or project levels.

Flagship successfully contributed to the development of the NCHADS guidance note on HIV partner tracing and related training of its implementing partners (IPs). There has, however, been limited success in tracing and testing partners, due largely to client reluctance to assist in tracing.

Overall, it appears that condom access in Cambodia is reasonably good. Flagship reports distributing about 1.5 million condoms a year (on target) – 85 percent through social marketing and 15 percent through free distribution by OWs. Limits on Flagship distribution of free condoms, combined with
condom price sensitivity for TG, MSM, and low-earning EWs, may be limiting access to condoms for some KPs.

Branded prevention programming has provided an integrated and inclusive approach to service delivery and behavior change for KPs. There is a need to update the approach to better align with current behavioral dynamics, (e.g., more effective use of social media, decreased emphasis on place-based activities, and increased demand for more personalized services/support).

There is no evidence that the project has developed a culture of innovation in the field, where knowledge of challenges and opportunities is most on point. The overly prescriptive nature of NCHADS standard operating procedures (SOPs) has limited innovations by Flagship and its IPs.

**Question 2: Care and treatment services**

Flagship’s TA support for case management has played a critical role in strengthening links between community and facility-based HIV services and yielded impressive results across the HIV treatment cascade. For example, through June 2016, over 90 percent of KPs with reactive finger-prick test results completed confirmatory testing. All 227 KP clients with positive confirmatory tests were enrolled in care. Loss to follow-up (LTFU) for KP enrolled in care dropped from 38 percent in Year 1, to 4 percent in Year 4. IPs reported that TA from Flagship contributed significantly to the effective operation of case management systems, including integration of community and facility-based case management through the Group of Champions, which was confirmed by field observations.

Significant cost efficiencies for clinics and CSOs could be achieved through a national differentiated-care approach for stable and non-stable patients. Flagship is undertaking a pilot on differentiated care.

Flagship data for Years 3 and 4 indicate that the loss rate for confirmatory HIV testing for EWs and LTFU from HIV treatment was significantly higher than for other KPs. Challenges are the adverse economic impact on EWs of an HIV diagnosis and their mobility. No project level analysis of these challenges and no adjustments to programming have been made.

Data for three Flagship-supported sites in Year 3 indicate that over 90 percent of eligible patients accessed viral load (VL) testing and that 96 percent of those achieved viral suppression.

Flagship TA to integrate referral to family planning (FP) and support direct provision of FP, was highly rated by implementation staff interviewed by the evaluation team. Site-level data indicate that utilization of FP methods by EWs is low (e.g., 27 percent in Siem Reap in Year 3). In Year 4, Flagship halted social marketing of FP products at Drop-in Centers (DICs) and in high-risk venues in favor of referrals – a step that is likely to exacerbate the already low uptake of FP.

Gender-based violence (GBV) and human rights have been weakly integrated into the project.

**Question 3: Project effectiveness at scaling up proven innovative HIV interventions**

Flagship’s rollout of active case management is the best example of successful scale-up. The scale-up of community-based finger-prick HIV testing was significant but diminished by the very low rate of case detection. The inability to scale-up more effective case-detection approaches (e.g., RTS and PDI+) to supplement finger-prick testing is a good example of how Flagship struggles to identify solutions to problems and take them to scale on an accelerated schedule.

Although the Center of Excellence (CoE) provided limited TA to other sites, its contribution to expanding the reach or improving the performance of other sites appears to be minimal. The PEPFAR pivot effected scale-up by limiting the overall reach of Flagship activities. Flagship TA to Global Fund sites had minimal impact due to limited funding and a lower level of TA than in Flagship’s core sites.
The reports of the HIV Innovate and Evaluate Project (HIEP) include recommendations that could improve the performance of the Flagship project. The delay in awarding the HIEP contract delayed the work, limiting opportunities for adoption of findings. There is no clear strategy in place to translate HIEP recommendations into actions to improve project or site-level work.

**Question 4: Effectiveness of organizational and institutional development (OID) TA**

There are no comprehensive quantitative data to measure the impact of Flagship OID TA. However, CoE staff consistently reported high levels of satisfaction with Flagship’s OID TA in all areas, especially financial management. The improvements described by Flagship CoE have resulted in stronger organizations, which contributes positively to their sustainability through more efficient and effective internal systems. The key gap in Flagship OID TA was in the area of financial sustainability and fundraising. Flagship OID TA has primarily been confined to a standard menu. Flagship has not taken the opportunity to address other OID issues of critical importance, such as the outreach worker model, which is generally recognized as broken.

**Question 5: Effectiveness of strategic information capacity building**

One of Flagship’s key achievements has been improved capacity at site level to generate and report on data. However, data presented from Direct Service Delivery- (DSD) and GF-supported sites, and data provided by Flagship itself, varied in quality and contained inconsistencies across reporting periods and data sets. At most sites, as well as IP and provincial levels, capacity to analyze data, draw lessons learned, and apply those lessons to strengthen programs was limited. There has been no analysis of gaps along the cascade and LTFU by KP; nor have strategies been developed to address differential gaps and LTFU across KPs.

**Recommendations**

Following are the recommendation with the highest priority; other recommendations can be found in the main body of the report.

1. Reduce the number of community-based finger-prick tests being done by IPs. The absolute priority should be to test individuals who do not know their HIV status and who are at the greatest risk of infection due to their behaviors.

2. Identify ways to improve the conditions and the performance of the OW cadre, including compensation and responsibilities.

3. Move quickly to implement RTS in more facilities and implement PDI+ in more communities.

4. Support NCHADS to complete designing and implementing a differentiated model of care for PLHIV to lessen the burden on community and facility-level case managers and doctors and target those PLHIV who require support.

5. Engage proactively in the development of the next GF concept note to leverage the lessons from Flagship and design an improved approach to scale up.

6. In the final year of the project, Flagship’s OID support to CoEs and IPs should focus on strengthening the financial sustainability and social entrepreneurship of CSOs.
1. INTRODUCTION

This was an endline evaluation of the five-year, USAID/Cambodia HIV/AIDS Flagship Project being implemented under a Cooperative Agreement by the Khmer HIV/AIDS NGO Alliance (KHANA), its two consortium partners, FHI 360 and Population Services International/Population Services Khmer (PSI/PSK), and sub-recipient nongovernmental organizations (NGOs), with a budget of $30 million. The life of the project is from November 2012 to November 2017. An overview of the project is in Section 2 of this report.

PURPOSE OF THE EVALUATION

The purpose of this evaluation was to

1. Assess the project’s performance and the extent to which it has been able to meet its intended objectives.
3. Make recommendations to inform and improve future program directions and effectiveness.

The evaluation covered the period from project commencement in November 2011 to June 30, 2016. The scope of work for the evaluation is set out in Annex 1.

EVALUATION QUESTIONS

The questions to be answered by the evaluation are

1. Which of Flagship’s HIV prevention innovations and services for key populations (KPs) (entertainment workers [EWs], men who have sex with men [MSM], transgender people [TG], and people who inject drugs [PWID]) are high-impact and efficient in detecting new cases of HIV, increasing access to condoms, and increasing uptake and yield of HIV testing among underserved and neglected groups (EWs, MSM, TG, and PWID)?
2. How effective was Flagship’s technical assistance (TA) in improving the quality and integration of HIV/AIDS care and treatment services and of the Integrated Active Case Management approach: tracking referrals from the community to health facilities, monitoring the care and treatment cascade and enrollment on antiretroviral therapy (ART), adherence and viral suppression, and reducing lost-to-follow up (LTFU) cases?
3. How effective was the project at scaling up proven innovative HIV prevention, care, and treatment interventions? How have the studies/evaluations conducted by the HIV Innovate and Evaluate Project (HIEP) been used to determine which innovations should be replicated and to improve the Flagship project?
4. How effective was the consortium’s approach to sustainability and organizational development, including strengthening the financial management, program management, and technical implementation capacity of the government, local NGOs, networks of key populations (EWs, MSM, TG, PWID), and PLHIV at the national, provincial and community levels?
5. How has the project built local capacity to understand and effectively use service delivery data to plan and monitor progress of the HIV cascade and the continuum of prevention, care, and treatment services?
EVALUATION METHODS

The evaluation was designed to comply with the USAID Evaluation Policy (2011) and the US President’s Emergency Plan for AIDS Relief (PEPFAR) Evaluation Standards of Practice (2014). The evaluation is consistent with USAID’s definition of a performance evaluation and PEPFAR’s definition of a process evaluation. A full description of the evaluation design and methodology can be found in Annex 2. The evaluation was conducted by a seven-member team, consisting of three international consultant specialists in the areas of HIV, capacity and organizational development, and evaluation; two HIV technical experts from USAID; two local evaluators; and a logistics assistant. It took place between July and November 2016, with field work from August 22 to September 12.

The key components of the methodology are outlined below.

Document review: Background documents provided by USAID and the Flagship Project were reviewed and analyzed, among them the Cooperative Agreement; project work plans and progress reports; PEPFAR’s Cambodia Strategic Direction Summary and Country Operational Plan (COP); HIEP research reports; and guidelines and standard operating procedures (SOPs) of the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Disease (NCHADS). A full list of documents reviewed is in Annex 6.

Performance data: Data from Flagship’s Performance Monitoring Plan (PMP) were analyzed to identify outputs and outcomes relevant to the evaluation questions. Trends in performance data were examined and performance was assessed against targets. Where data were missing or where disaggregated data were preferred, the evaluation team requested that the project provide specific data, where possible.

Qualitative data collection: Interviews were held concurrent with visits to Flagship sites with Flagship’s Joint Technical Team, technical staff from consortium partners, and staff of NGOs and health facilities that were project implementing partners (IPs). Clients of Flagship-supported services participated in focus group discussions (FGDs) during site visits. Interviews and discussions were held with staff of USAID, PEPFAR, and the Centers for Disease Control and Prevention (CDC), national and provincial health authorities, and international development partners at the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). Such consultations were conducted in Phnom Penh and each of the five provinces where the Flagship Project is working. Flagship site selection gave priority to Center of Excellence (CoE) implementing sites that were receiving funding for direct service delivery. The evaluation team also visited Global Fund (GF) sites receiving Flagship TA. Site selection also ensured a mix of sites covering all of the KPs (EW, MSM, TG, and PWID). Interview guides are in Annex 3, and people and organizations consulted are listed in Annex 4. All people interviewed provided informed consent first.

Analysis: A thematic review of qualitative data from interviews and FGDs connected the data to the evaluation questions, focusing on relationships, context, interpretation, nuances and homogeneity, and outliers in relation to key informant views on the evaluation questions. Qualitative data substantiated quantitative findings derived from project reports, HIEP research reports, other assessments and analyses conducted by the project, and the PMP; it also provided more insights and context than quantitative data could provide and answered questions where no other data were available. At the conclusion of data collection, the evaluation team triangulated all sources of information from document review, the PMP, and key informant interviews to draft preliminary findings and conclusions. For

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1 The USAID technical expert team members were Billy Pick from the Office of HIV/AIDS, Washington, DC, and Michael Cassell from the Office of Public Health, Regional Development Mission Asia.
validation and feedback these were presented at debriefing meetings to USAID, PEPFAR, and the Centers for Disease Control (CDC); the Flagship Project and its IPs; and other stakeholders.

Limitations: The main limitations for this evaluation were these:

1. There were limitations on the extent to which the efficiency of Flagship prevention innovations could be measured by a performance/process evaluation (Question 1). The evaluation team was, however, able to make findings on efficiency based on qualitative data.

2. Within the time and resources available it was not possible for the evaluation team to collect quantitative data other than that provided by the project. This limitation was minimized by comparing the analysis of other data, where relevant, against project data.

3. The evaluation was a rapid appraisal, with limited scope and time to validate findings and conclusions. Rapid appraisals have, however, proven very effective in identifying good performance and areas for improvement. The team sought to validate preliminary findings and conclusions through three debriefing meetings at the end of the field work and seeking feedback on the draft evaluation report.

4. As Flagship IPs may have had influence over which clients were present at project sites when the team visited, there may have been some bias in the client data collected.
2. PROJECT BACKGROUND

KEY CONTEXTUAL ISSUES

Cambodia is one of the few countries that has successfully reversed its generalized epidemic. It is estimated that HIV prevalence peaked at 1.7 percent in 1998 and by 2015 had declined to 0.64 percent.\(^2\) Higher prevalence is found among KPs: 2.3 percent among MSM; 5.7 percent among TG; 4 percent among low-risk EWs; 13.5 percent among high-risk EWs; and 24.8 percent among PWID.\(^3\) Among adults, the estimated number of deaths from AIDS in 2015 was 2,042, with 651 new HIV infections.\(^4\)

National HIV cascade data for 2015 indicates good progress in achieving the 90-90-90 targets. An estimated 83 percent of all People Living with HIV (PLHIV) have been diagnosed, and 91 percent of those diagnosed are on antiretroviral therapy (ART).\(^5\) While only 64 percent of PLHIV on ART had documentation of viral suppression, of those who were viral load-tested, 93 percent were virally suppressed. By 2017, additional viral load machines will provide capacity to test all PLHIV on treatment. Analysis of partial cascade data for KPs in 2015 indicates that progress against the 90-90-90 targets for all four KPs (MSM, TG, EWs, and PWID) is trailing the general population in relation to ART initiation and/or retention.\(^6\)

Cambodia’s achievements in HIV control have positioned it to be the first lower-middle-income country capable of virtually eliminating HIV transmission by 2025. To realize this aim there is, however, still considerable work to be done. A key priority is to identify, reach, and HIV-test the estimated 15,000 PLHIV yet to be diagnosed. This is challenging because information on their risk profile is limited. Other priorities for Cambodia’s HIV response are improving the effectiveness of prevention programming; early diagnosis and treatment of HIV and HIV/tuberculosis (TB) co-infected people; improving ART coverage in underserved areas and for KPs; better epidemiological targeting, including finding hard-to-reach and high-risk KPs; reducing stigma in health services and creating a supportive policy and legal environment; stronger follow-up along the cascade; improving the quality of care and treatment; greater synergies between the HIV response and other parts of the health sector; and strengthening long-term sustainability so success is not ephemeral.\(^7\)

Cambodia’s Strategic Plan for HIV/AIDS and STD Prevention and Control 2016-2020\(^8\) has three core components:

1. **Boosted Continuum of Prevention to Care and Treatment (B-COPCT):** identify and reach new infections and ensure they are brought into and retained in treatment, with a KP focus.

2. **Boosted Continuum of Care (B-COC):** retention and improvement of quality for PLHIV in care.

3. **Boosted Linked Response (B-LR):** targets elimination of new infections among children and responding to the needs of their mothers.

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\(^3\) Ibid, p. 8.

\(^4\) Ibid, p. 6.

\(^5\) Ibid, p. 9.

\(^6\) Ibid, p. 10.


The Boosted Integrated Active Case Management (B-IACM) approach integrates all three strategies and is designed to identify, reach (i.e., finding HIV cases), intensify, and retain individuals (i.e., Identify, Reach, Intensify and Retain or IRIR) along the prevention, testing, and care and treatment continuum from contact with an outreach worker through ART enrollment and retention. There is a particular focus on finding HIV cases, reducing loss to follow-up (LTFU), targeting testing strategies to KPs, and partner tracing. In September 2016, Cambodia introduced Test and Start for all PLHIV.

The major financiers of Cambodia’s HIV response are the Global Fund (48 percent), PEPFAR (25 percent), and the Royal Government of Cambodia (27 percent). Donor funding has declined in recent years and is expected to continue to do so.

OVERVIEW OF THE USAID/CAMBODIA HIV/AIDS FLAGSHIP PROJECT

The five-year, $30 million Flagship Project commenced operations in November 2012 and will close in November 2017. The Cooperative Agreement was awarded to the Khmer HIV/AIDS NGO Alliance (KHANA), a national civil society organization (CSO), which leads a consortium of FHI 360 and Population Services International/Population Services Khmer (PSI/PSK).

Flagship’s overarching project goal is “to enhance the impact, reduce costs, and improve the effectiveness of the national response through technical innovation and improvements in quality and capacity to deliver sustainable HIV services.” The goal is to be achieved through achievement of four objectives:

1. Foster local capacity to design and showcase innovative, evidence-based, state-of-the-art, replicable, and cost-effective technical HIV innovations to enhance the impacts and reduce the costs of quality targeted HIV prevention for KPs.
2. Foster local capacity to improve the quality and integration of HIV care and treatment services, building on Cambodia’s successful continuum of prevention to care and treatment (CoPCT) model for KPs, PLHIV, and their partners.
3. Foster local capacity to strengthen the use of strategic information, including for surveillance, monitoring, evaluation, and data utilization, to inform program improvement and the efficient placement and utilization of resources.
4. Strengthen local organizational capacity to ensure that local partners can lead in scale-up of Flagship innovations.

Flagship aims to reduce Cambodia’s financial dependence on the United States Government (USG) for its HIV response and support the transition of PEPFAR funding from service delivery to TA.

The project is fully aligned with NCHADS strategic directions and follows NCHADS SOPs.

Flagship’s main sites are Phnom Penh and the provinces of Siem Reap and Kampong Cham, where the project has established and is building the capacity of CoEs to develop and test high-impact and cost-effective technical innovations targeting KPs and PLHIV. The CoE model is central to Flagship’s mandate to transfer skills to local partners. CoEs are also intended to provide a foundation for evidence-informed programming for future HIV financing. So far 16 CoEs have been established – seven focusing on prevention among KPs, new case detection, and linkages to care and treatment; two with a community care focus; and seven with an HIV clinical focus. The prevention-oriented CoEs are managed by five Cambodian CSOs and the community care CoE by two Cambodian CSOs’ the clinical CoE is located in a mix of referral and district hospital ART clinics and CSO ART clinics.
Flagship assessed the organizational and technical capacities of CoE IPs to inform plans for TA to build their capacity to implement innovations and become technical leaders. The intention, at the midpoint of the project, was to transition the CoEs to technical hubs (THs). The plan was for THs to play an increasing role in innovation, design, and transfer of skills and capacity to more recently formed CoEs and to take the lead in providing provision to other IPs both within and beyond the Flagship Project. The longer-term objective was for THs to play a significant role in TA provision under other funding mechanisms as the presence of international NGOs declined. However, the plan to establish TH did not proceed.

The Flagship consortium partners are also providing TA to Cambodia’s national HIV program and to CSOs working in Global Fund sites in Battambang, Banteay Meanchey, and Pursat provinces, with the intention of replicating Flagship innovations in non-CoE sites to achieve scale.

Under a separate award, USAID established HIEP to conduct in-depth evaluations of various aspects of the Flagship Project. The work of the HIEP is discussed in Section 3 under Scale-up.
3. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

PREVENTION INNOVATIONS AND SERVICES

Evaluation question 1: Which of KHANA’s HIV prevention innovations and services for KPs (EW, MSM, TG, PWID) are high-impact and efficient in detecting new cases of HIV, increasing access to condoms, and increasing uptake and yield of HIV testing among underserved and neglected groups (EWs, MSM, TG, and PWID)?

Introduction

The focus of Flagship has been to “develop and test new technical innovations” targeting EWs, MSM, TG, and PWID. Over the life of the project, Flagship has implemented a wide range of HIV prevention and testing activities at national and subnational levels. However, its signature achievement has been the massive scale-up of community-based HIV testing using finger-prick testing administered by lay counselors. Although NCHADS had approved use of this testing approach before Flagship was launched, the project has made rapid HIV testing available to the four key populations in communities where they live and work. According to project data, the combined network of Flagship direct service delivery (DSD) sites and Global Fund-supported sites, which receive TA from Flagship, had administered 58,285 finger-prick HIV tests through June 2016.

Finger-prick testing

NCHADS published its current Standard Operating Procedures for HIV Testing and Counseling in September 2012. This document authorized rapid, on-site HIV tests using a finger-prick specimen and conducted by health-care providers or trained lay personnel. Flagship took advantage of this SOP to train field staff and outreach workers (OWs) to administer finger-prick tests and launch KP-focused community-based testing. In Years 1 and 2 of the project, Flagship tested only EWs and MSM, with TG included under MSM. Beginning in Year 3, testing was expanded to include TG as a specific population and PWID.

The Flagship decision to launch a large-scale, community-based testing initiative targeting KPs appears to have been based on the belief that it would identify a sizable number of the undiagnosed in Cambodia and get them enrolled in pre-ART or ART programs. Unfortunately, it is widely recognized that the yield from the approach has been extremely low. It has also been consistently and markedly lower in Global Fund (GF)-supported than in Flagship DSD sites (see Table 1). The most plausible explanation for the better performance in DSD sites is the higher level of resources available at these sites to identify and reach clients, including a wider array of activities, more staff, and more training.

A separate but parallel dichotomy between sites supported by the Global Fund and Flagship is how testing is monitored. GF-supported sites use an indicator to count the total number of tests, whereas Flagship sites monitor testing yield – i.e., the percentage of reactive tests. This creates different priorities in the different types of sites and complicates interpretation of the monitoring data across sites (e.g., performance comparisons between GF-supported and Flagship sites).

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Table 1. Number Tested, Number Reactive and Yield, Direct Service Delivery Sites (DSD) and Global Fund / Technical Assistance Sites (GF/TA), by Project Year (Data provided by the Flagship project)

<table>
<thead>
<tr>
<th>Year</th>
<th>Tested DSD</th>
<th>Reactive GF/TA</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1: Tested</td>
<td>8,974</td>
<td>NA</td>
<td>8,974</td>
</tr>
<tr>
<td>Year 1: Reactive</td>
<td>30</td>
<td>NA</td>
<td>30</td>
</tr>
<tr>
<td>Year 1: Yield</td>
<td>0.33%</td>
<td>NA</td>
<td>0.33%</td>
</tr>
<tr>
<td>Year 2: Tested</td>
<td>4,191</td>
<td>13,149</td>
<td>17,340</td>
</tr>
<tr>
<td>Year 2: Reactive</td>
<td>25</td>
<td>37</td>
<td>62</td>
</tr>
<tr>
<td>Year 2: Yield</td>
<td>0.60%</td>
<td>0.28%</td>
<td>0.36%</td>
</tr>
<tr>
<td>Year 3: Tested</td>
<td>2,990</td>
<td>11,747</td>
<td>14,737</td>
</tr>
<tr>
<td>Year 3: Reactive</td>
<td>31</td>
<td>42</td>
<td>73</td>
</tr>
<tr>
<td>Year 3: Yield</td>
<td>1.03%</td>
<td>0.36%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Year 4: Tested</td>
<td>4,581</td>
<td>12,653</td>
<td>17,234</td>
</tr>
<tr>
<td>Year 4: Reactive</td>
<td>53</td>
<td>36</td>
<td>89</td>
</tr>
<tr>
<td>Year 4: Yield</td>
<td>1.16%</td>
<td>0.28%</td>
<td>0.52%</td>
</tr>
<tr>
<td>Total: Tested</td>
<td>20,736</td>
<td>37,549</td>
<td>58,285</td>
</tr>
<tr>
<td>Total: Reactive</td>
<td>139</td>
<td>115</td>
<td>254</td>
</tr>
<tr>
<td>Total: Yield</td>
<td>0.67%</td>
<td>0.31%</td>
<td>0.44%</td>
</tr>
</tbody>
</table>

Over the life of the project, yield has improved among DSD sites but fluctuated in Global Fund-supported sites. And, while overall yield has improved slightly over the course of the project, it has not led to significant numbers of new people on treatment. According to Flagship data, the 58,285 finger-prick tests led to only 254 reactive HIV tests and total of 227 people enrolled in pre-ART or ART programs; however, although the testing yield was low, the pre-ART/ART enrollment was high: 89.3 percent.

Based on discussions with Flagship staff and IPs in the field, one of the reasons for the poor yield is the lack of data on KP sub-groups and the behaviors that put them at greatest risk of HIV infection. Consequently, many of the people tested do not actually have a heightened risk of HIV infection. The lack of data, which includes limited availability and use of partner-tracing and case-profiling data, makes it difficult for field and outreach staff to identify and test people outside of the known—and generally lower-risk—groups already reached by the project. In addition, the outreach model that drives the Flagship approach has not been able to move beyond the working-class or low-income people who have been traditionally reached by KP programs in Cambodia (e.g., the USAID-funded PRASIT project). It is worth noting that NCHADS guidelines that all KP members be tested at least twice a year has contributed to the problem by presuming, for example, that all gay men or EWs are at equal risk of HIV infection.

Field and outreach staff recognize the need to reach new KP segments where HIV risk and infection is greater. For example, they recognize the changing nature of sex work in Cambodia with apps and mobile phones to make connections outside of the entertainment venues and street locations where they focus their outreach efforts. They also repeatedly cite their inability to reach “high-society” members of MSM populations who they believe are at heightened risk.

Flagship has not been able to reach what are often referred to as “old” infections in Cambodia (i.e., people infected previously who are not currently on treatment or were never diagnosed). One of the challenges is whether and how a project focused on key populations should be finding and testing these people. Data from provincial hospitals indicates the vast majority of new HIV cases who walk in for testing in these locations are from the general population. For example, according to data provided by the provincial hospital in Battambang City, 177 of 204 of their walk-in cases in 2015–2016 (87 percent)
self-identified as general population. This self-identification does not preclude them from being current or past KP members, particularly given that risk elicitation and KP identification are not always straightforward in Cambodia. However, the high percentage of walk-ins who self-identify as general population does reinforce the belief that Flagship is not reaching them. The important question is whether or not it is in Flagship’s current remit to address people in the undiagnosed fraction who do not self-identify as members of a key population.

The main concern about the consistently low yield of finger-prick testing is the fact that it did not lead to any significant changes or actual innovations in the approach that would improve case detection among current or former KP members. Flagship’s Year 1 Progress Report acknowledges the low testing yield and explicitly states, “It is expected that the rate will increase once finger-prick testing by lay counselors is scaled up.” While the yield did increase in the second year of the project, it was still very low. In light of the very limited improvement, Flagship should have moved quickly to adjust the approach by the end of Year 2 at the latest. Introduction of the peer-driven intervention (PDI+) approach in Year 4 is a positive step to address the low yield but it is not clear why the launch was so delayed.

Flagship now finds itself in a position where the yield from the approach is unlikely to improve during the remaining months of the project and the expectation among IPs is that they will stick with the status quo. Continuing with the same approach will further undermine the viability and value of the existing cadre of OWs. Other than to provide convenient, twice-a-year HIV testing to KP members (per the NCHADS directive), there is no compelling reason to continue with a largely undifferentiated approach to community-based finger-prick testing. It would be better to redesign the role of the outreach worker to focus more on a cross-cutting, community-based initiative on case detection and support for prevention, testing, and treatment that is tightly focused on the KP sub-groups at greatest risk of infection (see Outreach Workers below).

**Risk-tracing Snowball (RTS)**

Snowball sampling is an effective and well-established technique used to identify and connect with unknown, hidden, and difficult-to-reach populations. Its use of “seeds” and “waves” of referrals, coupled with coupons, vouchers, and other incentives, is a proven approach to expand the pool of people linked to a specific behavior or event. It has been widely and successfully deployed in the global HIV response for many years and is closely associated with respondent-driven sampling, PDI+, and contact/partner tracing. In the Cambodian context, where the parallel push to find more undiagnosed cases and the need to identify individuals and KP sub-groups whose behaviors put them at greater risk of HIV infection are both priorities, the pragmatic use of snowball sampling is an obvious and logical option.

Under Flagship, a concept note was developed in Year 1 for an RTS pilot using the Chhouk Sar clinic as the referral site. In Year 2, Flagship developed an RTS strategy, which was based on the partner-tracing snowball that had been started at Chhouk Sar in April 2012. The RTS pilot eventually began in early June 2014 and ran until late September. The pilot produced an HIV testing yield of 4.7 percent among active participants, which is more in line with the estimated prevalence among key populations. The pilot was extended in Year 3, and while the yield fell to 3.1 percent between October 2014 and September 2015, it was substantially better than the yield of the community-based model of finger-prick testing. Further modifications were made to the approach in 2015–16 (e.g., a fingerprint identification system was added) and Phase 2 of the RTS was launched in March 2016 with the approval of a research protocol the National Ethics Committee for Health Research (NECHR) of the Ministry of Health and the Protection of Human Subjects Committee (PHSC).

Given the track record of snowball sampling globally and its proven ability to reach targeted populations, including in the RTS pilot at Chhouk Sar, it is not clear why Flagship did not move more quickly to scale
up the use of RTS in other facilities. Given its superior yield, RTS should have been considered an essential complement – or potential replacement – for the limited case-finding of the community-based approach to testing.

Ironically, the NCHADS Concept Note on Sharpening the Boosted Continuum of Prevention to Care and Treatment (B-CoPCT) for Key Populations at Highest Risk in Cambodia, published in April 2014, advised use of snowballing as a rapid response method when programs are “missing populations at very high or overlapping risk.” For RTS to be continuing as only a research project at a time when Cambodia needs to improve its capacity to detect HIV cases is a significant missed opportunity to both prevent new infections and reduce the number of undiagnosed infections.

**Peer-driven Intervention (PDI+)**

PDI+ is essentially the translation of the facility-based RTS into a community-based model for connecting with unknown, hidden, and/or difficult-to-reach populations. PDI+ is widely used globally in multiple contexts and its efficacy is well established. Flagship launched its version of PDI+ in August 2016. According to Flagship staff, it is based on a model developed and used by the Alliance for Public Health in Ukraine, a close affiliate of KHANA within the International HIV/AIDS Alliance.

The concept note linked to the PDI+ pilot had a number of shortcomings that were well documented by USAID in its comments on the note. Critical decisions in the Flagship approach to PDI+ undermined the fundamental goal of a peer-driven intervention, which is to reach people who have not been reached by other approaches. For example, the decision to not simply adapt the approach used so successfully in the Integrated Biological and Behavioral Surveys (IBBS) in Cambodia for MSM and TG populations did not make sense; nor did the decision to focus PDI+ on the venues and hotspots where Flagship is already working and already struggling to identify HIV cases.

Discussions with the Flagship prevention team highlighted a number of other restrictions in the design and implementation of PDI+ that could undermine its effectiveness if it were to be scaled up in its current form. For example, the Flagship prevention team reported there are no protocols to provide vouchers to referred individuals to extend recruitment chains through their networks. This restriction essentially eliminates the “snowball” functionality of the approach, which is its greatest strength. Flagship staff said they intended to pursue an approach that allowed for multiple recruitment waves but were discouraged from doing so by both NCHADS and USAID. (In a follow-up discussion with USAID, the agency said it had not placed any such restriction on Flagship.)

The PDI+ development team recognized the importance of the incentive payment; for example, they felt it was useful in helping people to underwrite the cost of travel to service delivery sites. However, there was also an inordinate level of concern about people abusing the system to unfairly or improperly earn the incentives for referrals. This concern has led to a great deal of convoluted thinking and planning about how to structure the incentives to prevent this situation from happening. Given the major investment in conducting tens of thousands of finger-prick tests that have yielded so few cases and the success of incentive approaches in other countries and settings, the level of concern about incentives seems unwarranted and could limit the effectiveness of the PDI+ approach.

By the Flagship team’s own admission, the quest to design a foolproof approach means it will take at least another year to refine and demonstrate the value of PDI+. This is another example of how a lack of familiarity with proven approaches in other settings, a lack of willingness to quickly adapt approaches from other settings, and/or an inclination to over-engineer a project-specific approach delays implementation in Cambodia. For example, there is an obvious opportunity to learn from and collaborate with the LINKAGES team in Thailand, which is developing a comparable PDI+ approach that
is being tested in Chiang Mai; the pilot found that individuals referred by peers were more than twice as likely to test positive for HIV than those reached by community-based support staff.

The development and deployment of PDI+ is further complicated by the fact that NCHADS wants to introduce it slowly, further delaying the likelihood of improving the rate of HIV case detection. Based on NCHADS input, PDI+ will initially be used with MSM, TG, and PWID; it will not be used with EWs because NCHADS believes case-finding rates among this population have been “improving.” It also has concerns about the sustainability and scalability of PDI+ with Global Fund and domestic resources. However, in light of the long-standing underperformance of the current community-based approach to testing, there is a strong case — and there should be strong motivation — to find HIV cases by pursuing higher-yield options such as PDI+ and RTS, which can also reach a wider population. Without a shift in case-detection strategy, virtual elimination of HIV is unlikely to be achieved.

The Flagship team is finalizing some initial performance and costing assessments on PDI+. The team is expecting favorable performance findings. Ironically, the team is now worried about excessive repeat testing with PDI+, although they don’t seem as concerned about the same problem with the community-based approach. Consequently, they are considering adding the fingerprint option that was developed for RTS, despite the fact that this is likely to further delay deployment of PDI+.

**Risk-screening Tool**

Straightforward screening tools that help individuals rapidly and accurately assess their risks of HIV infection are a powerful way to improve case detection and the uptake of targeted HIV prevention. Globally, there are many different risk screening and assessment tools — both paper-based and technology-driven — that have been proven their value. Examples that may be useful to assess include tools developed by organizations as diverse as the AIDS Council of New South Wales, the CDC, and Gilead.10

The original Flagship-version of a risk-screening tool was paper-based and introduced in Year 2. Concerns about the ability of CoEs to track the data from the tool led to development of a tablet version11 that could aggregate and store data electronically. Piloting of the tablet version began in Year 3 and a slow rollout of it began in Year 4. One of the key data points from the original pilot testing in Siem Reap was the high percentage of screened individuals who were identified as high-risk (see Table 2). However, the validity of these risk assessments is questionable in light of the extremely low yield of Flagship’s HIV testing with the same people.

<table>
<thead>
<tr>
<th></th>
<th>High-risk</th>
<th>At-risk</th>
<th>Low-risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>TG</td>
<td>78%</td>
<td>1%</td>
<td>18%</td>
</tr>
<tr>
<td>MSM</td>
<td>59%</td>
<td>11%</td>
<td>30%</td>
</tr>
<tr>
<td>EW</td>
<td>49%</td>
<td>25%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Discussions with field and outreach staff who have recently used or are currently using the tablet produced similar findings: A very high percentage of people who are screened continue to be identified as high-risk in locations where case detection is extremely low, despite the fact that the tool was revised after the original pilot testing. The most disturbing reports were about a small number of people

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11 The original paper-based version was targeted solely at EWs and had questions on non-HIV issues, such as abortion. The tablet version has an HIV focus and covers all the key populations.
screened as low-risk who then had a reactive test for HIV. Both findings raise serious questions about the design and calibration of the tool. It should be noted that the lower KP prevalence rate and high ART coverage can reduce the effectiveness of risk screening in Cambodia.

The fact that the tool is not sufficiently refined to accurately differentiate risk decreases the ability to target prevention messages that are most relevant to individual clients. In addition, IPs report the primary difference in terms of follow-up interventions for people identified as high-risk is the frequency rather than the content of messaging; essentially, high-risk individuals are “counseled” every week rather than every two weeks for those who are at-risk and low-risk.

In general, the field and outreach staff who use the tool understand and appreciate the value of risk screening and the interactive nature of the tablet version. But they also have of concerns about it, including the time it takes to complete a screening, particularly in the challenging environments where they work with clients (i.e., it is significantly longer than the three minutes the introduction says it will take); the reluctance of some clients to answer honestly, which may be the reason for low-risk individuals testing positive for HIV; and the use of a high-value piece of technology in potentially unsafe settings combined with the fact that the facilities are financially responsible for replacing a tablet that is lost or stolen.

The evaluation team also had concerns about the value of the educational messaging at the end of the screening. The inability of the tool to disaggregate the “high-risk” category means that the messages are overly generic and not necessarily useful for changing risk behaviors.

Flagship’s tablet-based risk screening tool is another example of a slow and over-engineered approach to development, improvement, and rollout of a useful intervention. The approach again raises questions about why proven tools from other settings were not quickly adapted for use in Cambodia. In this case, Flagship has no data to show that a significant investment in the tool had a demonstrable impact on case detection or generated significant evidence of its contribution to prevention.

**Partner Tracing**

Flagship has played an active and wide-ranging role in the critically important activity of HIV partner tracing, ranging from support to NCHADS on drafting the guidance note on *Integrated Case Management and Partner Tracing and HIV Testing* to training on partner tracing to actual partner-tracing activities conducted by IPs. Flagship’s involvement with the drafting of the guidance note. However, despite its efforts, including expanding the role of the community case manager in Year 3 to do partner tracing, developing operational guidance, and establishing links with the Operational District (OD) case management and partner tracing structure, Flagship implementers had limited success in tracing partners and getting them to be tested.

The IPs consistently reported problems getting clients to participate in partner tracing. As a result, very little is actually done and very few partners are found. It is ironic that many of the reported problems closely mirror the challenges for uptake of partner tracing cited in the NCHADS guidance note. Variations of “disregard of consequences to contacts” were frequently cited; also cited were fear of revenge, concerns about confidentiality, unwillingness to confront sexual partners, and a lack of awareness of HIV consequences and treatment options.

In multiple locations, OWs said that KP members and their partners actually run away from them if they think they are going to be asked about their partners. The evaluation team did hear that an overzealous approach by one implementer to partner tracing led to serious breaches of confidentiality. While this may have been an isolated situation, there is a very fine line between the public health benefits of partner tracing and obligations to protect a client’s and a partner’s right to privacy.
Flagship partner tracing – and the lack of effective training and support for field teams to do it effectively – is an under-leveraged opportunity to identify HIV cases and get targeted prevention messages to people at risk of HIV infection.

**Case Profiles**

Closely aligned with partner tracing is the collection of case profiles on people newly infected with HIV. Around the world these profiles are a valuable tool in improving case detection. Flagship did not start using case profiles in community sites until Year 4 of the project. It is not clear why it was not implemented until the project was more than half over. There is some indication that the delay was due to the time invested in developing the case profile template, which reinforces the perception that process is a higher priority within Flagship than implementation.

Concerns about the delay in introducing case profiling are amplified by the fact that the data collected are not being used at either the site or project levels. As mentioned above, as partner tracing has not been a strength for Flagship, it is not surprising that case-profile data are not being used. However, the data from case profiles can be aggregated and analyzed to help identify trends in behaviors, locations, demographics, etc. and can be correlated with other data sets to improve case detection. In general, shortcomings in data use are a problem within Flagship and, related to case profiles, are another significant missed opportunity.

It is important to note that a process is underway to develop a new case profile template for use in facilities. USAID, WHO, CDC, Flagship, and other key stakeholders are involved in the development. The draft of this template is more robust than the version currently used at community level. It would be unwise to maintain two different templates; the more consistent the data collected across all sites, the more useful the data become. Since the current template has been used to inform the new version, it makes sense to use the new one in all locations once it has been finalized and approved. There are plans to test the new template in the Flagship provinces to determine how best to use it. The test will also be an opportunity to collect new – and potentially better – data on the current and historical risks associated with recently diagnosed cases.

**Outreach Workers**

A consistent theme in the evaluation team’s meetings and site visits were clear and strong complaints about the situation faced by Flagship OWs and their counterparts at GF-supported sites. There was broad agreement among management, field staff, and OWs themselves that they are seriously underpaid and significantly overworked. The same constituents also recognize that this combination of factors contributes to the high rate of turnover in the outreach cadre. High turnover creates a negative spiral for the project: New OWs require training, which is time-consuming and resource-intensive; they have limited experience, which means they are less and less effective in doing the work that needs to be done; and a high percentage of them are not retained, meaning that even newer ones must be recruited and trained.

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12 In collaboration with NCHADS, CDC also is providing technical and financial support for a case control study in Cambodia to identify the risk factors for HIV acquisition for newly identified PLHIV. This study is planned for the 12 highest-volume voluntary counseling and testing (VCCT) clinics in Cambodia based on VCCT data from January to June 2016. The data from the study are likely to provide much-needed insights into the nature and direction of the Cambodian epidemic that will allow for greater focus on the people at highest risk and the behaviors that put them at risk. Unfortunately, the findings from the study will not be available until September 2017, which is too late to have an influence on Flagship activities. But the findings should provide useful input for the future direction of the national response, especially if Flagship makes progress on scaling up RTS/PDI+ and improving risk screening, partner tracing and case profiling.
Under Flagship, tasks such as finger-prick testing, risk screening, and enhanced counseling have also increased the responsibilities and performance expectations of OWs. Discussions with them and with IPs at different Flagship sites highlighted related concerns about the lack of psychosocial support for OWs as well as safety concerns (e.g., late night work in potentially dangerous settings), the availability of essential supplies (e.g., persistent shortages of gloves for conducting finger-prick tests); venue access (e.g., lack of “official” identification cards that would give them greater legitimacy in the eyes of venue owners and potential clients); and reimbursements for reasonable costs (e.g., repairs to personal motorbikes used for work or the need to cover transport costs for a client to reach a clinic).

The challenges facing OWs are a serious concern because they are the linchpin in the implementation of activities at intervention sites. Of even greater concern is that although the challenges are longstanding, widely recognized, and well-understood, nothing significant has been done to improve the situation. For example, in the 2014 KHANA-Flagship report, *Peer-Provided HIV Testing and Counselling for Key Populations in Cambodia: Lessons Learned and Ways Forward*, under the heading “Reduce the turnover of lay counselors,” is the following paragraph:

“The high level of personnel turnover, and the additional resources required to regularly train and supervise new personnel need to be assessed, with a cost-benefit analysis comparing the provision of higher benefits and salaries to the additional resources required to regularly train and supervise new personnel. There is a need to invest more resources in improving the quality and retention of, and incentives for, lay counsellors, possibly by professionalizing the role of lay counsellors and peer case managers, and implementing a performance-based incentive scheme that rewards those who reach a specific quality benchmark for case management and number of clients reached.”

Although the report was published in 2014, there is no indication from discussions with stakeholders that the issues have been addressed. Stakeholders also continue to share their concerns about the compensation and workload with Flagship, though it is important to note that action on the core issue of compensation is constrained by the fact that the rate of pay is set in an NCHADS SOP.

As is the case with other opportunities for project improvements within Flagship (e.g., RTS, PDI+), the situation raises a series of direct questions: Why the delay? Why continue with a model that clearly is not working? If the project’s mandate is to innovate, why is that not being done in this case?

**Access to Condoms**

Overall, it appears that access to condoms in Cambodia is reasonably good, with products generally available in a wide variety of outlets, including street vendors, small shops, gas stations, and pharmacies. The shift away from a dominant, donor-supported PSI/PSK position in the condom market – down to roughly 50 percent from an 80 percent market share when Flagship was launched – has allowed other suppliers to enter the market. However, it is difficult to assess precisely how this shift has affected the key populations served by Flagship. There is anecdotal evidence that the market opportunity has been largely filled by low-cost/low-quality condoms, which do not have the same appeal to KPs as the branded condoms sold through social marketing programs and KPs have concerns about the quality and performance of the unbranded condoms. On a parallel note, the unbranded condoms being provided to Global Fund sites by NCHADS were derided by field and OWs who were interviewed during this evaluation., as unappealing to users and more prone to failure.

13 Data provided by PSI/Cambodia.

14 In a broader context, concerns by different stakeholders about the evolution and current state of condom programming in Cambodia could justify a discussion and assessment about the condom “market” in the country and the role of condoms in future USG projects.
In line with the project’s focus, Flagship has been working to ensure that condoms are available at or near high-risk venues but that appears to be a challenge, particularly given the reluctance of venue owners to stock condoms in their establishments. This reluctance can be traced to the continuing impact of the Law on the Suppression of Human Trafficking and Sexual Exploitation passed in 2008. As quoted in the HIEP final report on the Evaluation of the SMARTgirl Family Planning Integration Program in Cambodia (December 2015), the law has “created barriers to STI/HIV prevention efforts by making condom availability and accessibility more difficult for female sex workers.”

Flagship reports distributing about 1.5 million condoms a year through three channels: (1) peer-to-peer sales, (2) street-based condom sellers, and (3) condom vending machines.15 Of the total number distributed, 85 percent are sold through these channels; the remaining 15 percent are given to clients by CoE OWs. According to 2015 project data, there has been excellent on-site availability of condoms in MSM/TG project-identified hotspots (98.75 percent) but lower availability – in some cases, far lower – in other locations: 85 percent in high-risk cafes, 73 percent in karaoke establishments, 48.75 percent in clubs/bars, 35.75 percent in massage parlors, and 20 percent in beer gardens.

The low availability in the alternative venues is potentially problematic, given the reported diffusion of sex-work contacts to these types of venues. There are also general concerns about focusing too much on venues. The 2014 KHANA-Flagship report on Peer-Provided HIV Testing and Counselling said, “It appears that the traditional ‘hot-spot’-oriented outreach model currently implemented under the B-CoPCT is increasingly challenged to find, understand, and deliver relevant services to individuals with the greatest needs and highest risks.”

Both Flagship- and GF-supported sites do provide a limited number of free condoms to clients. For higher-risk clients who have more partners per week, the number of free condoms is fewer than the average number of partners, which forces them to purchase condoms (in interviews in the field, Flagship estimated that a higher-risk sex worker has nine clients per week but it provides a maximum of only seven free condoms). According to PSI/PSK, MSM and TG are more price-sensitive than EWs but interviews indicated that price is also a concern for EWs. The common denominator across KPs is their income, with low-earning EWs also complaining about the limited availability of free condoms and the increasing price in the general marketplace. In these cases, the concern is the correlation between low income and increased risk (e.g., a potential willingness to forgo condom use for a higher payment).

NB: There were reports by GF-supported sites that the elimination of socially marketed condoms had deprived them of an important source of revenue, in addition to reducing easy access to condoms by their clients. To ensure their clients have good access to condoms, these sites buy condoms on the open market and re-sell them at their cost. At least one GF-supported site serving MSM/TG also reported never receiving lubricant for distribution to clients.

Despite the fact that condom access appears to be generally good, there are concerns that consistent condom use among high-risk populations in Cambodia is declining. For example, the IBBS on TG published in 2016 showed a marked decline in condom use between 2012 and 2016, and condom use at last anal sex was 83.9% in 2012 but only 61.2% in 2016. Other data sets highlight similar concerns among EWs, particularly those who interact with foreign clients.16 PSI/PSK believes the reduced availability of socially marketed condoms and the associated advertising and messaging has contributed to this decline.

15 According to Flagship, the potential to distribute condoms through vending machines is high. However, the project has installed only a limited number of machines and even those are currently not working because of problems accepting the country’s new currency.
PSI also reports that condom availability in massage and karaoke venues has decreased from what was already a low base.

There are also concerns that the next generation of young people have had less exposure to messages about condoms, and consequently are less likely to insist on their use. For example, the 2010 and 2014 Cambodia Demographic and Health Survey (CDHS) found lower levels of knowledge about condom use among 15–19-year-olds than 20–24-year-olds and 25–29-year-olds. While there were improvements across most age groups, both women and men, between 2010 and 2014, there was a decline among women age 15–19: 82.4% in 2010, 80.1% in 2014 (see Table 3). Parallel data about comprehensive knowledge of AIDS is potentially more worrisome; in addition to showing less knowledge among 15–19-year-olds, there were declines in knowledge among women 15–19 and 20–24 between 2010 and 2014. There were increases in this knowledge across all age groups of men but the percentages by age remain low (see Table 4).

### Table 3. Knowledge of HIV Prevention Programs: Using Condoms, Percent (CDHS 2010 & 2014)

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### Table 4. Comprehensive Knowledge of AIDS, Percent (CDHS 2010 & 2014)

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Corresponding data also raise questions about the rate of reported condom use. For example, the evaluation of SMARTgirl found that 94 percent of EWs reported using condoms during sexual activity with clients; however, according to a 2013 Behavioral Surveillance Survey (BSS), 77 percent reported having an abortion while working as an EW; this high rate of abortion undermines the validity of the reported rate of condom use. The 2013 BSS also found that many EWs do not use condoms consistently or correctly, and that women are often forced to or will accept additional money in exchange for not using a condom.

Among MSM, the HIEP Evaluation of the MStyle5656 Program for Men Who Have Sex with Men in Cambodia found that 80 percent reported using a condom the last time they sold sex in the previous three months. While this is an increase from 36 percent in 2007 and 77 percent in the 2013 BSS, the fact that 20 percent of MSM reported not using a condom when selling sex is worrying. The concern is heightened by an increase in the number of young MSM who have not had as much exposure to condom messaging as previous generations.

On a separate note, the analysis of the HIEP data found that among MSM with high exposure to the MStyle program, 24 percent obtained their most recent condom from a store, gas station, street vendor, or pharmacy; 16 percent from an MStyle OW, 16 percent from a non-MStyle OW, and 10 percent from an MStyle club. The heavy reliance on procuring condoms from OWs (32 percent) and the MStyle club (10 percent) raises questions about open market accessibility, availability of condoms at and near point-of-need, and the potential role of a social marketing program to better serve an important risk population.
For the TG community, there is positive news about condom use. The HIEP report on Srey Sros – *Evaluation of the HIV Program for Transgender Women in Cambodia* (June 2016) – found that higher exposure to either the integrated MSM/TG program or the TG-specific program had a positive impact on consistent condom use. More precisely, it also reported “consistent condom use was predicted by high exposure to the Srey Sros program.”

Flagship’s concentration on finger-prick testing at the community level appears to have limited its ability to build on a long-standing, effective condom program in Cambodia. Pushing condoms into the market is only one component of an effective program. Ensuring there is sufficient knowledge and motivation to use condoms is also important, as is a supportive enabling environment (e.g., favorable laws and policies, engaged venue owners). While Flagship reports distributing about 1.5 million condoms annually, there are gaps cracks in the condom program overall, including GF-supported sites without condoms or lubricants and others that are forced to buy condoms on the open market when they would benefit from participating in a social marketing scheme and limited reach to alternative venues. There are also shortfalls in other critical areas (e.g., knowledge, behavior change, enabling environment) that could undermine prevention efforts.

**SMARTgirl, MStyle, and Srey Sros**

Since their introduction in 2008 by the USAID PRASIT project, SMARTgirl and MStyle have played an important role in the HIV response in Cambodia. Their integrated and inclusive approach to population-specific service delivery and behavior change for EWs and MSM/TG respectively contributed to improvements in the response of these populations. The development in 2013 of Srey Sros as a TG-specific variation of the SMARTgirl/MStyle model has also improved the availability of HIV-related services for individuals in that community.

Based on discussions with IPs, site visits, and available data on the performance of the SMARTgirl, MStyle, and Srey Sros programs, there is an opportunity and perhaps a need to improve and update the approach so that it is more in sync with current behavioral dynamics, particularly among young people (e.g., expanded and more effective use of social media, decreased emphasis on place-based activities, and increased demand for more personalized services and support).

An updated approach should also reflect the declining funding for response to HIV. For example, on the one hand, fewer resources for HIV put increased pressure on stand-alone HIV interventions to clearly demonstrate the value of their services. On the other hand, fewer resources are an opportunity to embrace broader integration with other health and social services, though there is an open question of who would fund the wider array of services.

SMARTgirl, MStyle, and Srey Sros are primarily HIV interventions that serve a working-class subset of KPs at a time when members of the populations potentially at risk of HIV are also part of other social strata in the country. Even within the working-class subset, SMARTgirl and MStyle are facing declining engagement with their core constituents (e.g., fewer members in their clubs). The primary exceptions to the HIV focus are syphilis testing for all populations (with limited uptake) and reproductive-health referrals for EWs. However, among clients, there is a clear demand for additional, need- and population-specific health services at drop-in centers (e.g., hepatitis testing, treatment for sexually transmitted...

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17 While it is outside Flagship’s remit, the growing market share of low-quality/low-appeal condoms could be problematic on multiple levels. For example, low quality can undermine general confidence in condom performance; low appeal can drive up the price of preferred products; and the combination of low quality and low appeal can contribute to non-use, particularly if it reduces the availability of other products.
infections [STIs], prescription pick-up points). There is also strong interest in other types of social services, such as job training and job placement.¹⁸

IPs also recognize the opportunity to evolve their drop-in centers to help address revenue streams and sustainability. For example, they see fee-for-services (e.g., low-cost STI testing and treatment) as a potential way forward. They also see social marketing as a bridge to sustainability. One facility was interested in opening a public café in its center as a way to better use the space and generate income but were discouraged from doing so by Flagship. The general input from Flagship has been to stick to the existing model, despite clear recognition in the field that its appeal is waning.

In the mHealth sphere, the value of the SMARTgirl/MStyle/Srey Sros-branded websites does not seem worth the investment of resources, including staff time and outsourced support. The websites have limited traffic and little up-to-date content that would compel visitors to actively engage with them in ways that would contribute to behavior modification or reinforcement. (The reported 632,623 views on the MStyle website are questionable, given the comparable “likes to views” for each of the three branded sites: the ratio of likes to view is 1:207 for MStyle compared to 1:5 for SMARTgirl and 1:3 for Srey Sros.)

The evaluation team did not have an opportunity to review the Voice4U operation in detail but the usage (7,181 incoming calls between October 2015 and June 2016) as well as positive comments from IPs are a reasonable justification for continuing it. It would be valuable to do an in-depth analysis of the nature of incoming calls, the number of repeat callers, and the impact of the outgoing voice message reminders to determine if the service it is providing is worthwhile. An analysis of this type should also correlate its findings with other data points from the SMARTgirl/MStyle/Srey Sros to see if and how they are expanding the reach and effectiveness of the branded services.

**Innovation Agenda**

Attaching an “innovations” label to the prevention and testing activities supported by Flagship does not make them innovative. As mentioned above, with the exception of the scale-up of HIV finger-prick tests, all of the activities are widely implemented in multiple settings in the region and around the world. Rather than simply label activities as innovations, Flagship would have been well-served to develop and promote a culture of innovation at all levels of the project, particularly in the field where knowledge of challenges and opportunities is most on point.

Despite regular consultations with IPs, the top-down, command-and-control structure and management of Flagship actively discouraged innovation in the field. In multiple sites, field-level partners stated that they had been instructed to do precisely what Flagship demanded. In response to the direct question – “Does Flagship work for you or do you work for Flagship?” – the universal response was that they work for Flagship. They see themselves solely as implementers, not as innovators.

It is important to note that the detailed and prescriptive SOP published by NCHADS also discourages innovations by Flagship and its partners in the field. This is unfortunate because effective work with KPs hinges on adapting to changing contexts and circumstances that influence individual and community behaviors.

The lack of support for field-driven innovation, including community-led innovation, is directly reflected in Flagship decisions to continue pursuing initiatives that are clearly not working. While the low yield of HIV finger-prick testing is the most obvious example, shortcomings in other areas (e.g., seriously under-

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¹⁸ Although there is no equivalent SMARTgirl/MStyle intervention for PWID, this population, which for the Flagship project is served by Korsang, were equally interested in broader health and social services, including job training and placement.
resourced and under-performing Global Fund sites, lack of precision of the risk screening tool, declining membership in SMARTgirl and MStyle clubs, limited utility of the Flagship Unique Identification Code (UIC) have not been addressed by Flagship in meaningful ways. In addition, the slow pace of work on developing and implementing more effective activities (e.g., RTS, PDI+) is a broader reflection of a limited capacity to innovate.

**Recommendations for the Duration of the Flagship Project**

Note: Priority recommendations are in bold.

1. **Reduce the number of community-based finger-prick tests being done by iPs.** The absolute priority should be to test individuals who do not know their HIV status and who are at greatest risk of infection due to their behaviors. Low-risk individuals seeking biannual testing per existing NCHADS guidelines should be encouraged to visit VCCT sites to be tested; if a VCCT site is not readily accessible, partners should then provide the necessary service in the field.

2. **Identify ways to improve the conditions and the performance of outreach workers, including compensation and responsibilities.** The existing model for staffing outreach work is broken; continuing with it through the remainder of the project would be a waste of resources. It is not practical to fully redesign the role of OWs, given the time remaining in the project, but changes must be made.

3. **Move quickly to implement RTS in more facilities.** The current version of RTS is sufficiently robust to be implemented more broadly and on an accelerated schedule. Continued modifications and piloting reduce the ability to prove the real-world viability and value of this testing approach in Cambodia before the end of the Flagship project.

4. **Move quickly to implement PDI+ in more communities.** Based on its initial piloting of PDI+ and the proven history of the approach in multiple settings, Flagship should accelerate the rollout, possibly including variants of the approach to look at differential efficacy.

5. **Develop ways to determine whether the expansion of RTS and PDI+ is identifying HIV cases among people who currently self-identify as “general population.”** If the assumption that many of the new cases being identified at VCCT centers are former and part-time members of a KP group, it is likely that RTS and PDI+ will extend testing to individuals outside the relatively narrow confines of the KPs reached by current use of community-based testing.

6. **Identify and test other risk-screening and assessment tools to identify different strata of risk behaviors among key populations.** The limitations of the current Flagship risk-screening tool call into question the value of its continued use. In the remaining months of the project, Flagship should identify and trial existing risk-screening tools from other countries and settings to identify more accurate, precise, and effective approaches that can inform future use of them in Cambodia.

7. **Analyze and use the case-profile data that have been collected.** During Year 4, Flagship sites collected extensive data on individuals who have had a reactive HIV test. The data from case profiles have not been analyzed; doing so could help boost partner tracing, improve efforts to identify individuals and KP sub-groups at greater risk of infection, and identify high-transmission locales at both partner and project levels.

8. **Increase the number of free condoms available to clients at Flagship sites.** The gap between need and availability should be closed so clients have enough condoms. The incremental cost of providing additional condoms is low and the benefit of making them more available, particularly for clients engaged in sex work, is very high.
9. **Work with IPs and their clients to assess the strengths and weaknesses of the current drop-in center and outreach model for KPs.** There is not enough time left to re-engineer the current drop-in/outreach model but it would be useful if the project tapped the knowledge and experience of its partners and clients to begin thinking about the next generation of engagement with KPs.

10. **Flagship stakeholders should draft a series of recommendations on how to identify and reach PLHIV who may not know their HIV status or who are not accessing care and treatment services.** If the modeling is correct, there are about 15,000 PLHIV in Cambodia who have not yet been identified. Virtual elimination of HIV in the country will not be possible without getting the vast majority of these people on treatment.

11. **Flagship stakeholders should draw up a series of recommendations on how to ensure that HIV prevention remains a national priority.** Cambodian experience has shown how a strong focus on prevention can dramatically reduce the number of new HIV infections. However, global experience has also shown that neglecting prevention can lead to a resurgence of infections.

### CARE AND TREATMENT SERVICES

**Evaluation Question 2:** How effective was Flagship’s technical assistance in improving the quality and integration of HIV/AIDS care and treatment services and the Integrated Active Case Management approach (tracking referrals from the community to health facilities, monitoring the care and treatment cascade, enrollment on ART, adherence and viral suppression, and reducing lost-to-follow up cases)?

**Introduction**

The case management system that Flagship established and supported through training and mentorship has played a critical role in strengthening links between community- and facility-based services and in retaining PLHIV, including HIV-positive KP, in care. Flagship-supported community support volunteers (CSV) serve as community-based case managers who link KP to confirmatory testing and support retention of KP clients in care. At the facility-level, case management supporters (CMS), case management providers (CMP) and case management assistants (CMAs) support and track patients, supervised by a case management coordinator (CMC).

At the community level, Flagship worked with the ARV User’s Association (AUA) and Salvation Center Cambodia (SCC) to train and place CMPs in facilities, and to support links between CMPs and CSVs to minimize LTFU. Throughout the project, Flagship provided continuing support to both CSVs and facility-based case managers through annual refresher trainings, mentoring, and supervisory site visits. This support has resulted in impressive results across the HIV treatment cascade.

**Referrals from Community to Health Facilities for HIV Testing Services**

The case management system established by Flagship, together with training and mentoring for both community and facility case managers, has proven very effective at ensuring that KPs who receive finger-prick testing in communities also access confirmatory testing at facilities: During the nearly four years of the Flagship project, over 90 percent of KP clients who received finger-prick tests through Flagship-supported community-based sites, successfully accessed confirmatory testing (see Annex 5, Figure 5).

The rate of failure to reach confirmatory testing increased significantly in Year 3, coinciding with the PEPFAR pivot in 2015: in that year 100 percent of the loss to confirmatory testing occurred in GF-supported sites. Interviews at such sites found that depletion of resources at the GF-supported TA sites – resulting in loss of case managers and high turnover of OWs – significantly undermined the ability of GF-supported sites to provide effective case management s, or, in some cases, to accompany clients to confirmatory testing.
At interviews in both DSD- and GF-supported sites, service providers noted the benefits of Flagship TA in supporting effective links between community-based finger-prick testing and facility-based confirmatory testing, as did staff at the referral hospitals that provided confirmatory testing. Key elements of successful referral to health facilities cited in interviews with the evaluation team included accompanying clients to facilities and providing support to cover transportation costs – both elements of the Flagship approach.

**Enrollment in Care**

The case management system that Flagship set up and supported was very effective at ensuring that patients who accessed confirmatory testing and tested positive also enrolled in care. At the six Flagship-supported health facilities, 1,604 patients whose confirmatory tests were positive, 94.5 percent enrolled in care (data for August 2013 through June 2016). Flagship was particularly successful at supporting KP enrollment in care: Through June 30, 2016, 100 percent of Flagship-supported KP clients who accessed facility-based confirmatory testing enrolled in care (227 people). This means that KP rates of enrollment in care following a confirmatory test outstripped rates among the general population at Flagship B-IACM sites (see Annex 5, Figure 6). Over the course of the project, enrollment in care for all patients following a confirmatory test increased from 79 percent in Year 2 to nearly 98 percent in Year 3 (OD-level data) – and doctors at referral hospitals attributed the increase to the effective work of the facility-based case managers. This achievement speaks to the effectiveness of the Flagship-supported facility-based CMPs and their ties to community-based case managers: Those interviewed explained how close ties to community-based case managers engendered an atmosphere of trust that facilitated enrollment of KP patients in care.

**Retention in Care**

Reducing loss to follow up among patients enrolled in care has been one of the most important achievements of the Flagship project. Flagship has been especially effective at reducing LTFU among KP, for whom LTFU KP dropped from 38 percent in Year 1 to less than 4 percent in Year 4 (see Figure 1).

![Figure 1. Lost to Follow-Up: Referred KP Clients Enrolled in Care who were Lost to Follow-Up (excluding those who died), Percent](image)

Although patients referred from GF-supported sites consistently accounted for most of those LTFU, their numbers dropped significantly during project implementation, so that by Year 4, over 90 percent were retained in care (see Annex 5, Figure 7).
Service providers and clients interviewed during the assessment noted that Flagship-supported CMPs and CMSs based at facilities, together with the community-based CSVs, played a critical role in supporting retention in care and reducing LTFU. Case managers reported that support in drafting guidelines for implementing their work and building staff capacity and knowledge helped them do their jobs. AUA and SCC, in particular, reported benefits to case management from Flagship support, as did referral hospitals – noting frequent TA visits and the accessibility of TA support on demand. The evaluation team observed the case managers in action and noted the importance of their work: In Siem Reap, for example, where SCC had two CMSs based at the referral hospital and seven CSVs who also supported adherence, the team observed how CMSs were seamlessly integrated into facility functions, assisting and tracking patients who were attending facility-based services. When patients missed appointments, the CMSs called CSVs who were able to follow up in the community and support patients to return to services, obtain their medications, and see doctors. The Siem Reap Referral Hospital reported that this system has reduced the number of missed appointments and reported that "without this support there would have been more drop out…. When we have a problem, we just inform the SCC staff here and they reach out to their staff in the field and resolve the problem." In Phnom Penh, four facility-based CMPs from AUA support patients to register in care, refer them to FP services, and undertake case management responsibilities, including for patients who are referred from other departments in the hospital, providing counseling and following up for patients who miss appointments. AUA CMPs reported that they track patients who miss appointments, call them, and if unable to locate patients, follow-up through their partner NGOs that provide home-based care; they also offer regular facility-based group education sessions, and these, together with transportation support for patients in care to attend facility services, were reported to boost retention in care. Doctors interviewed at ART sites in Phnom Penh reported that "case management has improved over the past year with AUA support." TA prevention sites were also well-linked to facility-based case managers, such as one site in Banteay Meanchey that reported that its OWs respond to calls from the facility case manager, follow up with patients who have missed appointments, and also remind patients in advance about when they need to go to the health facility to get their ART.

Beyond direct and technical support to facilities and communities, the evaluation team also found that Flagship support to a Group of Champions (GoC)19 helped all stakeholders to coordinate their efforts to retain patients in care. In Siem Reap, the evaluation team found that the GoC was actively and effectively working to support retention in care – bringing stakeholders together weekly for a one-day meeting, which included discussion of individual cases and strategizing to reduce LTFU. GoC members reported that Flagship support had been instrumental both in establishing the GoC and in ensuring its continued functioning.

Challenges the evaluation team noted included a heavy case load for facility-based CMAs, CMPs, and CMSs. One CMS reported seeing more than 30 patients a day, and a CMA at a CDC-supported site in Battambang noted that he was actively managing about 630 ART clients from two ODs and from VCCT at the referral hospital. At Mean Chey District Referral Hospital, the CMA was in charge of data entry for 580 patients, and a CMP interviewed by the evaluation team worked with an average of 20 patients a day and also held regular group discussions of about five patients per group. Community volunteers who

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19 As laid out in the Proposed Standard Operating Procedures for operationalizing the Boosted Integrated Active Case Management-Partner Notification, Tracing and HIV Testing (IACM-PNTT) approach at operational district (OD) level in Cambodia (Final Draft July 3rd 2016), members of the Group of Champions work together to use the IACM at OD level to identify and enroll new cases in the HIV cascade, reduce loss at each stage of the cascade, and retain cases in the cascade until viral load suppression.
support adherence and retention also reported heavy caseloads: In Siem Reap, for example, SCC community volunteers reported that they are responsible for 20 to 68 patients each.

Case managers and ART site staff noted that the heavy workload is associated with an absence of differentiated care — and associated government and facility regulations that require patients to seek services in person every two months to obtain their ART, along with the requisite consultation with the doctor and associated peer counseling session — regardless of the stability of the patient or the length of time the patient has been on ART. Differentiated care and relaxation of the requirement for stable patients to attend facility-based care bi-monthly would significantly reduce the workload for case managers and ART site staff and afford staff the time to offer appropriate care to those patients who need it most.

The evaluation team also noted that activities that could lighten the workload of case managers have not been taken forward: Some case managers, for example, reported that they had suggested implementing Short Message Service support for patient follow-up but the suggestion had not been approved. Similarly, case managers at one DSD prevention site reported that they requested mobile phones to support follow-up with clients but were informed that they would have to pay for any damages to or loss of phones and did not pursue this approach. Case managers at some GF-supported sites reported lack of financial support for talk time (top-up cards) for mobile phones, limited their ability to reach clients.

**EWs: Less Access to Confirmatory Testing and Higher LTFU**

The overwhelming majority of confirmatory test LTFU at both DSD and TA sites occurred among EWs (Figure 2). Indeed, EW confirmatory test LTFU actually increased between Years 3 and 4, even as overall KP confirmatory testing LTFU fell. Similarly, EW LTFU from care outstripped that of any other KP (Figure 3).

The evaluation team noted that although the performance of the cascade for EWs is comparatively poor, Flagship’s case management approach for them is the same as for other KPs. A number of sites implementing the SMARTgirl project noted the particular challenges associated with linking EWs to confirmatory testing, including the mobile and transient nature of the population and the adverse economic impact on them of an HIV-positive diagnosis. As one provider at a TA site in Pursat explained, EWs are afraid that fellow EWs will learn of their status and “women try to escape from the group if they are positive.” Despite this recognition of the EW-specific challenges at the site level, no project-level analysis has been conducted to assess the barriers EWs face to adhering to the cascade, and no specific adjustments have been made to address the specific barriers to their accessing confirmatory testing and adhering to care.
**Viral Load (VL) Suppression**

Data on VL suppression was available for only a few Flagship sites, and only for Year 3 (see Annex 5, Figure 8). These data indicate that over 90 percent of eligible patients accessed VL testing and 96 percent achieved viral suppression.

Few sites discussed VL during the assessment, but one CoE prevention site in Siem Reap reported that it coordinates with the referral hospital to obtain VL results in order to follow up with patients and support adherence.

**Pediatric Care**

At Angkor Hospital for Children (AHC), the evaluation team found that the pediatric HIV care cascade performed admirably, with only 1.4 percent LTFU; 96.5 percent of those eligible for a VL test received it, and of those, 97 percent achieved VL suppression in Year 4. Staff reported that Flagship support was invaluable: In additional to supporting clinical staff, Flagship supports seven peer educators (HIV program staff) and four pediatric peer counselors (indirect staff). Flagship TA on adhering to government guidelines was also greatly appreciated.
AHC staff also reported a number of gaps and challenges that may impact the performance of the HIV cascade in the future: Children in their care are becoming adolescents, yet AHC staff have no training on supporting adherence and retention for adolescents. Also, children age out of the AHC system at 16, and links between pediatric and adult care of PLHIV are tenuous. This means that young adults risk being LTFU. Flagship has been working with AHC and NCHADS to obtain approval for adolescent-specific care and treatment protocols; however, this effort has not yet borne fruit. AHC staff also reported poor links between PMTCT and pediatric care, noting that pregnant women must be treated at the facility in their area of residence, a requirement that continues after she has given birth. With 30–40 percent of AHC patients coming from outside Siem Reap, this poses challenges for mothers to bring their children in for care and makes it difficult for mothers to receive the care and support they themselves need. No support mechanisms are in place at AHC to monitor and ensure safe breastfeeding for HIV-positive mothers and babies.

AHC staff also reported challenges in providing TA to government facilities to increase capacity in pediatric care associated with AHC’s status as an NGO facility and government regulations that do not support NGOs providing TA to government sites. Flagship has been working with AHC to address this barrier, but the effort had not yet been successful at the time of the evaluation.

Flagship recently assisted with drafting a Memorandum of Understanding (MoU) between NCHADS and AHC that allows AHC to serve as a mentor for government pediatric sites.

Integration – Family Planning (FP)

Flagship has provided TA to both prevention and care and treatment sites to integrate referral to FP and direct provision of FP to clients. Flagship trained FP/HIV integration counselors/officers at prevention sites on FP counseling and referral and FP counselors at care and treatment sites to provide counseling and referrals. Flagship’s Phnom Penh-based training on integrating FP services into ART clinics received high marks from facility-based service providers. After attending the training, the referral hospital in Siem Reap started providing pills, condoms, and injectables, and reported that: "The Family Planning training was beneficial. Before we never thought about providing family planning, we just referred."

Despite these efforts, however, utilization of FP methods is still low among KPs. Consolidated Flagship data on FP utilization was not available; however, some sites did report the data to the evaluation team. A SMARTgirl project in Siem Reap, for example, reported that FP utilization by its clients reached just 27 percent in Year 3 (see Figure 4).
The HIEP study, *Patterns of Utilization and Barriers for Key Populations to Use HIV Clinical Services at Health Facilities in Cambodia* (November 2015) found in the sample heavy reliance by EWs on condoms for contraception, as well as relatively high utilization of abortions.\(^{20}\) There is no evidence to suggest that this situation has improved significantly, and in Year 4, the project halted social marketing of FP products in high-risk venues in favor of referrals — a step that is likely to exacerbate the already low uptake of FP.

At site level, service providers are aware of some of the barriers to FP uptake — one DSD site for EWs cited myths that "FP makes you fat" and another site identified the need for counseling skills to improve FP uptake — and requested (and received) Flagship training on counseling techniques. However, no project-level analysis has been conducted to ascertain the reasons for the low FP uptake, and the barriers to uptake have not been documented.

**Integration – PMTCT**

Flagship’s OD-level ANC data do not track HIV-positive ANC patients to determine whether they accessed PMTCT via non-Flagship sites; nor does it disaggregate patients on PMTCT to differentiate those Flagship PMTCT recipients who were diagnosed at Flagship sites from those who transferred in from non-Flagship sites. As a result, the evaluation team was not able to assess coverage, adherence, or LTFU for PMTCT at Flagship-supported sites.

Similarly, data from Flagship-supported prevention sites on referrals to HIV testing and PMTCT or case management for pregnant women were not available; nor were data on links to pediatric treatment. Only one prevention site visited reported on PMTCT — a TA site which reported two cases of HIV-positive pregnant women who had not received PMTCT, were not tested for HIV at delivery, and were LTFU.

**Integration – STIs**

While some Flagship-supported sites collected and reported data on STI referrals, no consolidated project data on referral for STI testing and treatment was available. Overall, STI testing and treatment were poorly understood and not well integrated into Flagship-supported prevention sites, and data on STI referrals, infection rates, and treatment from care and treatment sites were not available. One MSM TA site reported 21 syphilis cases among 143 tested — a nearly 15 percent infection rate — but was

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\(^{20}\) Seventy-one percent of EW that had ever been pregnant had had an abortion, and among EWs who had ever had an abortion, the average total number of abortions was 2.4.
unsure about treatment regime or availability of treatment. A DSD MSM site in Siem Reap reported a lack of doctors qualified to treat syphilis – only one clinic has a qualified doctor – and noted a similar lack of doctors qualified to diagnose or treat anal STIs. Steep prices or non-availability of STI drugs were also noted by NGO service providers.

Integration – Gender-Based Violence (GBV) and Human Rights
To date, GBV and human rights have not been well-integrated into the Flagship project, despite a recent gender assessment of USAID-supported projects in Cambodia which noted that GBV impacts women, children, EWs, and the LGBT community. Issues of violence were noted at a number of the prevention sites visited, but no activities are in place to facilitate access to legal support. One DSD site reported that it conducts group education sessions for PLHIVs and partners about gender-based violence, client rights, and stigma and discrimination.

Recommendations for the Duration of the Flagship Project
1. Support NCHADS to complete designing and to implement a differentiated model of care for PLHIV to lessen the burden on community and facility case managers and doctors and target those PLHIV who require support.
2. Conduct a rapid assessment (one-month maximum) of specific barriers EWs face in accessing confirmatory testing and remaining in care and adjust the case management approach accordingly.
3. Support Flagship CoEs to provide TA in order to expand the Group of Champions model to other ODs.
4. Advocate for integration of treatment services for HIV-positive mothers and children to (a) allow new mothers to receive care and treatment at facilities that provide pediatric care and (b) build capacity in pediatric care and treatment at provincial health facilities.
5. Provide FP training and mentoring support, including on counselling techniques, to community and facility case managers.
6. Provide GBV training and mentoring support to service providers.
7. Include MSM-friendly STI service provision into TA for health facilities.

SCALE-UP
Evaluation Question 3: How effective was the project at scaling up proven innovative HIV prevention, care, and treatment interventions? How have the studies and evaluations conducted by the HIV Innovate and Evaluate Project been used to determine which innovations should be replicated and to improve the Flagship project?

Introduction
Flagship has had limited success in scaling up HIV interventions. On balance, the project has had more success in scaling up a care and treatment intervention than it has had with prevention and testing interventions: The rollout of active case management under Flagship’s leadership is the best example of successfully scaling up an approach that had clear benefits for patient outcomes. The scale-up of community-based finger-prick testing for HIV was also significant but the success of the rollout was diminished by the very low rate of case detection. In addition, the continuing scale-up of finger-prick testing despite early and ongoing concerns about the yield illustrates how a commitment to scale-up without thinking through the consequences if outcomes are not meeting expectations can be a net negative. The inability to scale-up more effective case-detection approaches (e.g., RTS and PDI+) to
complement or supplement finger-prick testing is a good example of Flagship’s struggles to identify solutions to problems and take them to scale on an accelerated schedule.

The reports produced by HIEP have provided a wealth of information about different aspects of Flagship and its associated activities. Although the HIEP reports have been published relatively recently, there does not appear to be any substantive uptake of the findings by Flagship or any sign of planned improvements as a result of the reports.

**Scale-up: Active Case Management**
Flagship’s deployment of community- and facility-based case managers demonstrates the value of bringing to scale an approach that directly affects the health sector’s ability to improve patient services and achieve better patient outcomes. The ability of Flagship to mobilize and prepare CSOs to fill this vital role illustrates how thoughtful project design, focused implementation, and good collaboration with government can bring an important service to scale in targeted sites. Strong support from such stakeholders as provincial health departments and ARV user organizations reinforced the value of the case-management approach and the usefulness of the scale-up.

Although Flagship did deploy case managers “at scale,” the rollout highlighted the need for even more staff to handle the patient load if the contributions of the case-management approach are to be sustained. In this case, scale-up was essential to a better understanding of how this approach could contribute to HIV care and treatment in Cambodia and what staffing, training, and support are required to provide an effective level of service to both patients and facilities as additional sites adopt the case management approach.

**Scale-up: Finger-prick Rapid Assays**
The ability of Flagship IPs to conduct more than 58,000 finger-prick rapid assays is another example of the project’s ability to bring an activity to scale. The many factors at play (e.g., training, test kits, quality assurance, record keeping, reporting) required a well-organized and well-coordinated approach to make this happen. However, as noted, the drive to bring finger-prick testing to scale was undermined by the project’s inability to adjust the approach when the goal of finding new cases was falling short.21 Continuing to scale up an approach that was not working without moving aggressively to improve, complement, or replace it with more effective approaches was a very poor decision that essentially negates the positive of scaling up this type of testing.

**Scale-up: Centers of Excellence**
One of the fundamental reasons for CoEs is to demonstrate the value of different activities and use the centers to promulgate the knowledge and skills required to duplicate these activities in other sites. Knowledge and skills transfer among peers is known to be a very efficient and effective way to replicate proven activities. By supporting a working relationship across a network of practitioners, it is also an excellent way to spur innovation.

Unfortunately, Flagship CoEs were not used to any meaningful extent to drive scale-up. They did provide limited TA to other sites but their contribution to expanding the reach or improving the performance of other sites appears to be minimal. The primary responsibility for delivering TA was assumed by the Flagship central operation and not devolved to the CoEs, which is in line with Flagship’s top-down approach to management and implementation and the decision to not pursue the original plan.

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21 It is important to note that while Global Fund sites were focused primarily on number of tests, which is linked to the Fund’s reporting requirements, the point of widespread testing is to identify cases. It was a mistake to assume that simply increasing the number of tests done would be seen as a sign of success when the data were analyzed.
to use CoEs as technical hubs. For all intents and purposes, the fact that CoEs were not encouraged (or even allowed) to innovate and were not encouraged to share their expertise meant that they were really Centers of Excellence in name only.

**Scale-up: Global Fund-supported sites**

The scaling-up strategy for prevention and testing hinged on extending the reach of core activities by delivering them through sites using financial resources provided by the Global Fund. To support the scale-up of service provision via GF-supported sites, Flagship used its extensive training capacity to build the requisite knowledge and skills to implement core activities, such as finger-prick testing, for which the scale-up was initially successful because staff were trained across the network of GF-supported sites. Continuing training support for the scale-up was less successful due to such factors as high OW turnover and limited availability of training sessions for replacement staff.

The PEPFAR pivot also affected the scale-up by limiting the reach of Flagship activities. In addition, the bifurcation of KHANA’s TA capacity – e.g., separating Flagship TA from GF TA – did not seem like the most efficient or effective way to ensure that GF-supported sites received the necessary support.

Although Flagship activities were rolled out to dozens of sites supported by Global Fund resources and by Flagship TA, the sites struggled to provide the full range of services due to limited funding and TA. In multiple sites visited by the evaluation team, the resource limitations resulted in a scaling-down of activities rather than a scaling-up. Due to the financial constraints, these sites prioritized testing as many people as possible, which resulted in high numbers of tests but negligible case detection and a major reduction in core prevention activities, among them condom and lubricant programs.

If scaling-up is contingent on using financial resources from multiple sources, there must be unambiguous agreement on priorities and commitments among the parties to ensure that activities are done well. In its dual capacity as prime contractor for Flagship and key sub-recipient for the Global Fund, KHANA should have alerted USAID, the Global Fund, and NCHADS about the shortcomings of the planned approach to scaling-up activities and advocated strongly to ensure the necessary adjustments were made to solve the problems.

**HIEP: Quality**

The reports generated by the HIV Innovate and Evaluate Project reflect the commitment by the research team to a robust and rigorous approach to evaluation. The quality of the reports, ranging from the detailed descriptions of the methodologies to the thoughtful explanations of the findings to the clarity of the writing, is high. Most important, the reports draw clear conclusions and make sound recommendations that are based on the evidence collected and analyzed during the evaluations and that make the reports highly useful.

**HIEP: Dissemination**

The HIEP dissemination strategy hinges on publishing comprehensive reports and holding large workshops to present the findings. The primary concerns among Flagship stakeholders about this dissemination approach is the fact that the full reports are only available in English and that the workshops are held in Phnom Penh. The HIEP team has tried to address the first concern by publishing and sharing detailed presentation handouts for the workshops in Khmer and by offering English/Khmer translation during the workshops. They have tried to address the second concern by paying travel costs...
for stakeholders from outside Phnom Penh to participate in workshops; for example, HIEP paid for 13 provincial health directors to attend the workshop in late August 2016.

At the August workshop, HIEP surveyed participants and found a generally high degree of satisfaction with the workshop. However, the lowest score (61–71 percent) was related to agreement that “presenters had communicated information clearly and that the information was useful for themselves or for their organization.”

HIEP does supplement the dissemination workshops with specific presentations for key stakeholders (e.g., NCHADS, Flagship partners, USAID) but that does not fill the main gap in the dissemination strategy, which is delivering and discussing findings and recommendations with implementing teams in the field. While it may be the responsibility of other stakeholders – such as the Flagship central staff – to ensure that this information gets to the field, it would be better if HIEP had a hands-on role in ensuring that field organizations and staff understand the data and the implications of its evaluations.

**HIEP: Use**

Without a doubt, the findings and recommendations of HIEP reports should be implemented because that could improve the performance of Flagship activities. However, a dilemma with their use is the fixed nature of Flagship activities. As noted, the rigidity is due partly to the management and implementation approaches of the main Flagship partners and partly to prescriptive NCHADS SOPs. A reluctance or inability to change combined with the absence of a culture of innovation within the project means that sound recommendations for improvement go largely unheeded, particularly for activities in the field.

It is unfortunate that HIEP did not launch simultaneously with Flagship, which limited the opportunities for Flagship to act on HIEP evaluations. Given that 83 percent of participants at the last dissemination workshop “agreed or strongly agreed that the workshop was relevant to themselves or their organization” and that 74 percent “agreed or strongly agreed that the workshop motivated them to take action,” it is worrying that little is changing because of the HIEP work.

**Recommendations**

1. **Scale up the two “snowball” approaches to HIV testing:** (1) the facility-based RTS and (2) the community-based PDI+. As discussed in response to Evaluation Question 1, the significantly higher yield of these testing approaches combined with their ability to reach beyond the KPs that Flagship has tested and retested makes scaling up these approaches a priority, even if the scale-up is limited in the remaining months of the project. Expanding the use of RTS and PDI+ will provide more extensive, much-needed, real-world evidence that the approaches work in Cambodia and should be widely used.

2. **Expand the reach of Flagship DSD sites beyond their designated catchment areas.** The catchment areas for DSD sites are already fluid, but as better-resourced interventions these programs can and should extend their reach so that a broader segment of KPs within PEPFAR-supported provinces have access to their services. The HIEP report on MStyle confirms that the reach of that program is already being extended: MStyle “reached the majority of MSM within its catchment area as well as a notable proportion of MSM outside its catchment area.” Demonstrating that DSD sites can actively and intentionally extend their reach beyond a catchment area, however loosely it is defined, could be an effective way to explore reinvention of the existing drop-in center model. A borderless reach could be appealing to KPs who prefer to remain relatively anonymous in their own communities and it makes the DICs more virtual than physical, which is also aligned with current trends.
3. **Engage proactively in the drafting of the next Global Fund concept note.** Effectively scaling up any interventions in Cambodia requires close collaboration and coordination between all the stakeholders who provide and allocate funding for HIV response. The upcoming process of developing the next concept note for the Global Fund is a prime opportunity to leverage the lessons from Flagship and design an improved approach to scale-up that takes full advantage of the different strengths of the key stakeholders.

4. **Ensure that Flagship stakeholders understand and address the findings, conclusions, and recommendations from HIEP evaluations.** The primary concern about the HIEP reports and workshops is not that stakeholders find them relevant or that they motivate stakeholders to take action; the primary concern is whether or not the findings, conclusions, and recommendations actually lead to any improvements. At a minimum, Flagship and HIEP should jointly agree on priorities for action after an evaluation and outline what steps will be taken to ensure that the evaluations are used. The priorities for action should also be discussed with NCHADS, given that and changes or improvements may not align with its SOPs.

**ORGANIZATIONAL DEVELOPMENT**

**Evaluation Question 4:** How effective was the consortium’s approach to sustainability and organizational development, including strengthening the financial management, program management, and technical implementation capacity of the government, local NGOs, and networks of KPs (EWs, MSM/TG, PWID), and PLHIV at the national, provincial, and community levels?  

The project’s fourth objective is to “strengthen local organizational capacity to ensure that local partners can lead in scale-up of Flagship innovations.”

**Organizational Development of Flagship CoEs**

In Years 1 and 2, Flagship conducted a baseline organizational capacity assessment of CSOs selected to become CoEs, using the Purple O Meter instrument to identify priority areas for capacity-building. Scoring for Purple O Meter indicators ranges from 1 – 5, with 1 being very poor capacity and 5 “exemplary” capacity. The combined average score for all CoEs for each indicator ranged from 2.9 to 4.9. The combined mean score of all CoEs for all indicators was 3.9. The weakest area was organizational governance and structures, with a mean score for all CoEs of 2.9. The next weakest area was systems for financial management and sustainability with a combined mean score of 3.2. The strongest area of capacity was monitoring and evaluation (M&E) systems at 4.9. This in all likelihood was a result of capacity-building work by previous projects. Next strongest was working relationships with other stakeholders at 4.4. The average score for all indicators for each CoE ranged from a low of 2.4 to 4.5 with a mean of 3.9. (See Annex 5, Table 5 for the scores for each indicator by CSO.) Despite quite high levels of organizational capacity at baseline, no CoE met the minimum criteria for Purple O Meter certification.

It was planned to repeat the Purple O Meter assessment in Year 3 of the project to gauge the capacity of CoEs to become technical hubs. The repeat assessment is now planned to for Flagship’s last year.

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23 This section of the evaluation reports focuses on assessing the effectiveness of the Flagship approach to the sustainability and organizational development of local NGOs that were project IPs. The work of the project in relation to the sustainability of government partners has focused on program management and technical implementation capacity in relation to prevention and care and treatment programming. An assessment of the project’s inputs in these areas is covered earlier in this report. While the Flagship Project has undertaken some organizational development work with KP networks, the major organizational development work has been done by IPs, especially CoEs. The list of stakeholders to be consulted, which was provided by USAID/Cambodia, did not include any KP networks, presumably for reasons related to prioritization. As there were no consultations with these stakeholders, the evaluation’s assessment of work in this area relies on document and data review and interviews with KHANA.
Until that assessment, there is no comprehensive quantitative data to measure the extent of progress with CSO organizational and institutional developments. Following the repeat organizational and institutional (OID) assessment in Year 5, KHANA is planning to provide Purple O Meter certification to those CoEs and CSOs that meet the minimum requirements because verification of OID status will them when they apply for funding from other donors.

The one area where there is quantitative data to measure progress with OID is financial management. Eight of the nine CSO CoEs have moved from an advanced to a full grant level of financial management following Flagship OID strengthening. The full grant is awarded to CoEs that have robust financial systems, which require less monitoring by the project. During site visits, CoEs nominated financial management TA from Flagship as one of the most valued areas of OID.

Each CoE drew up an action plan to address areas of OID that required strengthening based on the findings of the Purple O Meter assessment. In general, Flagship OID TA has prioritized the areas of governance, financial management, and human resource management systems, based on the assessment findings. Other TA areas have included strategic planning, resource mobilization, and internal organizational policy. OID TA has primarily been delivered through coaching and mentoring during site visits, supplemented by a limited number of training workshops in the areas of governance and leadership and financial management.

CoE staff consistently reported high levels of satisfaction with the Flagship's OID TA in all areas but especially in financial management. Other areas of TA frequently mentioned as valuable were internal management systems, organizational governance, staff management, internal policies, and program management. One CoE representative said that in addition to organizational strengthening in specific areas, Flagship TA had been broadly beneficial in improving the organization as a whole. Another said that improvements in technical and organization capacity resulting from Flagship TA had increased staff morale, resulting in improved staff retention.

The improvements described by Flagship CoEs have resulted in stronger organizations, which heightens their sustainability through more efficient and effective internal systems. This makes these organizations more attractive to other donors. While the sustainability of these organizations has improved in these ways, however, the major threat to their existence is the downward trajectory in donor presence and funding in Cambodia and the absence of government financial support for CSOs. Consultations with CoEs indicated that the main gap in Flagship OID TA was a lack of TA on financial sustainability and fundraising. One CoE mentioned the need for training on proposal writing, drafting concept notes, and how to best respond to guidelines for international funding opportunities. Another, however, reported that Flagship had helped them look into the possibility of user fees for clinical services under the ID Poor scheme. There is clearly a need for additional TA for CSOs on how to best position themselves for a post-donor environment in Cambodia.

At project design, the original intention was to build the technical and organizational capacity of the CoEs so they could become technical hubs, providing TA to non-Flagship implementers to facilitate scale-up of Flagship innovations. USAID/Cambodia made a mid-project decision to adjust Flagship’s scope of work to abandon the technical hubs concept in favor of other priorities for the project.

Consultations with CSO CoEs indicated that Flagship’s Objective 4 team had been responsive in addressing emerging OID issues identified by the CoE. For example, at his request one CoE executive director was mentored on staff management issues. The evaluation team, however, did not find evidence of that Flagship had addressed highly important project-wide issues that did not fall within their standard areas of OID TA. For example, it has been apparent for some time that the OW remuneration of $60 per month is insufficient to attract and retain suitable staff, and that the very high OW turnover rate has
had a significant impact on the project’s prevention and HIV testing work. Yet this significant OID issue has gone unaddressed. This is a major missed opportunity.

The Objective 4 team reported that a challenge was the Flagship’s determination to increase the yield from HIV case detection efforts has resulted in OID being given a lower priority by both the consortium partners and CoEs.

Organizational Development of KP Networks

While its primary OID TA focus has been CoEs, the project has also supported building the development of organizational and advocacy capacity in the Cambodian PLHIV Network (CPN+) and three KP networks – SMARTgirl (EWs); the Cambodian Network of People who Use Drugs (CNPUD); and Bandahn Chaktamouk (BC), the MSM/TG network. TA has primarily been provided through quarterly coordination meetings with the networks, annual reflection meetings, and check-ins by phone; a limited amount of Flagship-provided training on governance and leadership and KP new generation leadership training; support for participation in external trainings (on, e.g., human rights, sexual orientation and gender identity, leadership, and advocacy); mentoring (in communication, advocacy, and meaningful participation in policy forums); and consultancies.

Among TA results have been

- New governance by-laws, newly elected boards, and strategic plans for BC and CPN+
- Elections for the SMARTgirl Executive Committee and CNPUD Advisory Group and Executive Committee
- A two-year operational plan for CPN+ with stronger communication and coordination systems, and drafting of an operational plan for BC
- Work plans and budgets for each of the KP networks
- Strengthened internal systems for all four networks
- A number of advocacy events and campaigns by BC, SMARTgirl, and CNPUD.

A network capacity assessment tool, similar to the Purple O Meter, has been developed, with initial assessments scheduled for the latter half of 2016. The one-year delay in administering this tool has limited its utility, given the limited time remaining for the Flagship project.

Recommendation

In the final year of the project, Flagship’s OID support to CoEs and IPs should focus on CSO financial sustainability and social entrepreneurship. This should include a strategy to position CSOs as organizations capable of undertaking niche services on behalf of the government on a contracting-out basis.

STRATEGIC INFORMATION (SI)

Evaluation Question 5: How has the project built local capacity to understand and effectively use service delivery data to plan and monitor the progress of the HIV cascade and the continuum of prevention, care, and treatment services?

M&E at DSD- and GF-supported Sites

One of Flagship’s key achievements has been improved capacity at site level to generate and report on data. For many sites visited by the evaluation team, Flagship support enabled the hiring for the first time of M&E. AUA and Chhouk Sar, for example, hired their first M&E officer with Flagship support. DSD
sites visited by the evaluation team universally expressed appreciation for Flagship’s support and training of M&E officers and for Flagship tools and training on using the tools that allowed them to produce and report their own service delivery data. Even sites that already had data collection and reporting capacity, such as the AHC, appreciated the number of trainings Flagship provided (three in the first three quarters of 2016) and noted improvements in the quality and especially the timeliness of their reporting. The assessment team noted that many DSD sites, as well as some TA sites, presented their achievements to the team in tabular and graphic format, including cascade data.

Several sites, while reporting that TA in data collection and entry was beneficial to their programs, also noted that antiquated computer equipment made it difficult for them to adequately process their data.

**Reporting and Data**

The assessment team noted that data presented from DSD and TA sites, as well as data provided by Flagship itself, struggled to maintain a uniform quality and suffered from inconsistencies in reporting periods and data sets. Data provided by some DSD sites, for example, tended to compare data from Year 4 with data from previous years, without accounting for the fact that Year 4 was not yet complete when the evaluation team was in Cambodia. Data on a number of Flagship indicators were not made available – either not collected or not reported to the evaluation team. In some cases, reporting delays were responsible for lack of data – such as the lack of Year 3 data on VL from several Flagship-supported sites – in part because VL data had not yet been incorporated into the NCHADS reporting system at the time of the evaluation.

**Data Analysis**

The most successful example the assessment team observed of data analysis for program strengthening was the Siem Reap Group of Champions, which held weekly meetings to review data, consider new cases, and discuss and address LTFU issues.

Most DSD and TA sites, however, had limited capacity to analyze the data collected, draw lessons learned, and apply those lessons to grow and strengthen programs. Site level data generation was geared to meeting Flagship reporting requirements, with limited on-site analysis, and data not required for reporting purposes were not reported or analyzed. Sites reported that Flagship data quality assurance (DQA) visits focused on helping sites to accurately report on required indicators and on meeting targets, but did not encourage them to analyze their own data, draw lessons, or innovate on the basis of their findings. Site staff described Flagship DQA visit activities as "check data, documents, finances, go to the community." These short visits did not allocate time to mentor M&E officers in data analysis.

The evaluation team also noted that site-level strategic information (SI) teams and M&E officers had numerous responsibilities and would not have had time to engage in thoughtful data analysis, even if that had been a focus of the project. Site-level M&E officers reported that they were required to submit service delivery data (finger-prick data and new case findings) to Flagship every week, and also engaged in a wide range of activities, such as those for UIC development and roll-out and in 2013 the Geographic Information System (GIS). At sites with just one M&E officer, all this left no time to engage in data analysis.

The lack of site-level analysis and innovation meant that important opportunities for learning and growth were missed: At some sites, risk assessment and case-profiling data piled up, with sites unsure of their findings or what they might learn from the data. In part, this may be because the M&E officer position is relatively new. However, the evaluation team discerned little effort on the part of Flagship to raise awareness of the benefits of data analysis or to encourage sites to analyze their own data.
For Flagship itself, cascade data were also used primarily for project reporting, and gaps along the cascade and LTFU by KP have not been analyzed; nor have strategies been identified to address differential gaps and LTFU across KPs – such as the disproportionate loss of EWs to confirmatory test and LTFU from care of EW, discussed in the care and treatment section above. Similarly, data on important elements of integration of HIV services – such as the discussion above of antenatal care (ANC) data discussion in the care and treatment section – has not been collected or analyzed to identify gaps or develop strategies to address them.

**HIEP Studies**

The Innovate and Evaluate studies reviewed by the evaluation team provided useful insights into key aspects of project activities, as discussed above in the scale-up section; however, no sites visited by the assessment team could report on any findings from these reports, and the M&E officers at some sites were unaware of them. For this reason, useful findings were not translated into programmatic learning or growth.

**Unique Identifier Code**

In Year 2, Flagship developed a Unique Identification Code for KPs and piloted it in a number of Flagship-supported ODs. Officially launched in May 2014, by March 2016, 82 percent (38,962/47,412 KP) of the KPs reached had been assigned a UIC. Flagship worked in close collaboration with NCHADS to integrate the UIC in health facilities providing Opportunistic Infections/ART services.

The UIC has allowed Flagship to generate important data on KP across the cascade. However, the evaluation team noted a number of shortcomings in the UIC system: Originally envisioned as a mechanism to link NGO and national data systems, the UIC has yet to be linked to a national facility-based UIS. At the time of the evaluation, the UIC had been integrated into only six health facility sites. Flagship staff, stakeholders, and service providers at Flagship-supported sites reported implementation challenges as well, including poor acceptance of the UIC system by KPs and difficulties with clients losing their UIC cards. Stakeholders also reported that, in addition to the Flagship-supported UIC, there are several other systems being considered at the national level, with no decision yet on which would eventually prevail.

**Geographic Information System (GIS)**

A significant amount of SI effort in Flagship has focused on GIS – including a comprehensive GIS mapping of KP hotspots in Year 2 and use of the GIS map as a platform to integrate routine information obtained from community and facility HIV testing and counseling. These activities have contributed to the important work of conducting KP size estimates, and generating data on overlapping KP risk factors. However, there is little evidence that GIS mapping has been used to improve Flagship program performance. An HIEP evaluation, *Evaluation of the Geographic Information System Mapping of Key Populations in Cambodia*, (May 17, 2016), found that actual utilization of GIS data was low: Only 2 of 13 institutions reported having used the data to guide program development, and only 9 reported having received the data. Similarly, the evaluation team found that GIS data have not significantly contributed to planning and monitoring the progress of the HIV cascade.

**Recommendations for the Duration of the Flagship Project**

1. **Expand and strengthen DQA site visits beyond the current focus on reporting requirements to mentoring and supportive supervision in data analysis and data use in program development at the site level.**

2. **Conduct a rapid analysis (e.g., 30 days) to prioritize SI activities and identify which activities to focus on and which to drop.** In the time remaining for the project,
Flagship should focus on those SI activities that directly contribute to its ability to monitor the HIV cascade and drop activities that have not proven useful.

3. Work with NCHADS to identify ways to best link Flagship and NCHADS data systems.

CROSS-CUTTING FINDINGS AND CONCLUSIONS

Consortium partnership issues: The Flagship Project consortium, headed by a Cambodian prime with two international NGOs, was a new way of working for each partner. Previously each partner had its own USAID contract, with less need for collaborative work. Consultations with each of the consortium partners found that there were significant tensions relating to management and partnership issues, particularly in the first two years of the project. KHANA reported that different organizational cultures and cross-cultural communication issues contributed to the relationship difficulties. All consortium partners reported an improvement in partner relationships by Year 3. It is clear that these relationship tensions and the time taken to develop more effective systems of working together contributed to the slow progress of the project in its first two years.

Flagship IPs, however, reported benefits from the consortium approach because it resulted in a single source of USAID funding, one M&E system, and better coordination of consortium partner TA. Previously, it was not uncommon for NGO IPs to be receiving USAID funding from multiple sources, which increased their transaction costs and required separate financial and M&E reports.

Technical assistance to NCHADS: The Flagship Project has conducted quarterly coordination meetings with NCHADS, and consortium partners have been active contributors to its technical working groups. An advantage of the consortium approach has been that it has improved coordination of the technical inputs to NCHADS by KHANA, FHI 360, and PSI/PSK and provided a single point of contact for NCHADS.

Stakeholders reported that Flagship’s TA inputs on the development of NCHADS B-IACM and support for its implementation in the six PEPFAR focus provinces has been effective. Rollout of the B-IACM approach beyond these provinces has, however, been more limited. The primary mechanism for Flagship assistance for more general adoption of the B-IACM approach has been through TA to a limited number of the provinces supported by Global Fund resources. The key impediment to this work was the Global Fund’s decision to give a no-cost extension to Cambodia’s HIV grant, which effectively halved the size of grant for 2016 and 2017. Implementers in Global Fund sites reported during evaluation team site visits how the reduction in funding had limited their project activities, including adoption of Flagship innovations, which in turn limited opportunities for Flagship to provide effective TA.

A number of external factors beyond Flagship control have negatively impacted its implementation. The project, appropriately, works in close alignment with NCHADS and follows NCHADS SOPs, but the high level of operational detail in NCHADS SOPs can restrict Flagship flexibility. For example, NCHADS KP concept notes specify that OWs will be paid $60 a month. As noted in the section on Prevention Innovations and Services, the low pay has resulted in significant OW turnover and created difficulties in recruiting OWs with suitable skills. Similarly, another NCHADS SOP defines LTFU as not having attended an ART clinic within the last three months. This is a barrier to a differentiated care approach for stable patients, who need less frequent clinic visits. The time taken to change NCHADS SOPs, and the priority NCHADS has accorded this, also limits Flagship flexibility.

The Flagship TA model: Flagship CoEs reported quite high levels of satisfaction with the regular TA site visits by consortium partners. A particular focus of TA was provision of advice on how to improve performance in areas where targets were not being met. It was clear from descriptions of the TA by CoEs that it was primarily oriented to the Flagship menu of programming and innovations. The rigidity of
indicators reinforced this approach. While there was dialogue with implementing sites on how to improve their performance, this was primarily concerned with the project’s standard service modules. What appears to have been lacking, based on information from site visits, was a more iterative, two-way dialogue between consortium technical experts and CoE staff to tap into local knowledge in exploring ways to improve the project. The implementation model was too top-down and menu-based. CoEs were not given latitude or encouraged to develop their own solutions or innovations. This reflected the overall top-down approach that offered little opportunity for ground-up feedback except as it related to centrally determined programming. This approach is not consistent with the original vision for CoEs as outlined in the Overview of the Flagship Project in this report under Project Background.

**Cost of interventions:** An overarching objective of the Flagship Project has been to reduce the cost of interventions in support of the transition from donor to domestic funding. The two primary areas where the project has undertaken work that may result in cost savings are (1) moving from the aim of HIV testing all KPs twice a year to testing based on a risk assessment; and (2) contributing to discussions on the need for a differentiated care approach for PLHIV to realize efficiencies for ART clinics and community-care CSOs. Except for these two areas, the evaluation found little evidence of the project focusing on reducing the cost of interventions. It is, however, recognized that innovations can, especially at early stages of implementation, be more expensive.

**HIV resurgence:** One positive result is that there is no epidemiologic evidence of any resurgence in HIV infections among KPs in Cambodia during the project, except for an increase in HIV prevalence among TG in some urban hotspots, as found in the recent NCHADS IBBS. While there could be pockets of increased HIV infections among KPs not being reached by the project, given the large number of community-based, peer-led, HIV tests conducted by Flagship, any resurgence in HIV infection would be expected to be reflected at least to some extent in new HIV diagnoses among those tested, which has not been the case. One possible contributing factor for the lack of any resurgence may be the high proportion of PLHIV on ART, coupled with high levels of VL suppression.

**Enabling environment:** The deterioration in the enabling environment for HIV programs in Cambodia has been well-documented. The government’s Village and Commune Safety Policy, with a focus on “cleaning the streets,” has created difficulties with law enforcement agencies for HIV prevention programs working with KPs, such as street-based sex workers, MSM, TG, and PWID. The 2015 Law on Association and Nongovernmental Organizations has created concerns among CSOs about advocacy activities, which can be seen as promoting human rights. A common theme from Flagship site visits was reports of harassment of KPs by police, which hinders outreach work and the willingness of KPs to carry condoms. While some local advocacy work has been undertaken, overall, Flagship activities relating to the enabling environment at both national and local levels have been quite limited. The reason for this may be related to the environment of repression in relation to advocacy, human rights, and the roles of CSOs. The Key Populations Challenge Fund recently funded LINKAGES to focus on legal and structural barriers impeding uptake of HIV-related outreach and health services by KPs and their partners. This gives Flagship an opportunity to cooperate and coordinate with LINKAGES in this work.

**Financial sustainability of CSOs:** CSOs in Cambodia are entirely reliant on donor funding. While Flagship’s Objective 4 work has helped to improve CSO internal organizational capacity, which is one dimension of sustainability, there have been no efforts to enter into a dialogue with the government on the financial sustainability of the CSOs involved in HIV response. While the difficulty of undertaking this type of advocacy in the current political environment is acknowledged, this issue is becoming progressively more important as donor funding declines. As it would appear that the primary concern of the Royal Government of Cambodia is to inhibit CSO advocacy activities, positioning support for HIV CSOs as contracting out service delivery that CSOs are uniquely positioned to provide may be less sensitive.
ANNEX 1. SCOPE OF WORK

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 11-16-2015
Last update: 8-29-2016
Amendment #1

Refer to the USAID How-To Note: Developing an Evaluation SOW and the SOW Good Practice Examples when developing your SOW.

I. TITLE: Cambodia HIV/AIDS Flagship Project Midterm Evaluation

II. Requester / Client

☐ USAID Country or Regional Mission
Mission/Division: Office of Public Health and Education / USAID Cambodia

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☐ 3.1.1 HIV  ☐ 3.1.4 PIOET  ☐ 3.1.7 FP/RH
☐ 3.1.2 TB  ☐ 3.1.5 Other public health threats  ☐ 3.1.8 WSSH
☐ 3.1.3 Malaria  ☐ 3.1.6 MCH  ☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: approx. $270,000 (Note: GH Pro will provide a cost estimate based on this SOW)

V. Performance Period

Expected Start Date (on or about): July 7th 12, 2016
Anticipated End Date (on or about): January 12, 2017

VI. Location(s) of Assignment: (Indicate where work will be performed)

Cambodia: Phnom Penh, Siem Reap, Kampong Cham, Battambang, Banteay Meanchey, and Pursat

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:
Performance Evaluation (Check timing of data collection)

- Midterm
- Endline
- Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

- Baseline
- Midterm
- Endline
- Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

Other Analytic Activities

- Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

- Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

- Midterm
- Endline
- Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

- Baseline
- Midterm
- Endline
- Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis...
VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

<table>
<thead>
<tr>
<th>Project/Activity Title</th>
<th>HIV/AIDS Flagship Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Number</td>
<td>Cooperative Agreement No. AID-442-A-13-00001</td>
</tr>
<tr>
<td>Life of Project</td>
<td>From November 14, 2012 to November 13, 2017</td>
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<tr>
<td>Funding</td>
<td>US $30,000,000.00</td>
</tr>
<tr>
<td>Implementing Organization(s)</td>
<td>Khmer HIV/AIDS NGO Alliance (KHANA)</td>
</tr>
<tr>
<td>USAID’s Agreement Officer’s Representative (AOR)</td>
<td>Bunna Sok</td>
</tr>
</tbody>
</table>

Office of Public Health and Education, USAID Cambodia

Background of project/program/intervention:

**Development Context**

Cambodia has been at the forefront of the fight against HIV and AIDS, and is one of the few countries in the world that has successfully reversed its generalized HIV epidemic and achieved MDG 6 before 2015. With a population of 14.7M, 74,572 people (0.67%) are living with HIV.\(^{24}\) Estimates suggest that HIV prevalence peaked at 1.7% in 1998 and has been declining ever since. Cambodia successfully cut adult infection rates in the general population by more than half in the past 14 years and provides HIV treatment to over 80 percent of eligible individuals; epidemic control\(^{25}\) was attained in the early 2000s. In 2014, it is estimated that among adults there were about 2,000 HIV-related deaths and 627-1300 new HIV-infections\(^{26}\). With targeted, effective interventions and high-levels of ART coverage among PLHIV, Cambodia is poised to become the first low-income country to achieve virtual elimination of HIV transmission within the next decade.

Despite this success, there are remaining areas of concern at the sub-national level where ART coverage is still low and within certain high-risk groups where high prevalence still exists. The populations with the highest prevalence include: 2.3% among men who have sex with men (MSM); 2.6% among female entertainment workers (EW); 4.1% among transgender (TG); and 24.1% among injection drug users (IDU). They, together with their partners, remain the priority for prevention. Reaching hidden groups and those with overlapping risk behaviors (e.g. EW and MSM who use drugs) has been a challenge. Furthermore, as the mobile and migrant population in Cambodia has grown, this has increasingly posed a challenge. The Asian Epidemic Model suggests that of the estimated 694 new adult HIV-infections in 2014, heterosexual transmission was the driving force behind the epidemic; around 58% of all new infections were in males and females with no identifiable risks, 12% in FSW, 14% in their clients, and 13% in IDU. Greater efforts are needed with prevention, identifying new cases of HIV, and ensuring that individuals living with HIV are retained across the HIV care cascade.

Policy, legal and social issues pose critical challenges to the national response. Legislation such as the 2008 Law on Suppression of Human Trafficking and Sexual Exploitation resulted in the closure of brothels, so EW shifted sex work to entertainment venues and other sites. This has made it more difficult to assess which segments of this population are most at-risk. In addition, fear of prosecution under the Village and Commune Safety Policy has pushed many high-risk individuals underground. However, there have been positive steps, including policies supporting needle and syringe programs and Methadone Maintenance Therapy.

Cambodia is committed to achieving Zero New HIV Infections by 2020. The National Center for HIV/AIDS, Dermatology, and STI (NCHADS) within the Ministry of Health (MOH) developed the

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\(^{24}\) PEPFAR Cambodia Blueprint July 2015 Transition Plan

\(^{25}\) Defined as the point where the number of new HIV-infections has declined and falls below AIDS-related deaths.

\(^{26}\) PEPFAR Cambodia Blueprint July 2015 Transition Plan
strategic framework *Cambodia 3.0*, which was launched in 2012. It focuses on active case detection, immediate/early initiation of ART, immediate enrollment in care, and retention in treatment. *Cambodia 3.0* links the standard operating procedures (SOPs) for the Boosted Continuum of Prevention, to Care and Treatment (B-CoPCT), which is for most-at-risk populations (MARPS), and the Boosted Linked Response for Prevention, Care, and Treatment of HIV and Sexual and Reproductive Health Issues (B-LR) with the introduction of Treatment as Prevention (TasP). These are the critical pillars in Cambodia’s approach to virtual elimination of HIV by 2020. Virtual elimination is defined as an HIV-incidence of 3 per 100,000 people or less and a mother-to-child transmission rate of 2% or less. However, the Royal Government of Cambodia (RGC) is facing competing health and development priorities, a changing HIV epidemic context, and stressed donor funding, so there is a need to help ensure intervention models and service-delivery systems are high impact and low cost. The current HIV response in Cambodia is predominantly funded by external resources. The USG remains by far the largest bilateral donor to the HIV/AIDS response in Cambodia, while the Global Fund to Fight AIDS, TB and Malaria is the largest overall donor on an annual basis.

**Project/Activity Information**

**a) History**

USAID awarded the 5-year HIV/AIDS Flagship Project (Flagship) to a consortium of partners. It is led by KHANA (prime), and FHI 360 and PSI/PSK provide technical assistance. The overarching goal of Flagship is to enhance the impact, reduce costs, and improve the effectiveness of the national response through technical innovation and improvements in quality and capacity to deliver sustainable HIV services. Through this, the consortium is to help reduce Cambodia’s dependence on USG funding for service delivery in the health sector, and support the transition of funding from service delivery to technical assistance. The goal is to be achieved through the fulfillment of four objectives:

1) Foster local capacity to design and showcase innovative, evidence-based, state-of-the-art, replicable, and cost-effective technical HIV innovations to enhance the impacts and reduce the costs of quality targeted HIV prevention for MARP.

2) Foster local capacity to improve the quality and integration of HIV care and treatment services (building on Cambodia’s successful CoPCT model) for MARP, PLHIV and their partners.

3) Foster local capacity to strengthen the use of strategic information including surveillance, monitoring, evaluation, and data utilization, to inform program improvement and the efficient placement and utilization of resources.

4) Strengthen local organizational capacity to ensure that local partners can lead in scale-up of Flagship innovations.

To strengthen the national response and facilitate achievement of Cambodia 3.0, Flagship is establishing and supporting Centers of Excellence (CoE) at the community and health facility level in six high burden Operational Districts (ODs). In these CoEs, Flagship is testing new technical innovations targeting MARPs – EW, MSM, TG, and IDU – and people living with HIV (PLHIV). Flagship is also providing technical assistance to implementing partners and the national program at sites not directly supported through USAID to implement the SOPs of Cambodia 3.0.

Much of the focus in Year 3 has been on consolidating the progress made in the first two years by community CoEs and Flagship-supported Health Facilities, and on sustaining the technical innovations that have been introduced in CoEs and expanding them to non-CoE IPs in high burden ODs. Two CoEs were added to reach MSM and IDU: one in Siem Reap and one in Phnom Penh. Additionally, several new innovations were developed and tested in Year 3 as part of Cambodia 3.0. In collaboration with the USAID Innovate and Evaluate project, the Cambodian national program, and academia, several exploratory and evaluation research studies were also designed and implemented.
There have been significant changes in the HIV funding environment, which affected Flagship’s Year 3 work plan. In May 2014, GFATM announced that the HIV Single Stream Funding Phase 2 would be extended without cost until the end of 2017, which practically halved the initial budget from 2016 onwards. This reduction, coupled with the ending of the USAID SAHACOM project in September 2015, is a challenge that could potentially have significant adverse consequences on the level of community-based prevention, care and support services for PLHIV and MARPs in Cambodia. The implementation of some of Flagship’s technical innovations in non-CoE implementing partners will be affected, as will the level of technical assistance that Flagship provides to these partners.

b) Approach and Implementation

Flagship’s approach is to support select community implementing partners and health facilities as Centers of Excellence (CoE), and build their capacity to develop and test high-impact and cost-effective technical innovations. By building on current program successes and structures, Flagship benefits from existing expertise and contributes to sustainability and alignment. The CoE model is central to the Flagship mandate of skills transfer to local partners. Furthermore, it provides a foundation for a cohesive, coordinated, and evidence-informed program framework for future HIV financing.

Facility-based CoE: Based on discussions and agreement with NCHADS, six Health Facilities (referral hospitals) were selected in Year 1 in the high burden ODs of Tbaung, Lech, Sensok, Kandal, Kampong Siem and Siem Reap. These Flagship-supported Health Facilities are being supported to improve the quality and linkages across the HIV care cascade for PLHIV and MARPs. In addition, from Year 2 onwards, Flagship has been providing TA to Angkor Children’s Hospital in Siem Reap to implement innovative approaches for improving the quality of care and building pediatric AIDS care capacity in the context of the Cambodia 3.0 strategy.

Community-based CoE: Flagship has invested significant TA and effort in transforming 10 IPs into CoE in 4 high burden ODs (Kandal, Cheung, Siem Reap and Kampong Siem) to implement innovative community-based strategies in prevention, new case detection and linkages to and retention in care and support. These CoE include those working in care and support (Salvation Centre Cambodia, Chhouk Sar, ARV Users Association and KHANA Livelihoods and Learning Center) and prevention (Phnom Srey Organization for Development, Cambodian Women for Peace and Development, Men’s Health Cambodia and Men’s Health Social Service).

In Year 3, Flagship supported the establishment of a smaller second cohort of CoE: 1) Korsang, to deliver harm reduction interventions to PWUD/PWID in Phnom Penh; and 2) MHC a specialized IP working with MSM and TG in OD Siem Reap.

Organizational capacity of all CoE was assessed using the KHANA ‘Purple-O-Meter’, an NGO Capacity Assessment tool, as well as a technical checklist adapted from FHI 360’s Technical Quality Assessment tools. The technical checklist was used to assess CoE technical capacities and to inform the development of a TA framework to support implementation of technical innovations.

Lastly, after two years of innovative programming, TA, and organizational support, Flagship will identify technical support providers from CoE’s and other implementing partners. An innovation-specific technical checklist was developed in Year 3 to assess the skills of CoE staff in providing TA to other organizations on Flagship innovations and branded service packages. This will facilitate innovative replication and allow Flagship to develop a database of technical support providers, creating locally-owned, cost-effective capacity building. In the long term, the technical support providers will play a lead technical support role in facilitating scale-up of Flagship innovations.

c) Expected Results

Based on the Cooperative Agreement, the Flagship will reach over 55,000 direct beneficiaries,
including 29,215 EW, 5,100 partners of EW, 6,092 MSM, 3,998 TG, 813 PWID, and 7,888 PLHIV, including 257 positive pregnant women and 789 sero-discordant couples. A key expected project outcome is establishment of 22 CoE at IP and demonstration program sites, as well as four health facility CoE. These will transition to become TH, grounded in local expertise and positioned to lead the future direction of the Cambodia HIV response. Flagship will also establish an SI CoE and a Technical CoE, which will evolve from FC teams to become sustainable mechanisms to underpin the Cambodia HIV response. Flagship will pilot, test and facilitate scale up of the Flagship successful innovations to propel Cambodia towards achieving virtual elimination of HIV by 2020.

Strategic or Results Framework for the project/program/intervention (paste framework below)
If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

Results Framework/Theory of Change

Figure 1 shows the Flagship Project model below:

Flagship focus its efforts on geographic areas with a high concentration of MARPs and PLHIV in 6 provinces: Phnom Penh, Siem Reap, Kampong Cham, Battambang, Banteay Meanchey, and Pursat. This geographical coverage is within the 30 high burden ODs selected by NCHADS, based on epidemiological and demographic data.

In these areas, and in accordance with the B-CoPCT and B-LR, emphasis was placed on reaching individuals at highest risk of HIV transmission. Targeted beneficiaries are MARPs and their partners; PLHIV and their partners; pregnant women; and people co-infected with TB and HIV. To be more streamlined and cost-effective, targets, coverage area and implementing partners are reviewed annually based on current strategic information and the availability of resources.
IX. SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The evaluation will cover the period from November 14, 2012 to March 31, 2016, with the purpose to:

(a) assess the project’s performance and the extent to which it has been able to meet its intended objectives thus far;
(b) document lessons learned and best practices; and
(c) make recommendations that inform and improve future program directions and effectiveness.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The audience of the evaluation report will be the USAID/Cambodia Mission, the PEPFAR/Cambodia team, the Asia Bureau, the Global Health Bureau Office of HIV/AIDS, Office of the Global AIDS Coordinator, USAID implementing partners, the MoH/NCHADS, and other HIV/AIDS key stakeholders in Cambodia.

C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

USAID will consider the findings, particularly the evidence-based findings, in its strategic approach to HIV/AIDS. An Executive Summary will be provided to the Ministry of Health and the National Center for HIV/AIDS, Dermatology and STD (NCHADS) and the GFATM.

The findings of this mid-term evaluation will primarily be used to inform the design of any follow on activities and secondarily to strengthen the interventions of the HIV/AIDS Flagship project. It is expected that the host country partners, the GFATM, and other donors will also be able to use the report to better assist them in their future goals.

D. **Evaluation/Analytic Questions & Matrix:**

a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Research Methods</th>
<th>Application or Data Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which of KHANA’s HIV prevention innovations and services for Key Population (EW, MSM/TG, PWID) are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>How effective and efficient in detecting new cases of HIV, increasing access to condoms, and increasing uptake and yield of HIV testing among underserved and neglected groups (entertainment workers (EW), MSM/TG, and IDUs)?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>How effective was Flagship’s technical assistance in improving the quality and integration of HIV/AIDS care and treatment services and for the Integrated Active Case Management approach (tracking referrals from the community to health facilities, monitoring the care and treatment cascade, in enrollment on ART, adherence and viral suppression, and reducing lost-to-follow up cases)?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>How effective was the project at scaling up proven innovative HIV prevention, care and treatment interventions? How have the studies/evaluations conducted by HIV Innovate and Evaluate Project been used to determine which innovations should be replicated and to improve the Flagship project?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>How effective was the consortium’s approach to sustainability and organizational development, including strengthening the financial management, program management and technical implementation capacity of the government, local NGOs, and networks of Key Population (EW, MSM/TG, PWID), and PLHIV at the National, Provincial and community levels?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>How has the project built local capacity to understand and effectively use service delivery data to plan and monitor progress of the HIV Cascade and the continuum of prevention, care and treatment services?</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** This consultancy will not cover costing analysis, as this will be done by the HIV Innovate and Evaluate Project.

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions lead to an ineffective evaluation or analysis.)

E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and
resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

**General Comments related to Methods:**
This performance evaluation should focus on descriptive and normative questions mainly about what Flagship has achieved within the first 3 years of the project; how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making.

Flagship works through direct implementation and Technical Assistance in 6 provinces including Phnom Penh, Siem Reap, Kampong Cham, Battambang, Banteay Meanchey, and Pursat. The evaluation team will be required to conduct field visits to all six provinces. The field locations will be randomly selected from a master list of all Flagship sites in each province and shared with the evaluation Contract Officer’s Representative (COR) and Health Team in the evaluation work plan. The evaluation team will be split into two sub-teams for field data collection. Both teams will jointly collect data in Phnom Penh during the first week of data collection. Then teams will be split to collect data in different provinces. One team will cover the main provinces including Siem Reap and Kampong Cham. The other team will cover Pursat, Battambang, and Banteay Meanchey.

The evaluation team should employ a systematic and sound logic evaluation approach including desk review including trend analysis of the project progress report, key informant interviews, focus group discussion, and direct observation. Using in-depth qualitative approaches will allow us to gain insight on the outputs and potential impacts of both project activities and processes. Furthermore, the evaluation team should support its conclusions and recommendations using credible evidence-based information in anecdotal.

### Document and Data Review (list of documents and data recommended for review)

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

#### Relevant National Documents
- RGC/NCHADS strategy documents
- National policies and guidelines
- Sector-specific strategic plans
- Standard of Procedures (SOPs) related to HIV care and support for PLHIV and MARPs

#### Project Documents
- Copies of the Flagship Cooperative Agreement and all modifications
- Year 1, 2, and 3 Flagship Annual Progress Reports
- Project work plans
- Project M&E Plan
- Revised Cambodia PEPFAR COP2015
- Flagship assessment tools and checklists
- Any other relevant reports/tools

### Secondary analysis of existing data (This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key Informant Interviews (list categories of key informants, and purpose of inquiry)

Question guides will be employed during interviews with the following key informants for the HIV/AIDS Flagship project:

- KHANA Flagship project staff
- Community implementing partners staff
- Centers of Excellence (CoE) staff
- USAID health staff
- MOH/NCHADS staff
- Other HIV/AIDS key stakeholders in Cambodia (e.g., UNAIDS, WHO, CDC)

A list of relevant stakeholders and key partners will be provided to the evaluation team by USAID upon award of the contract. The evaluation team will be responsible for expanding this list as appropriate and arranging all meetings and appointments needed to complete the required work outlined in this document.

Focus Group Discussions (list categories of groups, and purpose of inquiry)

Discussions will be held with key population (EW, MSM/TG, PWID), to explore their perception of access to quality services, and if these services are meeting their needs.

FGDs will be conducted to illicit reactions from those involved as beneficiaries of the Flagship. As appropriate, discussion groups will be convened separately for men and women, to adjust for the potential power differential between men and women, and to assure women’s voice is heard equally to men. The Evaluation Team, with input from USAID/Cambodia and KHANA, will determine when discussant subgroups should meet separately, to avoid power differentials and to allow all to speak freely.

Group Interviews (list categories of groups, and purpose of inquiry)

Optional: Some of the key informant interviews can be clustered, as long as there are no power differentials, and all respondents feel comfortable in voicing their opinions within the group. (See list and description above under KII.)

Client/Participant Satisfaction or Exit Interviews (list who is to be interviewed, and purpose of inquiry)

Facility or Service Assessment/Survey (list type of facility or service of interest, and purpose of inquiry)

Cost Analysis (list costing factors of interest, and type of costing assessment, if known)

Survey (describe content of the survey and target responders, and purpose of inquiry)

Observations (list types of sites or activities to be observed, and purpose of inquiry)

Semi-structured observations at select facility and community Centers of Excellence (CoE), focusing on activities and inputs aimed at strengthening their capacity to implement high-impact and cost-effective innovations.

Data Abstraction (list and describe files or documents that contain information of interest, and purpose of inquiry)
**Case Study** (describe the case, and issue of interest to be explored)

**Verbal Autopsy** (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

**Rapid Appraisal Methods** (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

**Other** (list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)

If impact evaluation –
Is technical assistance needed to develop full protocol and/or IRB submission?
☐ Yes  ☐ No

List or describe case and counterfactual

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**X. HUMAN SUBJECT PROTECTION**

The Evaluation Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:
- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

**XI. ANALYTIC PLAN**

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.
All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program’s achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

**XII. ACTIVITIES**

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

**Background reading** – Several documents are available for review for this analytic activity. These include the HIV Flagship proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

**Team Planning Meeting (TPM)** – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:
- Review and clarify any questions on the evaluation SOW
- Clarify team members’ roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID’s approval
- Develop a preliminary draft outline of the team’s report
- Assign drafting/writing responsibilities for the final report

**Briefing and Debriefing Meetings** – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:
- Evaluation launch, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
• **In-brief with USAID**, as part of the TPM. This briefing may be broken into two meetings: a) at the beginning of the TPM, so the Evaluation Team and USAID can discuss expectations and intended plans; and b) at the end of the TPM when the Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s). The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

• The Team Lead (TL) will brief the USAID weekly to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

• **A final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. *(Note: preliminary findings are not final and as more data sources are developed and analyzed these findings may change.)*

• **Stakeholders’ debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID.

**Fieldwork, Site Visits and Data Collection** – The evaluation team will conduct site visits for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

**Evaluation/Analytic Report** – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.

**Data Submission** – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.
XIII. DELIVERABLES AND PRODUCTS
Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Launch briefing</td>
<td>July 7, 2016</td>
</tr>
<tr>
<td>□ Workplan with timeline</td>
<td>August 22, 2016</td>
</tr>
<tr>
<td>□ Analytic protocol with data collection tools</td>
<td>August 22, 2016</td>
</tr>
<tr>
<td>□ In-brief with the Mission</td>
<td>August 22, 2016</td>
</tr>
<tr>
<td>□ Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>□ Out-brief with the Mission with Power Point presentation</td>
<td>September 9, 2016</td>
</tr>
<tr>
<td>□ Findings review workshop with IP and stakeholders with Power Point presentation</td>
<td>September 12, 2016</td>
</tr>
<tr>
<td>□ Draft report</td>
<td>Submitted to GH Pro: September 30, 2016</td>
</tr>
<tr>
<td></td>
<td>GH Pro submits to USAID: October 5, 2016</td>
</tr>
<tr>
<td>□ Final report</td>
<td>Submitted to GH Pro: November 4, 2016</td>
</tr>
<tr>
<td></td>
<td>GH Pro submits to USAID: November 8, 2016</td>
</tr>
<tr>
<td>□ Raw data (cleaned datasets in CSV or XML with data dictionary)</td>
<td>Submitted to GH Pro: November 4, 2016</td>
</tr>
<tr>
<td></td>
<td>GH Pro uploads to DDL: November 11, 2016</td>
</tr>
<tr>
<td>□ Report Posted to the DEC</td>
<td>January 12, 2016</td>
</tr>
</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 15 Business days (to accommodate USAID/Cambodia and RDMA reviews).

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:
- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities
List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

Recommended: a four-person team, including one international consultant as the Team Lead and three locally-hired consultants as team members.

Edit as needed to the Team Lead’s position description.

**Team Lead:** This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.

**Roles & Responsibilities:** The team leader will be responsible for (1) providing team leadership; (2) managing the team’s activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.

**Qualifications:**

- Minimum of 10 years of experience in public health, which included experience in implementation of HIV/AIDS activities in developing countries, with a focus on NGO implemented community-based interventions.
- Advanced degree in public health or related field (PhD or MPH desirable)
- Demonstrated experience leading health sector project/program evaluations, utilizing both quantitative and qualitative methods
- Knowledge of the HIV/AIDS epidemic and local NGO capacity
- Experience with PEPFAR-funded care and support activities
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in Cambodia is desirable
- Familiarity with USAID & PEPFAR projects
- Familiarity with USAID and PEPFAR policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

**Key Staff 1 Title:** Evaluation Specialist

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

**Qualifications:**

- At least 8 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Advanced degree in public health or related field, or equivalent work experience
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
• Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
• Experience in data management
• Able to analyze quantitative, which will be primarily descriptive statistics
• Able to analyze qualitative data
• Experience using analytic software
• Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
• Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
• Strong data interpretation and presentation skills
• An advanced degree in public health, evaluation or research or related field; or work experience comparable to the advanced degree.
• Proficient in English
• Experience working in the region, and experience in Tanzania is desirable
• Good writing skills, including extensive report writing experience
• Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
• Experience and demonstrate knowledge in conducting programmatic evaluations and/or assessments related to capacity building
• Experience working in the region, and experience in Cambodia is desirable
• Familiarity with USAID and PEPFAR M&E policies and practices
  – Evaluation policies
  – Results frameworks
  – Performance monitoring plans
  – PEPFAR Next Generation Indicators Reference Guidance
  – PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
  – PEPFAR Evaluation Standards of Practice
  – Site Improvement through Monitoring System (SIMS)

Key Staff 2

Title: HIV Specialist (1 GH Pro consultants + 1-2 USAID staff attached to this Team)

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in HIV prevention, care, and treatment, particularly in relation to NGO programs and community-based interventions with linkages to clinical services for PLHIV and MARPS. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:
• At least 10 years’ experience in public health, with technical knowledge and experience in HIV prevention, care and treatment
• Strong background in program design and implementations, with USAID project implementation experience preferred
• Expertise in supply and demand for HIV services at the community and clinical level
• Familiar with the programming needs of PLHIV and MARPS (i.e., EW, MSM, TG, and IDU), and their partners
• Familiar with PEPFAR guidelines and policies, including
  – PEPFAR Next Generation Indicators Reference Guidance
  – PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
  – PEPFAR Evaluation Standards of Practice
  – Capacity Building and Strengthening Framework
- Gender Strategy
- Country Operational Plans (COP)
- Site Improvement through Monitoring System (SIMS)

- Familiar with the NCHADS Cambodia 3.0 strategy
- Familiar with other donors and implementing partners supporting HIV/AIDS in Cambodia
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Experience working in the region, and experience in Cambodia is desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 3

Title: Capacity and Organizational Development (OD) Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate capacity and organizational strengthening activities, particularly among local NGOs and government partners working with the HIV Flagship project to strengthen HIV/AIDS community-based services, with linkages to clinical services. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:
- Background and at least 5 years’ experience in organizational capacity development/strengthening.
- Knowledgeable in capacity building assessment (e.g., OCATs) and evaluation methodologies
- Experience working in organizational capacity development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities
- Experience in implementing and/or evaluating projects working with local NGOs in the health field.
- Proficient in English
- Experience working in the region, and experience in Cambodia is desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local Evaluation Logistics /Program Assistant will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Local Evaluators (2-3 local consultants) to assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed.
Local Evaluators will have a good command of English and local language(s). They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.

Other temporary Translators (2 local translators, 1 for each team) as required, depending on the participants at meetings and interviews, as well as the demand to translate data collection tools, transcripts and other documents. Recommend translator be present during interview to translate for the consultant in real time as the local evaluators conduct the interview.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who: USAID intends to assign a HIV Specialist to this Evaluation Team from RDMA or USAID/GH. If available, this person will function as member of the Team for the full period of performance of this evaluation.
☐ Significant involvement – If yes, specify who:
☐ No

Staffing Level of Effort (LOE) Matrix (Optional):
This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

### Staffing Level of Effort (LOE) Matrix:

**Level of Effort in days for each Evaluation/Analytic Team member**

**Revised LOE Table: August 2, 2016**

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation/Analytic Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team Lead / OD Spec</td>
</tr>
<tr>
<td>Number of persons →</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Launch Briefing</td>
</tr>
<tr>
<td>2</td>
<td>Desk review</td>
</tr>
<tr>
<td>3</td>
<td>Team planning tasks (prior to in-country work)</td>
</tr>
<tr>
<td>4</td>
<td>Preparation for Team convening in-country</td>
</tr>
<tr>
<td>5</td>
<td>Travel to country</td>
</tr>
</tbody>
</table>

Work transferred from Team Planning Meeting: Development of Work Plan/Method; devt of interview guides, devt of report structure, etc.

Site selection; TL working with Logistics Assistant on budgeting, scheduling, etc; Liaison with Mission. For LA, includes setting up appointments, all bookings and budgeting.
<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Team Lead / OD Spec</th>
<th>Eval Spec</th>
<th>HIV Spec</th>
<th>Local Evalu</th>
<th>Logistics/ Prog Assist</th>
<th>USAID Staff: HIV Spec</th>
<th>Translators (as needed)</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Team Planning Meeting &amp; In-brief with Mission</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
<td></td>
<td>Shorter as some planning tasks will be done ahead of the in-country work.</td>
</tr>
<tr>
<td>7 Data collection / Site Visits (including travel to sites)</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>7</td>
<td>12</td>
<td>10</td>
<td>Reflects agreed stakeholders and site visits requested by Mission.</td>
</tr>
<tr>
<td>8 Data analysis (in-country)</td>
<td>3.5</td>
<td>3.5</td>
<td>3.5</td>
<td>3.5</td>
<td>3.5</td>
<td></td>
<td></td>
<td>Some data analysis transferred to be concurrent with report writing.</td>
</tr>
<tr>
<td>9 Debrief with Mission with prep</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10 Stakeholder debrief workshop with prep</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11 Depart country</td>
<td>0.6</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>12 Data analysis (concurrent with drafting report)</td>
<td>1</td>
<td>2</td>
<td>2</td>
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<tr>
<td>13 Draft report(s)</td>
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<td>6</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 GH Pro Report QC Review &amp; Formatting</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>15 Submission of draft report(s) to Mission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 USAID Report Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Revise report(s) per USAID comments</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Finalize and submit report to USAID</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>19 508 Compliance Review</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>20 Upload Eval Report(s) to the DEC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total LOE per person</td>
<td>42</td>
<td>40</td>
<td>40</td>
<td>56</td>
<td>23</td>
<td>35</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Total LOE</td>
<td>42</td>
<td>40</td>
<td>40</td>
<td>28</td>
<td>23</td>
<td>35</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted? [ ] Yes [ ] No

**Travel anticipated**: List international and local travel anticipated by what team members.

Phnom Penh, Siem Reap, and Kampong Cham.

**XV. Logistics**

**Note**: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.
Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access

Specify who will require Facility Access:

☐ Electronic County Clearance (ECC) (International travelers only)

☐ GH Pro workspace

Specify who will require workspace at GH Pro:

☐ Travel -other than posting (specify): International travel to Cambodia, and in-country travel for data collection

☐ Other (specify):

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

• Review SOW and recommend revisions as needed
• Provide technical assistance on methodology, as needed
• Develop budget for analytic activity
• Recruit and hire the evaluation/analytic team, with USAID POC approval
• Arrange international travel and lodging for international consultants
• Request for country clearance and/or facility access (if needed)
• Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
• Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
<tr>
<td><strong>Before Field Work</strong></td>
</tr>
<tr>
<td>• SOW.</td>
</tr>
<tr>
<td>o Develop SOW.</td>
</tr>
<tr>
<td>o Peer Review SOW</td>
</tr>
<tr>
<td>o Respond to queries about the SOW and/or the assignment at large.</td>
</tr>
<tr>
<td>• Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV’s for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.</td>
</tr>
<tr>
<td>• Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.</td>
</tr>
<tr>
<td>• Local Consultants. Assist with identification of potential local consultants, including contact information.</td>
</tr>
<tr>
<td>• Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.</td>
</tr>
<tr>
<td>• Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).</td>
</tr>
</tbody>
</table>

| **During Field Work** |
| • Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team’s work. |
• Meeting Space. Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
• Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
• Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

After Field Work
• Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT
Provide any desired guidance or specifications for Final Report. (See How-To Note: Preparing Evaluation Reports)

All deliverables that are in written format must be in plain grammatically correct English language; be submitted in appropriate electronic format (i.e. Microsoft Word, Excel, Power Point Presentation, and PDF); and meet all the requirements.

All findings must be substantiated by quantitative and/or qualitative data (evidence). Use of the qualitative data as evidence must be specific and clear (e.g. how many informants out of how many interviewed reported finding “A,” instead of “many” or “some” of the informants said so, although it is not meant to be used against representativeness). Data shall be disaggregated by sex as appropriate to the most possible extent. Each of the recommendations needs to be supported by a specific conclusion that is drawn upon a specific set of findings. They must be action-oriented and practical, and be accompanied by recommended responsible parties.

The Evaluation/Analytic Final Report must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).
   a. The report must not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes).
   b. The structure of the report should follow the Evaluation Report template, including branding found here or here.
   c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
   d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:
   • Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages);
   • Table of Contents (1 page);
   • Acronyms
   • Evaluation Purpose and Evaluation Questions (1-2 pages)
   • Project Background (1-3 pages)
   • Evaluation Methods and Limitations (1-3 pages)
   • Findings, Conclusions & Recommendations
     o Findings
     o Conclusions
The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

The Evaluation Report should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIX. USAID CONTACTS

<table>
<thead>
<tr>
<th>Primary Contact</th>
<th>Alternate Contact 1</th>
<th>Alternate Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Peoulida Ros</td>
<td>Alison Bird</td>
</tr>
<tr>
<td>Title:</td>
<td>M&amp;E Specialist</td>
<td>Deputy Program Director</td>
</tr>
<tr>
<td>USAID Mission:</td>
<td>Program Office, USAID/Cambodia</td>
<td>Program Office, USAID/Cambodia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office of Public Health and Education, USAID/Cambodia</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:pros@usaid.gov">pros@usaid.gov</a></td>
<td><a href="mailto:abird@usaid.gov">abird@usaid.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:ssuon@usaid.gov">ssuon@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td>855-23-728373</td>
<td>855-23-728308</td>
</tr>
<tr>
<td></td>
<td>855-12-553155</td>
<td>855-12-803428</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>855-12-472478</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternate Contact 3</th>
<th>Alternate Contact 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Christina Lau</td>
</tr>
<tr>
<td>Title:</td>
<td>Health Development Officer</td>
</tr>
<tr>
<td>USAID Office/Mission</td>
<td>Office of Public Health and Education, USAID/Cambodia</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:clau@usaid.gov">clau@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td>855-23-728316</td>
</tr>
<tr>
<td></td>
<td>855-23-728303</td>
</tr>
</tbody>
</table>
List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

<table>
<thead>
<tr>
<th>Technical Support Contact 1</th>
<th>Technical Support Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Lily Asrat</td>
<td></td>
</tr>
<tr>
<td>Title: Senior Evaluation Advisor</td>
<td></td>
</tr>
<tr>
<td>USAID Office/Mission</td>
<td>USAID Office of HIV/AIDS, Bureau for Global Health</td>
</tr>
<tr>
<td>Email: <a href="mailto:aasrat@usaid.gov">aasrat@usaid.gov</a></td>
<td></td>
</tr>
<tr>
<td>Telephone: 571 551-7192</td>
<td></td>
</tr>
<tr>
<td>Cell Phone: 571-451-6079</td>
<td></td>
</tr>
</tbody>
</table>

**XX. REFERENCE MATERIALS**
Documents and materials needed and/or useful for consultant assignment, that are not listed above
The key components of the methodology for the evaluation were as follows:

**A. Data review and collection**

1. **Document review**
   
   Evaluation team members reviewed key background documents provided by USAID in the following categories:
   
   **PEPFAR documents:** relating to PEPFAR strategic directions in Cambodia and the Country Operational Plan.
   
   **USAID documents:** The project’s Cooperative Agreement between USAID/Cambodia and KHANA, including modifications.
   
   **Project documents:** Including annual work plans, annual and semi-annual progress reports, the Performance Monitoring Plan and related project performance data, and research and technical papers, including those produced by USAID’s HIV Innovate and Evaluate Project.
   
   **Cambodia HIV/AIDS response documents:** Including strategic guidance, clinical management guidelines, concept notes and standard operating procedures of NCHADS.

2. **Review of performance related data**
   
   The Performance Monitoring Plan (PMP) data for the project was analysed to identify achievement of key outputs and outcomes relevant to the evaluation questions. Trends in data were examined and performance indicator data were compared to targets. The evaluation team conducted secondary analysis of project data to identify trends over time for key indicators and cross tabulated key indicators by demographics, including sex-disaggregated data in addition to age, location or other demographics, where possible. Data analysis was confined to the period November 14 2011 (project commencement) to June 30 2016, or the period for which data was provided by the project.

3. **Qualitative data collection**:
   
   The evaluation team collected qualitative data from interviews with:
   
   1. USAID/Cambodia
   2. The Flagship Project’s Joint Technical Teams
   3. Flagship Project Sub-Recipients/implementation sites, including key population beneficiaries
   4. Key stakeholders nominated by USAID/Cambodia, with supplementary interviews with stakeholders identified by the evaluation team.
   5. Follow up interviews with KHANA management, Flagship consortium partners and USAID/Cambodia.

3 (a) **USAID/Cambodia**
The evaluation team participated in an In-Brief with USAID/Cambodia, PEPFAR/Cambodia and CDC/Cambodia. This covered an outline of the operating environment for the project, identification of key issues to be addressed by the evaluation, key parameters for a follow-on project, and inputs on key evaluation questions.

Following the completion of site visits and stakeholder interviews, the evaluation team conducted a mid-point consultation meeting with USAID/Cambodia, PEPFAR/Cambodia and CDC/Cambodia to discuss issues that had arisen in the course of data collection and to obtain additional input related to the evaluation questions.

3 (b) Joint Technical Teams

At the commencement of data collection, the evaluation team met with the Flagship’s Joint Technical Team (JTT) and held separate meetings with the Flagship Consortium technical staff for each of the project’s four objectives (Prevention; Care and Treatment; Organizational Development; and Strategic Information). These meetings were designed to explore evaluation questions relevant to each objective.

The evaluation team held separate meetings with KHANA, FHI 360 and PSI/PSK to brief them on the evaluation methodology, answer questions on the evaluation, explore project management and partnership issues, and collect additional data.

3 (c) Site visits: Flagship Project Sub-Recipients/ implementation sites

The evaluation team visited a selection of Flagship Project implementation sites in Phnom Penh and each of the five provinces where the project is being implemented (Kampong Cham, Siem Reap, Banteay Meanchey, Battambang and Pursat).

Project site selection was undertaken by the Team Leader in consultation with USAID/Cambodia, using criteria provided by the Mission. The criteria used for site selection was:

1. Sites should be selected from Phnom Penh and each of the five provinces where the project is being implemented.
2. In Phnom Penh, Siem Reap and Kampong Cham, priority should be accorded to visiting sites that are classified as Centers of Excellence and/or sites receiving direct service delivery support.
3. The selection of sites should ensure that the evaluation team visits a range of sites covering all key population groups (i.e., MSM, TG, EW and PWID).

During site visits, the evaluation team met with:

1. Management, senior staff and implementation staff of Sub-Recipients/clinical staff at ART Clinics
2. Key population members and PLHIV who are clients of the service (individual and small group)

3 (d) Focus Group Discussions

Focus group discussions were held with the clients of Flagship Project services (key population groups and PLHIV) in the absence of staff of these services to ensure confidentiality of responses. Interviews with beneficiaries were on an anonymous basis (i.e. names of FGD participants were not collected).

The evaluation team split into two sub-teams for stakeholder consultations and site visits in both Phnom Penh and the provinces. In Phnom Penh:
• Team 1 primarily focused on prevention programming within the context of Identify, Reach, Intensify and Retain (IRIR) (Team 1 members: David Hales (technical lead), Chea Bunnary, Michael Cassell, USAID).

• Team 2 primarily focused on care and treatment programming within the overall context of the Boosted-Integrated Active Case Management (B-IACM). (Team 2 members: Katya Burns (technical lead), Bunsoth Mao, Billy Pick, USAID).

Each team, as relevant, asked questions relating to each project objective in consultations and site visits. In Phnom Penh, David Lowe, the Team Leader alternated between Teams 1 and 2.

Following USAID/Cambodia’s advice, the two teams conducted field work in the following provinces:

• Team 1: Kampong Cham, Pursat and Battambang Provinces
• Team 2: Siem Reap and Banteay Meanchey Provinces. (David Lowe joined Team 2 for the provincial field work.)

For the provincial visits, the two teams visited a range of Flagship sites (prevention, community care and HIV treatment).

3 (e) Consultations with key stakeholders

The evaluation team conducted consultations with the following categories of key stakeholders:

• National level Cambodian government entities such as NCHADS, the National AIDS Authority, the national TB program, and the national drugs authority.

• The Provincial Health Department in Phnom Penh and each province where the project is being implemented.

• Other United States Government development partners: Cambodia/PEPFAR and Cambodia/CDC staff.

• Other international development partners: UNAIDS and WHO.

3 (f) Follow up interviews with JTTs and/or consortium partners

After the completion of site visits and stakeholder consultations, the evaluation team held follow up interviews with KHANA management and the Flagship consortium partner technical teams for each objective to further explore issues that had arisen during site visits and stakeholder interviews.

3 (g) Data collection instruments

Consultations with staff and clients at Flagship Project sites and interviews with stakeholders were semi-structured, using interview guides developed by the evaluation team. The interview guides contained questions on key areas that needed to be explored to answer the evaluation questions. They were, however, not intended to be used as a rigid list of questions as there was a need to shape interviews in response to the information respondents provided.

3 (h) Participation in interviews

USAID/Cambodia staff were not present in any of the meetings the evaluation team conducted with stakeholders and Flagship Project consortium partners to avoid the possibility of this influencing the responses to questions. Similarly, Flagship Project consortium partners were not present in any of the meetings the evaluation team conducted with Sub-Recipients.

3 (i) Informed consent
The evaluation team explained the purpose of the evaluation to all those interviewed. The team also explained that they would not be using information collected in a way that would disclose the source, and that responses would be aggregated when reported. All persons were informed that they had the right to decline to answer any questions and to end their participation in evaluation activities at any point, without adverse consequence. Oral consent for participation in interviews and focus group discussions was sought in all instances.

B. Analysis

The evaluation team collected qualitative data through interviews with stakeholders and during site visits. A thematic review of qualitative data was performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what was happening and the perception of those involved. Qualitative data was used to substantiate quantitative findings derived from project reports and the PMP, to provide more insights and context than quantitative data could provide, and to answer questions where other data did not exist.

Following the completion of stakeholder interviews and site visits, the evaluation team met to conduct a thorough analysis of all data and to develop preliminary key findings, conclusions and recommendations related to the evaluation questions. This analysis included triangulation of information from document review, PMP data, and data collected from interviews and site visits. This analysis formed the basis of the evaluation report.

The team’s analysis was based on the key evaluation questions, evaluation methods and application or data use, as set out in the table below.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Evaluation Methods</th>
<th>Application or Data Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Which of Flagship’s HIV prevention innovations and services for Key Population (EW, MSM/TG, PWID) are high-impact and efficient in detecting new cases of HIV, increasing access to condoms, and increasing uptake and yield of HIV testing among underserved and neglected groups (entertainment workers (EW), MSM/TG, and PWID)?</td>
<td>• Document review • PMP data review • Secondary data analysis • Project site visits &amp; interviews • FGD with clients • Stakeholder interviews</td>
<td>• Assessment of the impact and efficiency of KHANA’s HIV prevention services in specified areas (see evaluation question) • Feedback for course correction • Recommendations for future project</td>
</tr>
<tr>
<td>2. How effective was Flagship’s technical assistance in improving the quality and integration of HIV/AIDS care and treatment services and for the Integrated Active Case Management (IACM) approach (tracking referrals from the community to health facilities, monitoring the care and treatment cascade, in enrollment on ART, adherence and viral suppression, and reducing lost-to-follow up cases)?</td>
<td>• Document review • PMP data review • Secondary data analysis • Project site visits &amp; interviews • FGD with clients • Stakeholder interviews</td>
<td>Assess of the effectiveness of TA in improving the quality and integration of C+T services &amp; the IACM • Feedback for course correction • Recommendations for future project</td>
</tr>
<tr>
<td>3. How effective was the project at scaling up proven innovative HIV prevention, care and treatment interventions? How have the studies/evaluations conducted by HIV</td>
<td>• Document review • PMP data review • Secondary data analysis</td>
<td>Assessment of the effectiveness of the project in scaling up</td>
</tr>
</tbody>
</table>
### Evaluation Question

Innovate and Evaluate Project been used to determine which innovations should be replicated and to improve the Flagship project?

<table>
<thead>
<tr>
<th>Evaluation Methods</th>
<th>Application or Data Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Project site visits &amp; interviews</td>
<td>proven HIV interventions</td>
</tr>
<tr>
<td>• Stakeholder interviews</td>
<td>• Assessment of the utility of HIV Innovate and Evaluate Project studies in assessing which project innovations are proven</td>
</tr>
</tbody>
</table>

#### Evaluation Methods

- Project site visits & interviews
- Stakeholder interviews

#### Application or Data Use

- Proven HIV interventions
- Assessment of the utility of HIV Innovate and Evaluate Project studies in assessing which project innovations are proven

### How effective was the consortium’s approach to sustainability and organizational development, including strengthening the financial management, program management and technical implementation capacity of the government, local NGOs, and networks of Key Population (EW, MSM/TG, PWID), and PLHIV at the National, Provincial and community levels?

<table>
<thead>
<tr>
<th>Evaluation Methods</th>
<th>Application or Data Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Document review</td>
<td>Assessment of the effectiveness of organizational development TA</td>
</tr>
<tr>
<td>• PMP data review</td>
<td>• Feedback for course correction</td>
</tr>
<tr>
<td>• Secondary data analysis</td>
<td>• Recommendations for future project</td>
</tr>
<tr>
<td>• Project site visits &amp; interviews</td>
<td>• Assessment of the effectiveness of organizational development TA</td>
</tr>
<tr>
<td>• Stakeholder interviews</td>
<td>• Feedback for course correction</td>
</tr>
<tr>
<td></td>
<td>• Recommendations for future project</td>
</tr>
</tbody>
</table>

#### Evaluation Methods

- Document review
- PMP data review
- Secondary data analysis
- Project site visits & interviews
- Stakeholder interviews

#### Application or Data Use

- Assessment of the effectiveness of organizational development TA
- Feedback for course correction
- Recommendations for future project

### How has the project built local capacity to understand and effectively use service delivery data to plan and monitor progress of the HIV Cascade and the continuum of prevention, care and treatment services?

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#### Evaluation Methods

- Document review
- PMP data review
- Secondary data analysis
- Project site visits & interviews
- Stakeholder interviews

#### Application or Data Use

- Assessment of the effectiveness and results of strategic information capacity building
- Feedback for course correction
- Recommendations for future project

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### C. De-briefs

At the conclusion of the field work and following data analysis, the evaluation team conducted three de-brief meetings with:

1. **USAID/Cambodia, PEPFAR/Cambodia and CDC/Cambodia**
2. **Flagship Project consortium partners (KHANA, FHI 360 and PSI/PSK)**
3. **Stakeholders and Flagship Sub-Recipients.**

The purpose of these de-briefs was to share the evaluation team’s preliminary key findings, conclusions and recommendations, and to receive feedback, validation and further input. Feedback from the de-briefs was considered by the team in drafting the evaluation report.

### D. Limitations

Key limitations for this evaluation are:
1. This is a performance evaluation conducted prior to the conclusion of the USAID-funded project; it is not intended to be a rigorous quasi-experimental or experimental design outcome or impact evaluation with predetermined counterfactual groups. It does not attempt to attribute change in health outcome or impact to the project itself. This limitation applies to evaluation question 1.

2. For evaluation question 1, while the team may be able to make qualitative findings and conclusions regarding efficiency, there are likely to be limitations on the extent to which efficiency can be measured by a performance/process evaluation.

3. Within the time and resources available it will not be possible for the evaluation team to collect quantitative data other than what the program provides. This limitation will be minimized by the comparing the analysis of other available data, where relevant, against project data.

4. The evaluation is a rapid appraisal, which limits its scope and time to validate findings. Rapid appraisals have proven to be very effective in identifying good performance and areas for improvement. The team will attempt to validate finding through the debriefing meetings and USAID/Cambodia’s feedback on the draft evaluation report.

As implementing partners may have influence over which clients are present at project sites when the evaluation team visits, there may be some bias in data collected from clients.
ANNEX 3. DATA COLLECTION INSTRUMENTS

This annex sets out the interview guides that were used in meetings with different categories of key informants.

Introduction and informed consent for all stakeholder interviews and Flagship site visits

We are conducting an independent evaluation of the USAID/Cambodia HIV/AIDS Flagship Project.

The purpose of the evaluation is:

1. Assess the project's performance and the extent to which it has been able to meet its intended objectives.
3. Make recommendations that inform and improve future program directions and effectiveness.

The information we collect from you today will be used by the evaluation team in developing our findings and conclusions. However, the evaluation report will not name individuals as the source of information. The report will describe the sources of information in more general ways which will protect your confidentiality.

You have the right to decline to answer any question and to end the interview at any time without adverse consequence.

Do you have any questions about the purpose of the evaluation or this interview?

Is it OK to proceed with the interview?

Meetings with KHANA, FHI 360 and PSK/PSI management (separate meetings)

The purpose of meeting separately with the management of each of the Consortium Partners is to brief them on the evaluation team’s work plan and approach, answer any questions they have about the evaluation and to ask questions regarding Flagship management and partnership issues and a follow-on project.

Structure of meeting:

1. Evaluation team to provide a brief outline of the team’s Work Plan and approach to the evaluation.

2. Evaluation team to outline opportunities for Consortium Partners to input to the evaluation:
   - Joint meetings with technical teams for each objective
   - This meeting
   - Mid-point check in following completion of stakeholder interview and site visits for questions and discussion on key issues that have emerged (either a joint meeting with consortium partners or separate meetings: afternoon of 5th and morning of 6th September
   - Debrief meeting for Consortium Partners: 9-11 am Monday September 12
• Review and feedback on draft report.

Questions:

1. How effectively has the Flagship Project been managed by KHANA? (Strengths, weaknesses?)
   a. How have any issues relating to management of the project been effectively addressed? How?
   b. How effectively have the Flagship Consortium partners been able to manage a project involving such a large number of innovations?

How effectively have the three Flagship consortium partners worked together? (Strengths, weaknesses?)
   a. Is there a clear delineation of roles and functions for the consortium partners and has this been implemented effectively?
   b. What issues have there been with the coordination of TA for Flagship SRs by the Consortium Partners? How have these issues been resolved?

How have Flagship consortium partnership issues (either positive or negative) impacted on the project's performance?
   a. How have any partnership issues been addressed?

What are the key lessons learned in relation to management and partnership from this project?

USAID has asked for the evaluation team to make recommendations to improve future program directions and effectiveness for both the Flagship Project and any follow-on project.
   a. What key changes are needed to make the Flagship Project more effective (technical and/or management)?
   b. An objective of the Flagship Project is to reduce Cambodia’s dependence on USG funding for health service delivery and to support transition from funding service delivery to technical assistance. What high priority activities need to take place before the end of the Flagship Project to support both sustainability and transition to a new USAID/Cambodia HIV project?
   c. How could any follow-on HIV project by USAID/Cambodia best build on the achievements of the Flagship Project? What would be the key priorities for a follow-on project? What approaches or implementation modalities should a follow-on project adopt?

Questions for Flagship consortium partner technical teams

Four sets of questions were developed for separate meetings with the technical teams in 1) Prevention, 2) Care and Treatment, 3) Strategic Information and 4) Organizational Development.

Flagship Consortium Technical Staff: Prevention

1. Among the different under-served and neglected groups that are the focus of project activities, what have been the most effective approaches to:
   a. Detecting new cases of HIV?
   b. Increasing access to condoms?
   c. Increasing the uptake and yield of HIV testing?
d. Availability of needles & syringes? MMT?

Why are the different approaches so effective?
   a. How do you determine if an approach is effective?
   b. What are the challenges/barriers to making them more effective?

What approaches have performed below expectations?
   a. What are the reasons for the poor performance?

To what extent have you achieved your objectives?
   a. How would you rate your ability to achieve high-impact at a reduced cost?

What are the challenges/barriers to scaling up effective approaches, both within existing sites/catchment areas and to additional sites/areas?
   a. How are you addressing these challenges/barriers?
   b. What are your key achievements in scaling-up effective approaches?

What approaches would you add to improve the overall effectiveness of HIV prevention with the under-served and neglected key populations?
   a. Has adding approaches been discussed? If so, with whom and what is the outcome of those discussions?

How has the project used the studies/evaluations conducted by HIV Innovate and Evaluate Project? Please describe if/how these studies have been used to determine which innovations should be replicated and to improve the Flagship project? Can you recommend ways in which the studies/evaluations could be improved to best support program goals?

Within under-served and/or neglected groups, there tend to be sub-groups with: 1) a higher risk of HIV infection due to their risk behaviors; 2) particularly poor access to services; or 3) both a higher risk and particularly poor access to services.
   a. What information do you have on the profile of sub-groups with a higher risk of infection and/or particularly poor access to services?
   b. What behaviors and/or contextual factors put them at higher risk of infection or limit their access to services?
   c. How have you tailored the prevention services and/or their delivery to ensure you are reaching and meeting the needs of these sub-groups? If so, how?
   d. How do you monitor your interaction with these sub-groups to ensure you are adapting to their changing needs and circumstances?

What information do you have on sustained behavior change related to HIV prevention (e.g. risk perceptions/behaviors; condom use; testing behavior)?
   a. Is specific data available on sub-groups at higher risk of infection?
   b. What can/should be done to ensure that prevention services contribute to sustained behavior change?

What has been done to build local capacity to understand and use service-delivery data to plan and implement prevention activities?
a. What are some key findings/learnings from service-delivery data that have influenced:
   - Planning prevention activities?
   - Implementing prevention activities?

In addition to reporting on indicators in the PMP, how is service-delivery data used to monitor and improve prevention activities?

Based on what has been learned through the launch and ongoing implementation of the project, what would a basic theory of change look like for the prevention activities? (e.g. inputs, activities, outcomes, impact)

Can you outline the project's vision for development of COEs in terms of their technical capacity and technical roles and functions?

What are the different types of TA provided by Flagship Consortium partners to develop the technical capacity of CoEs?

a. Which types of TA have been more effective than other types?

b. What evidence do you have of the effectiveness of different types of TA for the CoEs?
   How is this assessed?

c. What challenges have there been in developing the technical capacity of CoEs?

To what extent have the CoEs been able to develop sufficient technical capacity in line with your vision for CoEs?

a. In what ways are the roles of the CoEs now different to their roles prior to their development as CoEs?

To what extent is there difference in the performance of CoEs? Reasons for this?

**Flagship Consortium Technical Staff: Care and Treatment**

1. In your opinion, what have been Flagship TA's biggest successes in improving the quality and integration of HIV care and treatment services and supporting the Integrated Active Case Management approach? What are the elements that have led to these successes?

2. In your experience, which elements of HIV care and treatment services require the most TA support? Why do these elements require the most TA support?

3. How has Flagship's TA contributed to the various steps in the Integrated Active Case Management approach? Which steps in particular has Flagship's TA focused on (tracking referrals from the community to health facilities, monitoring the care and treatment cascade, in enrollment on ART, adherence and viral suppression, and reducing lost-to-follow up cases)?

4. In your experience, what are the biggest challenges to implementing the Integrated Active Case Management approach in Cambodia? What TA is required to address those challenges?

5. Which of the innovative HIV care and treatment approaches do you believe are most promising in terms of effectively improving quality of care and retention across the HIV treatment cascade? Why?

6. How has the project worked to scale up innovative HIV care and treatment approaches? What are the key achievements in scale up? What are the primary barriers to scale up and how would you recommend they be addressed?
7. How has the project used the studies/evaluations conducted by HIV Innovate and Evaluate Project? Please describe if/how these studies have been used to determine which innovations should be replicated and to improve the Flagship project? Can you recommend ways in which the studies/evaluations could be improved to best support program goals?

8. Can you outline the project’s vision for development of COEs in terms of their technical capacity and technical roles and functions?

9. What are the different types of TA provided by Flagship Consortium partners to develop the technical capacity of CoEs?
   a. Which types of TA have been more effective than other types?
   b. What evidence do you have of the effectiveness of different types of TA for the CoEs? How is this assessed?
   c. What challenges have there been in developing the technical capacity of CoEs?

10. To what extent have the CoEs been able to develop sufficient technical capacity in line with your vision for CoEs?
    a. In what ways are the roles of the CoEs now different to their roles prior to their development as CoEs?

11. To what extent is there difference in the performance of CoEs? Reasons for this?

Flagship Consortium Technical Staff: Strategic Information

1. How has the project worked to build local capacity to understand and effectively use service delivery data to plan and monitor progress across the HIV Treatment Cascade and the continuum of prevention, care and treatment services?

2. In your experience, what have been the project's biggest successes in building local capacity in these areas? What are the main challenges to building this capacity?

3. In your opinion, what are the remaining local capacity gaps in using service delivery data? Can you recommend how these gaps should be best addressed?

4. How has the project used the studies/evaluations conducted by HIV Innovate and Evaluate Project? Please describe how you have participated in these studies. How have these studies have been used to determine which innovations should be replicated and to improve the Flagship project? Can you recommend ways in which the studies/evaluations could be improved to best support program goals?

5. Is your department working with/on any of the innovative HIV prevention, care and treatment interventions supported by Flagship? If so, which ones? Do you think these approaches are useful? Why or why not?

Flagship Consortium Technical Staff: Organizational Development

1. What are the approaches that the project has taken to strengthening organizational development (governance, financial management, program management, etc.) of government, local NGOs, and networks of KPs and PLHIV, at the at the national, provincial and community levels?

2. How have these approaches differed in types of organizational development TA and intensity of TA by different partners (i.e. government, local NGOs, networks of KPs and PLHIV, at the at the national, provincial and community levels)?
3. What have been the results of organizational development TA for each of the different partners (i.e., government, local NGOs, networks of KPs and PLHIV, at the at the national, provincial and community levels)?

4. Which approaches to organizational development have been the most effective?
   a. How do you determine if an approach is effective?
   b. Has the effectiveness of approaches to organizational development differed by partner type?

What are the challenges and barriers you encounter in organizational development TA?
   a. How have you responded to these challenges?

What approaches to organizational development TA have performed below your expectations? What are the reasons for the poor performance?

What approaches have you have taken in developing the technical capacity of CoEs to provide technical leadership to other local partners and develop into Technical Hubs?

Which approaches to developing the technical capacity of CoEs have been the most effective? What have been the results?
   a. How do you determine if an approach is effective?
   b. Has the effectiveness of approaches to developing the technical capacity of CoEs differed by types of CoE?

What have been the challenges and barriers you encounter in developing the technical capacity of CoEs?
   a. How have you responded to these challenges?

What approaches to developing the technical capacity of CoEs have performed below your expectations? What are the reasons for the poor performance?

To what extent are the CoEs functioning effectively as CoEs? What are they doing differently?

To what extent have your achieved your objective for this component? (“Strengthen local organizational capacity to ensure that local partners can lead in scale up of Flagship innovations”)

What are the priorities for the Flagship Project before close out for organizational development and building the technical capacity of CoEs?

Review PMP performance vs objectives.

Questions for Flagship’s implementing partners

Flagship Implementing Partners/ Sub-recipients – Prevention Programming: Head Office Staff, Site Staff

1. Among the different under-served and neglected groups that are the focus of project activities, what evidence is there to indicate what have been the most effective approaches to:
   a. Detecting new cases of HIV?
   b. Increasing access to condoms?
   c. Increasing the uptake and yield of HIV testing?
   d. Availability of needles & syringes? MMT?

Why are the different approaches so effective?
How do you determine if an approach is effective?

What are the challenges/barriers to making them more effective?

What approaches have performed below expectations?

What are the reasons for the poor performance?

To what extent have you achieved your objectives?

How would you rate your ability to achieve high-impact at a reduced cost?

What are the challenges/barriers to scaling up effective approaches, both within existing sites/catchment areas and to additional sites/areas?

How are you addressing these challenges/barriers?

What are your key achievements in scaling-up effective approaches?

What approaches would you add to improve the overall effectiveness of HIV prevention with the underserved and neglected key populations?

Has adding approaches been discussed? If so, with whom and what is the outcome of those discussions?

How has the project used the studies/evaluations conducted by HIV Innovate and Evaluate Project? Please describe if/how these studies have been used to determine which innovations should be replicated and to improve the Flagship project? Can you recommend ways in which the studies/evaluations could be improved to best support program goals?

Within under-served and/or neglected groups, there tend to be sub-groups with: 1) a higher risk of HIV infection due to their risk behaviors; 2) particularly poor access to services; or 3) both a higher risk and particularly poor access to services.

What information do you have on the profile of sub-groups with a higher risk of infection and/or particularly poor access to services?

What behaviors and/or contextual factors put them at higher risk of infection or limit their access to services?

How have you tailored the prevention services and/or their delivery to ensure you are reaching and meeting the needs of these sub-groups? If so, how?

How do you monitor your interaction with these sub-groups to ensure you are adapting to their changing needs and circumstances?

What information do you have on sustained behavior change related to HIV prevention (e.g. risk perceptions/behaviors; condom use; testing behavior)?

Is specific data available on sub-groups at higher risk of infection?

What can/should be done to ensure that prevention services contribute to sustained behavior change?

What TA has the Flagship project given to your organization to build local capacity to understand and use service-delivery data to plan and implement prevention activities and how effective has this been?

What are some key findings/learnings from service-delivery data that have influenced:
Planning prevention activities?
Implementing prevention activities?

In addition to reporting on indicators in the PMP, how is service-delivery data used to monitor and improve prevention activities?

Based on what has been learned through the launch and ongoing implementation of the project, what would a basic theory of change look like for the prevention activities? (e.g. inputs, activities, outcomes, impact)

What types of organizational development TA have you received from the Flagship Project?

- How satisfied have you been with the TA?
- Are some types of Flagship organizational development TA more effective than other types?
- What have been the results in your organization of this TA?

What challenges have you faced in improving your organizational capacity in areas such as governance, financial management, program management, etc.?

- Has the Flagship TA assisted you to effectively address these challenges? If so, how?

What are the priority areas for additional organizational development TA from the Flagship Project prior to the close out of the project?

**Flagship Implementing Partners – Prevention Programming: Additional questions only for Flagship CoE sites**

1. What types of TA has the Flagship provided your CoE to develop the technical capacity of your CoE?
   - How satisfied have you been with this TA? (Strengths/weaknesses?)
   - Which types of TA have been most effective and least effective?
   - What have been the results of this TA for your organization?

2. As a result of Flagship TA, what capacities does your organization now have as a CoE which you did not have before the Flagship Project?

3. What are the priority areas for additional TA from the Flagship project to develop the technical capacity of your CoE prior to the close out of the project? Why are those areas priorities?

**Flagship Prevention Sites Project Beneficiaries Focus Group**

**Introduction and informed consent**

We are conducting an independent evaluation of the USAID/Cambodia HIV/AIDS Flagship Project. The services provided by [name of Flagship Sub-Recipient] are part of the Flagship Project.

You are being asked to take part in this meeting because you have used the services provided by [Flagship Sub-Recipient]. We want to hear your views on what you think about the services being provided by [name of Flagship Sub-Recipient]. We especially want to hear about whether or not these services meet your needs. We would also like to hear your ideas on how the services could be improved.
Your participation in this meeting is 100% voluntary. If you agree to participate in this meeting, we would like to ask you some questions about what you like about this service, what you dislike, and how the service has helped you. This meeting will be for about 30-45 minutes.

We will take notes of what you tell us, but no names will be recorded. Our notes will not be given to anyone who is not part of the evaluation team. When we write the evaluation report, no one will be able to identify who said what or know who participated in this meeting. We will not be telling anyone else what you said in a way that would identify you.

If there are some questions you do not want to answer that’s OK. You can also decide to leave the meeting at any time without any adverse consequence.

We ask all of you to keep everything we talk about today private. Please do not tell anyone who is not in the meeting what anyone said.

Do you have any questions about our work or this meeting?

Is it OK to start asking you questions?

**Questions**

1. Are you satisfied with the HIV prevention services provided by [organization/project]?
   a. What services have been the most useful for you? Why?
   b. What services have been the least useful for you? Why?
   c. What could be done to improve the services available to you? (Could they be more accessible? More convenient? More discreet? Other….)
   d. Are there other services that could be provided which would be beneficial to you? Are there particularly services linked directly to the prevention of HIV that would be beneficial?

How has the [organization/project] helped you changed your behavior so you do not get infected with HIV?
   a. Have there been other benefits of your changed behavior?

Does stigma and discrimination have any effect on the accessibility and/or delivery of services?
   a. If yes, what are they?
   b. If no, do you think the [organization/project] has contributed to a decline in stigma and discrimination?

As clients (i.e. project beneficiaries), do you have a role in determining which services are delivered and/or how they are delivered?
   a. If yes, what role have you played?
   b. If no, what role could you play? How would it improve the effectiveness of the services? Would you like to be more involved?

Do clients have a role in the actual delivery of services?
   a. If yes, what is it? How important is this role to the relevance, quality and/or effectiveness of the services?
b. If no, what role could you play? How would it improve the relevance, quality and/or effectiveness of the services? Would you like to be more involved? How would you like to be involved in the delivery of services?

Do clients have a role in assessing the relevance, quality and/or effectiveness of prevention services?

a. If yes, what is it? Has this role lead to any changes in how services are delivered?

b. If no, what role could you play? How would it improve the relevance, quality and/or effectiveness of the services?

What could [organization/project] do to reach more [EW, MSM, TG, PWID] with its HIV prevention services?

Would you be able to continue to sustain the behavior that prevents you from getting infected with HIV if you lived in an area where the services provided by [organization/project] were not available? If yes, how? If no, why not.

Flagship Implementing Partners/ Sub-recipients – Care and Treatment Programing: Head Office Staff, Site Staff

1. Which innovative HIV care and treatment interventions are you implementing with support from Flagship? Which approaches do you think are the best and why?

2. Please describe your work on partner tracing and testing. In your opinion, what are the main challenges? What are the most effective approaches?

3. What TA have you received to strengthen the quality of care and treatment? Has this TA been helpful? Please provide an example of how Flagship TA has improved your care and treatment services.

4. What TA have you received on integration of HIV and related services, such as TB, STI and family planning services? Has this TA been helpful? Please provide an example of how Flagship TA has improved integration of HIV and related services.

5. What TA have you received on the Integrated Active Case Management approach? Has this TA been helpful? Please provide an example of how Flagship TA has strengthened the Integrated Active Case Management approach.

6. What are your biggest challenges implementing your care and treatment interventions? Why are these challenges? What TA would be helpful to address these challenges and have you received this TA? If yes, has the TA helped you address these challenges and if so, how?

7. In your opinion, has the TA provided changed the way in which you provide services in the long-term? If so, what has changed in the way you provide services? What TA was the most helpful? If there is turn over in your staff, how will the benefits of TA received be sustained?

8. Have you received any TA on service delivery data collection and analysis methodologies? If so, please describe the TA you have received. How effective was the TA?

9. Please describe how you use service delivery data in your intervention. In your opinion, has analysis of service delivery data improved the performance of your intervention? If so, how? (Check for improved planning and improved implementation)

10. What are the main challenges your organization faces in collecting and analyzing service delivery data? What do you think should be done to address those challenges?

11. What types of organizational development TA have you received from the Flagship Project?
a. How satisfied have you been with the TA?

b. Are some types of Flagship organizational development TA more effective than other types?

c. What have been the results in your organization of this TA?

12. What challenges have you faced in improving your organizational capacity in areas such as governance, financial management, program management, etc.?

a. Has the Flagship TA assisted you to effectively address these challenges? If so, how? If not, why not?

13. What are the priority areas for additional organizational development TA from the Flagship Project prior to the close out of the project?

**Flagship Implementing Partners – Care and Treatment Programming: Additional questions only for Flagship CoE sites**

1. What types of TA has the Flagship provided your CoE to develop the technical capacity of your CoE?

a. How satisfied have you been with this TA? (Strengths/weaknesses?)

b. Which types of TA have been most effective and least effective?

c. What have been the results of this TA for your organization?

2. What capacities does your organization now have as a CoE which you did not have before the Flagship Project?

3. What are the priority areas for additional TA from the Flagship project to develop the technical capacity of your CoE prior to the close out of the project?

**Flagship Care and Treatment Sites Project Beneficiaries Focus Group**

**Introduction and informed consent**

We are conducting an independent evaluation of the USAID/Cambodia HIV/AIDS Flagship Project. The services provided by [name of Flagship Sub-Recipient] are part of the Flagship Project.

You are being asked to take part in this meeting because you have used the services provided by [Flagship Sub-Recipient]. We want to hear your views on what you think about the services being provided by [name of Flagship Sub-Recipient]. We especially want to hear about whether or not these services meet your needs. We would also like to hear your ideas on how the services could be improved.

Your participation in this meeting is 100% voluntary. If you agree to participate in this meeting, we would like to ask you some questions about what you like about this service, what you dislike, and how the service has helped you. This meeting will take approximately 30-45 minutes.

We will take notes of what you tell us, but no names will be recorded. Our notes will not be given to anyone who is not part of the evaluation team. When we write the evaluation report, no one will be able to identify who said what or know who participated in this meeting. We will not be telling anyone else what you said in a way that would identify you.

If there are some questions you do not want to answer that’s OK. You can also decide to leave the meeting at any time without any adverse consequence.
We ask all of you to keep everything we talk about today private. Please do not tell anyone who is not in the meeting what anyone said.

Do you have any questions about our work or this meeting?

Is it OK to start asking you questions?

Questions

1. Please tell us what services you have been provided.
   Prompts:
   - Ask about enrollment in care – how did they get enrolled?
   - If on treatment, how do they get their medication and how often?
   - Other tests – CD4? Viral load?
   - Other support – psychosocial?

Are you happy with the services you have been provided? What are you most happy with? Least happy with? Why?

What difficulties, if any, have you experienced getting care and treatment?
   Prompts
   - Stigma and discrimination from family / society
   - Attitude of service providers
   - Logistics and expenses
   - Other

Have you yourself, or others whom you know, ever stopped attending care and treatment services, or have you / others thought about stopping? If so, what were the reasons?

Are there other services you would like to receive but have not received? If so, which ones? Have you asked for these services? Please describe any way you have tried to get these additional services?

Please provide any suggestions about what can be done to improve the services that you are receiving.

Stakeholder questions

Cambodian Government National Health Programs (NCHADS, CENAT, NACD, NAA)

1. In what areas and in what ways has your national program worked with the USAID Flagship HIV Project?
   a. How satisfied are you with the joint work or collaboration your national program has undertaken with the Flagship Project? Probe for strengths and weaknesses and areas for improvement.

What do you see as the key achievements of the Flagship Project?
   a. Effectiveness in increasing uptake and yield of HIV testing and detecting new cases of HIV?
   b. Improving the quality of HIV care and treatment services?
   c. Improving the integration of HIV services with services provided by other national programs such as TB and NACD?
d. Supporting implementation of the Integrated Active Case Management approach?

e. For NCHADS: Supporting implementation of other SOPs and guidelines?

How effective is the Flagship Project in sharing information with government and other development partners on innovations being tested and lessons learned? Examples? Need for improvement?

To what extent have innovations and approaches used by the Flagship Project been replicated and scaled up within the Flagship project and by government?

What do you see as the key challenges that need to be addressed in Cambodia’s national response to HIV? To what extent is the Flagship Project helping Cambodia address these key challenges? In what ways could the project more effectively help Cambodia to address these challenges?

USAID has asked for the evaluation team to make recommendations to improve future program directions and effectiveness for both the Flagship Project and any follow-on project.

a. What key changes are needed to make the Flagship Project more effective (technical and/or management)?

b. An objective of the Flagship Project is to reduce Cambodia’s dependence on USG funding for health service delivery and to support transition from funding service delivery to technical assistance. What high priority activities need to take place before the end of the Flagship Project to support both sustainability following the end of the project and transition to a new USAID/Cambodia HIV project?

c. How could any follow-on HIV project by USAID/Cambodia best build on the achievements of the Flagship Project? What would be the key priorities for a follow-on project? What approaches or implementation modalities should a follow-on project adopt?

NACD: Additional questions

Provincial coverage for harm reduction programming appears to be low. Are there plans for scaling up harm reduction programming in provincial capitals with large numbers of PWID?

What plans does NACD have to make sterile needles and syringes more readily available to PWID?

It would appear that enrollment by PWID in Methadone programs is quite low, particularly in provincial areas. What plans are there for scale up in the availability of methadone programming?

Provincial Health Departments

1. What are the main areas where the USAID Flagship HIV Project has worked with your Provincial Health Department?

2. Has the USAID Flagship Project supported your Provincial Health Department’s work with hospital-based ART clinics? If so, in which ways?

3. What are the main areas in which your department has received TA support from Flagship?

4. How satisfied are you with the TA you have received from Flagship to strengthen the quality and integration of HIV/AIDS care and treatment services and for the Integrated Active Case Management approach?

5. Can you provide a few examples of ways in which TA has contributed to your work and/or the work of your department?

6. Which elements of the Integrated Active Case Management approach do you think are most challenging and have you received TA in these areas?
7. In this province has there been any scale up of HIV/AIDS services over the past 4 years either under the Flagship Project or more broadly? What have been the challenges or barriers to scale up? How have these been addressed?

8. Please describe your department's work with service delivery data. Is your department engaged in analysis or use of service delivery data for program strengthening? If so, please describe your department's work in this area and any TA in this area your department has received from Flagship.

9. Are there areas in which your department would like to receive TA, but has not yet received TA? If so, which areas?

Multilaterals (UNAIDS and WHO) and PEPFAR and CDC

1. In what areas and in what ways has your organization worked with the USAID Flagship HIV Project?
   a. How satisfied are you with the joint work or collaboration your organization has undertaken with the Flagship Project? Probe for strengths and weaknesses and areas for improvement.

What do you see as the key achievements of the Flagship Project?
   a. Effectiveness in increasing uptake and yield of HIV testing and detecting new cases of HIV?
   b. Improving the quality and integration of HIV care and treatment services?
   c. Supporting implementation of the Integrated Active Case Management approach?

How effective is the Flagship Project in sharing information with government and other development partners on innovations being tested and lessons learned? Examples? Need for improvement?

To what extent have innovations and approaches used by the Flagship Project been replicated and scaled up within the Flagship Project and by others?

How effectively has the Flagship aligned its efforts and collaborated with national health programs such as NCHADS, CENAT, NACD and NAA? Strengths/weaknesses/areas for improvement?

What do you see as the key challenges that need to be addressed in Cambodia's national response to HIV? To what extent is the Flagship Project helping Cambodia address these key challenges? In what ways could the project more effectively help Cambodia to address these challenges?

USAID has asked for the evaluation team to make recommendations to improve future program directions and effectiveness for both the Flagship Project and any follow-on project.
   a. What key changes are needed to make the Flagship Project more effective (technical and/or management)?
   b. An objective of the Flagship Project is to reduce Cambodia's dependence on USG funding for health service delivery and to support transition from funding service delivery to technical assistance. What high priority activities need to take place before the end of the Flagship Project to support both sustainability and transition to a new USAID/Cambodia HIV project?
   c. How could any follow-on HIV project by USAID/Cambodia best build on the achievements of the Flagship Project? What would be the key priorities for a follow-on project? What approaches or implementation modalities should a follow-on project adopt?
PEPFAR: Additional questions

How effectively has the Flagship Project been aligned with PEPFAR’s strategic directions in Cambodia? Probe for strengths and weaknesses and areas for improvement.

To what extent has the Flagship Project been flexible in response to changing PEPFAR strategic directions?

CDC: Additional question

Has there been a clear delineation of roles and functions between the USAID Flagship Project and CDC and has this been implemented effectively?
ANNEX 4. KEY INFORMANTS

This annex lists the names, positions and organizations of Flagship Consortium Partners, Flagship Sub-Recipients and stakeholders who participated in individual and small group interviews conducted as part of the evaluation.

The evaluation also conducted a number of focus group discussions with project beneficiaries. As participation in these FGD did not require participants to disclose their names (in the interest of confidentiality), names of FGD participants are not listed. A list of FGDs held is included.

<table>
<thead>
<tr>
<th>Name and position</th>
<th>Organization</th>
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<tbody>
<tr>
<td><strong>United States Government representatives</strong></td>
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</tr>
<tr>
<td>Sheri-Nouane Duncan-Jones, Office Director, OPHE</td>
<td>USAID/Cambodia</td>
</tr>
<tr>
<td>Christina Lan, Deputy Director, OPHE</td>
<td>USAID/Cambodia</td>
</tr>
<tr>
<td>Peouilda Ros, M&amp;E Specialist</td>
<td>USAID/Cambodia</td>
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<tr>
<td>Bunna Sok, Project Management Specialist, HIV</td>
<td>USAID/Cambodia</td>
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<tr>
<td>Marta Levitt, Senior HIV and HSS Advisor, OPHE</td>
<td>USAID/Cambodia</td>
</tr>
<tr>
<td>Sereyrathanak Suon, M&amp;E Specialist</td>
<td>USAID/Cambodia</td>
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<tr>
<td>Robert Newman, Country Director</td>
<td>US CDC/Cambodia</td>
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<tr>
<td>Ly Vanthy, Deputy Country Director</td>
<td>US CDC/Cambodia</td>
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<tr>
<td>Ahmed Saadani, HIV Care and Treatment Lead</td>
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<tr>
<td>Carrie Whitlock, Coordinator</td>
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<tr>
<td>Lori Newman, PEPFAR Strategic Information Advisor</td>
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<tr>
<td>Inga Oleksy, GF Liaison</td>
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<td><strong>KHANA management and technical staff</strong></td>
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<tr>
<td>Chuob Sok Chamreun, Executive Director/Chief of Party, Flagship Project</td>
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<tr>
<td>Chhim Kolab, Deputy Chief of Party, Flagship Project/ Key Personnel, Objective 2</td>
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<tr>
<td>Tuot Sovannary, Research Manager</td>
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<td>Prom Channrith, Key Personnel, Objective 3</td>
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<td>Sou Sochenda, Key Personnel, Objective 4</td>
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<td>Sron Samrithea, Social Enterprise Manager</td>
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<td>Yi Siyan, Research Director</td>
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<td>Ly Sangky, PD</td>
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<td>Hak Sreylen, Grant Management Officer, Objective 2</td>
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### FHI 360 management and technical staff

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<tbody>
<tr>
<td>Song Ngak, Deputy Chief of Party</td>
<td>FHI 360, Phnom Penh</td>
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<tr>
<td>Jean-Philippe Douset, Technical Advisor, HIV/AIDS</td>
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<tr>
<td>Chel Sarim, Technical Quality Advisor, Care and Treatment</td>
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<td>Nith Sopha, Technical Advisor, Entertainment Workers and HTC</td>
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<tr>
<td>Nim Nirada, Technical Quality Advisor, Care and Treatment</td>
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<tr>
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<td>Yorn Thoeun, Technical Quality Officer, Care and Treatment</td>
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<tr>
<td>Rin Channara, HMIS &amp; GIS Mapping Coordinator</td>
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<tr>
<td>Phal Sophat, Advisor, MSM &amp; TG</td>
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<tr>
<td>Heng Saly, Technical Officer, MSM &amp; TG</td>
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<tr>
<td>Sora Nora, Technical Officer, Service Integration</td>
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### Stakeholders: Phnom Penh

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<tr>
<td>H.E. Dr Teng Kunthy, Secretary General</td>
<td>National AIDS Authority</td>
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<tr>
<td>Dr Ly Penh Sun, Director</td>
<td>NCHADS</td>
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<tr>
<td>Ouk Vichea, Deputy Director</td>
<td>NCHADS</td>
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<tr>
<td>Ny Samol, Data Entry Manager</td>
<td>NCHADS</td>
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<tr>
<td>H.E. Dr Mean Chii Vun, former Director</td>
<td>NCHADS</td>
</tr>
<tr>
<td>H.E. Dr Mao Tan Eang, Director</td>
<td>CENAT</td>
</tr>
<tr>
<td>Dr Thong Sokunthea, Director, Legislation, Prevention and Treatment Department</td>
<td>National Authority for Combating Drugs</td>
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<tr>
<td>Dr Laurent Ferradini, HIV/TB Team Leader</td>
<td>WHO</td>
</tr>
<tr>
<td>Muhammad Saleem, Strategic Information Adviser</td>
<td>UNAIDS</td>
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<tr>
<td>Polin Ung, Community Mobilization and Networking Advisor</td>
<td>UNAIDS</td>
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<tr>
<td>Christian Pitter, Chief of Party</td>
<td>USAID HIV and Innovate Evaluate Project, Cambodia</td>
</tr>
<tr>
<td>Long Lavy, Deputy Director</td>
<td>Municipality Health Department, Phnom Penh</td>
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<tr>
<td>Sieng Sovathtevy, PASP Manager</td>
<td>Municipality Health Department, Phnom Penh</td>
</tr>
<tr>
<td>Dr Sin Eap, Deputy Director</td>
<td>MMT Center, Khmer Soviet Friendship Hospital</td>
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### Flagship sites: Phnom Penh

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<tr>
<td>Hon Sienghorn, Executive Director</td>
<td>ARV User’s Association</td>
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<tr>
<td>Ung Sopheak, PA</td>
<td>ARV User’s Association</td>
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<tr>
<td>Ro Ratha, M&amp;E</td>
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<td>Pech Sameth, AFO</td>
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<td>Emily Lush, Volunteer - Communication</td>
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<td>Heng Chheangkim, Program Manager/Fund Raiser</td>
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<td>Kong Vuthy, Project Manager</td>
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<td>Pen Dara, Executive Director</td>
<td>Chhouk Sar</td>
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<td>Seng Michramy, Program Manager</td>
<td>Chhouk Sar</td>
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<tr>
<td>Sos Mary, Doctor</td>
<td>Chhouk Sar</td>
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<td>Yun Phearun</td>
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<td>Tiang Phoeuk, Director and six staff members</td>
<td>Korsang</td>
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<tr>
<td>Focus Group: 7 PWID</td>
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<td>Oum Sokha, Director</td>
<td>ART Clinic, Mean Chey District Referral Hospital</td>
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<td>Em Ra, CMS</td>
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<td>Meach Sotheary, Executive Director</td>
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<td>Chhhorm Amm, Program Manager</td>
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<td>Pann Chandy, FP/HIV Officer</td>
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<td>Chuong Doeun, Field Staff</td>
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<td>Mao Kimrun, Executive Director</td>
<td>Men’s Health Cambodia</td>
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<td>Samrith Sereyroth, CSO</td>
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<td>Muong Narin, Deputy Director</td>
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<td>Dr Oeung Sophep, Director and staff</td>
<td>ART Clinic, Siem Reap Provinical Referral Hospital</td>
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<td>Heap Sun, Manager</td>
<td>Salvation Center Cambodia, Siem Reap</td>
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<td>Houn Hen, Program Coordinator</td>
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<td>Sao Chreb, CACN</td>
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<tr>
<td>Lim Naikhim, Program Coordinator</td>
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ANNEX 5. ADDITIONAL DATA – TABLES AND FIGURES

Figure 5. Percentage of finger-prick reactive KP clients who did not access a confirmatory test, by project year (TA and DSD sites combined)

*PY4 through June 2016. Source: Flagship Data

Figure 6. Percentage of Confirmed HIV+ Patients who Enrolled in Care at Facilities that Implemented the B-IACM Approach (OD-level data)

*Y4 through June 2016. Source: Flagship Data
Figure 7. Percentage of Referred KP Clients Enrolled in Care who were Lost to Follow-Up (excluding those who died) (TA and DSD sites compared)

*Y4 through June 2016. Source: Flagship Data

Figure 8. Strong Results in Viral Load Suppression: Percentage of eligible patients who accessed VL testing and percentage who achieved VL Suppression

Source: Flagship Data, project year 3
Table 5. Organizational capacity scores by indicator at baseline for Flagship Project Centers of Excellence

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<th>Indicator</th>
<th>AHC</th>
<th>AUA</th>
<th>BFD</th>
<th>Chhouk Sar</th>
<th>CWPD</th>
<th>Korsang</th>
<th>MHC</th>
<th>MHSS</th>
<th>PSOD</th>
<th>SCC</th>
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<td>Strong awareness and working relationships with other stakeholders</td>
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<td>Active referral network for health and non-health services</td>
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<td>5</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>5</td>
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<tr>
<td>Conducts effective targeted communications, policy, advocacy and gender work</td>
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<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>Conducts research, consultation and analysis as a foundation for policy, strategy and program work</td>
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<td>0</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<td>Staff have the knowledge and training needed to implement effective HIV, SRH/FP, TB and livelihoods programming</td>
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<td>4</td>
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<td>Systems in place to ensure staff have access to technical resources and knowledge</td>
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<td>3</td>
<td>2</td>
<td>5</td>
<td>5</td>
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<td>Strong transparent governance and a clear and well communicated strategy and structure</td>
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<td>Clear and documented human resources and administration systems and processes</td>
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<td>Clear and well understood system for M&amp;E</td>
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<td>Strong and robust systems for financial management and sustainability</td>
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<td>Actively seeks out and involves key populations</td>
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<td>5</td>
<td>3</td>
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<td>Systems to support involvement of PLHIV, KPs and other affected communities</td>
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<td>Average indicator score by organization</td>
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Source: Purple O Meter data provided by KHANA. AHC – Angkor Hospital for Children; AUA – ARV User’s Association; BFD – Buddhists for Development; CWPD – Cambodian Women for Peace and Development; MHC – Men’s Health Cambodia; MHSS – Men’s Health Social Services; PSOD – Phnom Srey Organization for Development; SCC – Salvation Centre Cambodia.
ANNEX 6. BIBLIOGRAPHY


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ANNEX 7. CONFLICT OF INTEREST/NON-DISCLOSURE STATEMENTS
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.
9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature ___________________________ Date 06/29/2016

DAVID LOWE
Title M.D.
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data: or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
   (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

[Signature]  [Date 18 Apr. 2016]

______________________________     __________________________
Name                                   Title
Assignment Number/Name:

I certify that I, MAO Bunsoth, will not discuss with, or reveal to, any representative of any business organization or other entity, or any individual person (except persons specifically assigned to my specific proposal evaluation group) either within or without the United States Government, any aspects of the pending procurement.

The term "any aspects of the pending procurement" includes, but is not limited to, information such as the identity and number of applicants, the method of procurement, the number and identity of Government personnel involved, and the schedule of key technical and procurement events in the source selection process. Except as specifically authorized by the Agreement Officer, the release of such information constitutes the unauthorized release of advance procurement or procurement information.

The term "any aspects of the pending procurement" also includes but is not limited to, information dealing with the development and/or design of the procurement, its corresponding RFP/RFA/DIQ, and information on the evaluation of another procurement that is may be relevant to or influenced by the development and/or design of said procurement.

I recognize that a significant factor in the success and proper completion of the source selection process is the strict confidentiality observed by all Government participants in the various proposal evaluation and evaluation review groups concerning all of the activities and procedures involved in source selection and that failure to comply with these requirements may compromise the ultimate source selection. I acknowledge that the unauthorized release of advance procurement or procurement information as defined herein may result in the termination of my participation in this procurement.

In the event I have released any of the advance procurement or procurement information covered hereby, I agree to advise the technical panel chair of the proposal evaluation or proposal evaluation review group to which I am assigned as soon as practicable. That advice will identify the business organization or other entity, or individual person, to whom the information in question was divulged and the content of that information.

DATE: March 30, 2016

NAME: MAO Bunsoth

SIGNATURE: [Signature]
Global Health Program Cycle Improvement (GH Pro) Project
NON-DISCLOSURE STATEMENT

Assignment Number/Name:

I certify that I, Katya Burns, will not discuss with, or reveal to, any representative of any business organization or other entity, or any individual person (except persons specifically assigned to my specific proposal evaluation group) either within or without the United States Government, any aspects of the pending procurement.

The term “any aspects of the pending procurement” includes, but is not limited to, information such as: the identity and number of applicants, the method of procurement, the number and identity of Government personnel involved, and the schedule of key technical and procurement events in the source selection process. Except as specifically authorized by the Agreement Officer, the release of such information constitutes the unauthorized release of advance procurement or procurement information.

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DATE: June 16, 2016

NAME: Katya Burns

SIGNATURE: __________________________
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement - Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.

6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.

7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 US Code § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to...
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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

__________________________________________
Signature

__________________________________________
Date

David Rales

__________________________
Name

__________________________
Title

Consultant

05/26/2016
Assignment Number/Name:

David Hales

I certify that I, David Hales, will not discuss with, or reveal to, any representative of any business organization or other entity, or any individual person (except persons specifically assigned to my specific proposal evaluation group) either within or without the United States Government, any aspects of the pending procurement.

The term "any aspects of the pending procurement" includes, but is not limited to, information such as the identity and number of applicants, the method of procurement, the number and identity of Government personnel involved, and the schedule of key technical and procurement events in the source selection process. Except as specifically authorized by the Agreement Officer, the release of such information constitutes the unauthorized release of advance procurement or procurement information.

The term "any aspects of the pending procurement" also includes but is not limited to, information dealing with the development and/or design of the procurement, its corresponding RFP/RFA/IDIQ, and information on the evaluation of another procurement that is or may be relevant to or influenced by the development and/or design of said procurement.

I recognize that a significant factor in the success and proper completion of the source selection process is the strict confidentiality observed by all Government participants in the various proposal evaluation and evaluation review groups concerning all of the activities and procedures involved in source selection and that failure to comply with these requirements may compromise the ultimate source selection. I acknowledge that the unauthorized release of advance procurement or procurement information as defined herein may result in the termination of my participation in this procurement.

In the event I have released any of the advance procurement or procurement information covered hereby, I agree to advise the technical panel chair of the proposal evaluation or proposal evaluation review group to which I am assigned as soon as practicable. That advice will identify the business organization or other entity, or individual person, to whom the information in question was divulged and the content of that information.

DATE: 05/26/2016

NAME: David Hales

SIGNATURE: [Signature]
For more information, please visit ghpro.dexisonline.com
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