UNDP CAMBODIA

EVALUATION OF COMMUNITY CAPACITY ENHANCEMENT PROJECT

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Evaluation of Community Capacity Enhancement Pilot Project

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1 Executive Summary and key recommendations

1.1 Executive Summary

The CCE Programme aims to empower communities through facilitated village Community Conversations using a set of participative learning and action tools. The Programme has been piloted since 2003 in 7 Provinces in Cambodia. This evaluation reviews what has been achieved over the pilot period and makes recommendations for the future of CCE in Cambodia.

CCE is part of the UNDP's response to HIV&AIDS. However, CCE is not solely an HIV&AIDS it is part of a broad programme aimed at building leadership capacity at all levels of society. CCE is the component of this programme aimed at empowering citizens at grass roots community levels to achieve the confidence and skills to discuss their problems and needs and to participate in designing and implementing solutions that address these needs.

CCE is not unique – other community level empowerment programmes exist. All rural and poor urban communities require support to develop their planning capabilities. CCE is one such programme which, when well implemented, provides this support.

The CCE pilot programme in Cambodia has demonstrated the potential for Community Conversations to empower community members. Participants have increased levels of confidence and the ability to speak out and state their concerns. Women who would previously have talked only within their families or with their peers are able to express their views in public. CCE participants are able to talk openly in groups of men and women of all ages and levels of authority. Understanding and awareness on HIV&AIDS subjects has increased in villages. Communities say that the stigma of HIV&AIDS has reduced though PLHAs say they are still experiencing discrimination in several ways. It is difficult to attribute changes in behaviour to CCs as villagers without CCs also demonstrate significant increases in knowledge. The difference therefore for villages where CCs have been active is that a *wider range* of people are readily able to discuss sensitive subjects such as sexual behaviour, HIV&AIDS and violence within families.

The methodology for CCs as described in strategies and manuals has not been followed closely in most villages according to the answers given in village focus groups. The Provincial CCE Facilitation Team reports do list the tools used and the CCs held. However, few villagers can recall the tools that they have used, few can identify how many CCs were held and how many each of them

attended. Most villagers say they attended only 2 to 4 CCs. That the CCs have achieved results is evident, but how this has been done is not clear to the communities. This means that villagers are not yet equipped to take on the roles of facilitation and to spread CCs to more people without additional support.

Villages do want to take control of CCs and are clear on how this can be done. They are able to describe the steps to manage CCs themselves with a very little external support. They are clear how they will organise CCs, how many they need to hold to achieve results, and they have strong ideas on how to form CC groups. They say that the same people should attend all CCs.

CCs have achieved success in raising awareness and empowering the marginalised to speak out. What remains is for communities to be able to plan and implement activities to address their issues and problems. Villages appear to expect external support for their projects. There is only limited and scattered evidence of communities organising themselves to mobilise their own resources to solve problems. This may be because they are used to expecting Government and NGO support for projects and services. However, there are local resources and there is social capital, so the challenge has to be to mobilise these, which is a key objective of CCE.

CCE pilots in Cambodia have been implemented by Government staff and not civil society organisations as is proposed in CCE Strategy documents. As a consequence, there are few if any visible links to civil society other than with the CC participants in villages. Almost no one not directly implementing CCE has heard of CCE. Yet most of the social development work done at community level is supported by NGOs. Those responsible for the Commune Investment Plan and its support in villages where CCE has been introduced have found CCE to greatly improve village level participation in planning processes. This contrasts with villages where there is no CCE where participation of communities is usually weak.

If CCE is to be introduced in more Provinces it is first necessary to demonstrate more fully the gains achievable and to improve the decentralisation and ownership of CCE at village level. Therefore the priority is to develop the pilots further in ways that can overcome the limitations observed. These include decentralising facilitation of CCs to village level, establishing links with civil society organisations (NGOs) at local level and getting support for this at higher levels of these organisations. CCE must be discussed with the officials in Phnom Penh responsible for decentralising and deconcentrating Government (D and D) so that CCE can become a tool for empowering communities within the D and D structures.

So to extend CCE to cover more of the 24 Provinces in Cambodia it is recommended that this is done in two stages: first the work done in the pilot provinces should be extended for one year. Facilitation must be within the communities, indicators and baselines to measure changes must be put in place and monitoring and support arrangements introduced. Management arrangements must be clarified and adjusted until they work effectively and efficiently. Linkages to both civil society and decentralised Government must be established for the pilot Provinces. Then secondly, these pilots must be reviewed and lessons learned. Following reviews, adjustments must be made to the CCE programme design, including the rewriting of the manuals and other instructional materials to fit the Cambodia experience and context. Then consideration can be given to extending the CCE programme to the remaining Provinces of Cambodia.

The cost of CCs has been calculated to be one third of the current costs if it is localised as recommended, with consequent gains in effectiveness and potential impact. However, rollout of the CCE programme beyond the 7 pilot Provinces will require significant funds. It is likely that extension to further Provinces should focus on a limited number of selected target communities as for the pilot Provinces. In this case the local costs per Province, other than central management and overheads, would be approximately US$5,000 per Province for 6 target villages for one year.

1.2 Key Recommendations

1.2.1 *Extension of pilot CCE project*

1. Extend the pilot period for one year using available budget savings in as many of the 7 Provinces as can be funded

2. Reduce the costs of pilot CCs by two thirds by localizing facilitation and using the cost structures proposed in this evaluation

3. Villages clear on CCE localisation so use their advice

4. Form teams of three facilitators per village

5. Prioritise PLHAs for appointment as Facilitators if they have the necessary capacity

6. At least one facilitator must be female

7. If Village chief or assistant is seriously interested, appoint as one facilitator

1.2.2 *CC group formation*

8. Maintain the same selected group of up to 30 participants for CCs for 24 CCs over one year

9. Select participants from all groups in the village

10. Select participants from each section of the village who are respected and have leadership qualities

11. Develop criteria for CC participation that ensure that the most marginalized of the community are adequately represented

12. Do not omit any marginalised groups from CCs, ensure that women, older people, youth, people with disabilities, the very poorest, ethnic minorities and others are included and that there is gender balance overall with a minimum 50% female participation

13. Ensure any PLHAs are included in CC group if they wish to be

14. Assign and agree a minimum of 5 families for each CC participant who will be given feedback after every CC, and at other times

1.2.3 *Support and monitoring*

15. Provide one Provincial CCE team member for up to 6 villages to give one month of training, support and monitoring per year

16. Provide up to 15 days of training to facilitators locally over the year, not all in one initial session

17. In training identify indicators to assess changes that can be attributed to CCs

18. Facilitators start CCs by establishing the baseline for these indicators, using CCE tools

19. Agree monitoring intervals to assess changes against indicators and other observed change

20. Repeat surveys against indicators at agreed intervals

21. Introduce a tried and tested system for collecting and feeding back on reports from CCs, such as 100% Condom Use monitoring

22. Provide constructive feedback to all reports that helps communities develop their CCs and produce reports that are useful for assessment and monitoring

23. Link CCE to other NAA work and share lessons across programmes – e.g. Multi Sector response pilots

1.2.4 *Links to D and D and civil society*

24. Link CCs to the Village and Commune planning processes by using appropriate tools, such as *5 friends of planning*

25. Ensure CC group members and other villagers are aware of 11 Step Planning timetable and participate in the planning processes with emphasis on social problem solving and action planning

26. Use CC tools to emphasise the mobilization of local resources to solve problems before seeking external support

27. Link CCs to NGO activity in target villages so that CC and its value for planning by communities is understood and used

28. Negotiate support for integration of CCE with local level NGO support at Provincial and National levels of the NGOs, as appropriate

29. Provide "earmarked" funds for social projects designed by CCE villages and presented through the Commune Investment Plan

1.2.5 *Rollout of CCE to further Provinces*

30. Review pilot CCE extension and ensure lessons are learned to feed into possible CCE rollout to further Provinces

31. Start discussions on future rollout of CCs across Cambodia with Ministry of Interior immediately

32. Set target date to start CCE rollout – say 3 months from end of one year pilot extension

33. Monitor progress with Organic Law for decentralization and ensure that CCE design is flexible to fit evolving decentralisation

34. Lever funding for cost of rollout, probably to up to 12 sites per Province – min US$5000 per 6 villages per Province plus management costs

2 Abbreviations

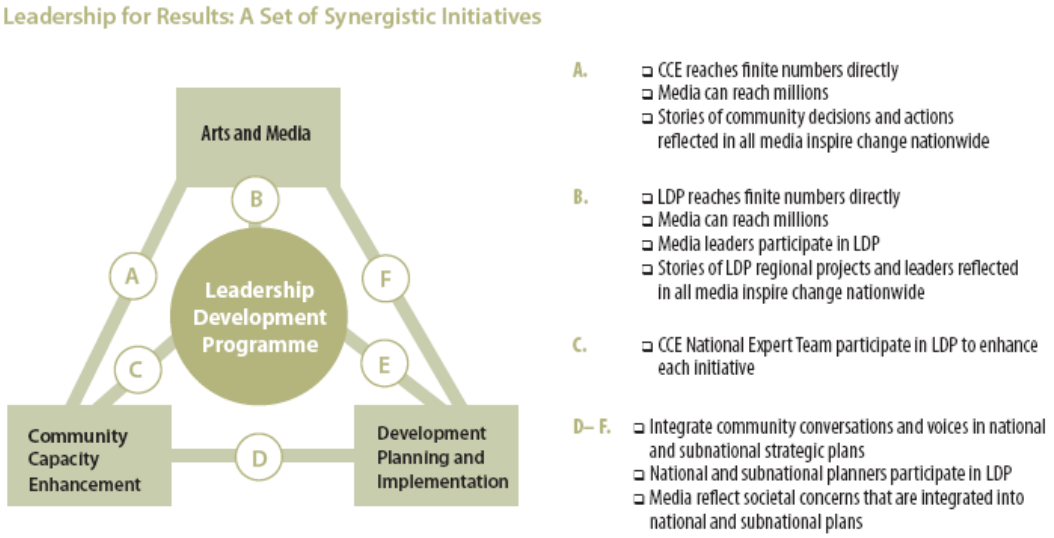
ADB	Asia Development Bank
CC	Community Conversation
CCE	Community Capacity Enhancement
CIP	Commune Investment Plan
CPN+	PLHA Network (NGO)
CS	Civil Society
CSO	Civil Society Organisation
D and D	Decentralisation and Deconcentration (of Local Government)
DFT	District Facilitation Team (of D and D system)
DIW	District Integration Workshop – D and D meeting to decide plans
DoLA	Department of Local Administration, MoI
ExCom	(Provincial) Executive Committee (manages rural development plans)
FHI	Family Health International
GTZ	German Technical Cooperation (Donor)
I/LNGO	International/Local NGO
LDP	(Transformative) Leadership Development Programme
M&E	Monitoring and Evaluation
MoH	Ministry of Health (Cambodia)
MoI	Ministry of Interior
MOSVY	Ministry of Social Welfare, Veterans and Youth
MoU	Memorandum of Understanding
MOWA	Ministry of Women's Affairs
NAA	National AIDS Authority (Cambodia)
NCHADS	National Centre for HIV&AIDS, Dermatology and Sexually Transmitted
NGO	Non Government Organisation
NSP	National Strategic Plan (HIV&AIDS) I and II
OVC	Orphans and Vulnerable Children
PAC	Provincial AIDS Committee
PAN	Provincial AIDS Network
PAO	Provincial AIDS Office
PAS	Provincial AIDS Secretariat
PFT	Provincial Facilitation Team (of D and D system)
PIF	Provincial Investment Fund
PLHA	People Living with AIDS
POT	Provincial Outreach Team
PRDC	Provincial Rural Development Committee
RGC	Royal Government of Cambodia
SPPA	Senior Provincial Programme Adviser (Seila)
STF	Seila Task Force
TA	Technical Assistance
UN	United Nations
UNAIDS	UN AIDS coordination agency
UNICEF	UN Children's Fund
USAID	United States Agency for International Development

3 Introduction

3.1 CCE background and objectives

3.1.1 *The CCE as part of a larger programme*

The Community Capacity Enhancement Program (CCE) is one component of three initiatives of the Leadership for Results Programme developed by the UNDP. The other two components comprise Development Planning and Implementation and Arts and Media. The Interaction of these three Components are illustrated in Diagram 2:



This evaluation covers only the Community Capacity Enhancement (CCE) component as piloted in seven of the 24 provinces of Cambodia[1] over the period 2003 two 2005. The principal activity of CCE are Community Conversations (CCs) introduced at village level to community groups by an implementing partner of UNDP. In Cambodia, the implementing partner has been the National AIDS authority (NAA). NAA has worked with provincial government HIV&AIDS response teams that include a number of Government Departments in each Province.

[1] The pilot provinces for CCE in Cambodia are: Battambang, Banteay Meanchey, , Kampot, Kampong Som, Svay Rieng and Pursat.

3.1.2 *Objectives of community conversations*

The purpose and objectives of CCE are described in the following extract from the strategy documentation for CCE of UNDP:

> The main objective of Community Conversations is to generate a response to HIV&AIDS that integrates individual and collective concerns, values and beliefs and addresses individual and collective attitudes and behaviours embedded in social systems and structures. Specifically, this approach aims to:
>
> Generate a deep understanding of the complex nature of the epidemic within individuals and communities, and to create the social cohesion that is necessary to create an environment for political, legal and ethical change.
>
> Support the development of self-esteem, self-confidence, tolerance, trust, accountability, introspection and self-management.
>
> Examine social contracts among various groups in the community – for example, between women and men, people living with HIV and those who have not been tested, the young and the old, the rich and poor – and to address girls' vulnerability.
>
> Build a pool of resource persons with transformative leadership abilities and facilitation skills in Community Conversations to scale up the community response to HIV and related development issues.
>
> Bring the voices of people into the national response, and integrate community concerns and decisions into national and decentralized plans with the aim of linking resources to individual and collective needs.
>
> Strengthen the capacity of non-governmental and community-based organizations to develop appropriate strategies for a response that places communities and individuals at the centre.

3.1.3 *CCE Expected Outcomes*

UNDP's strategy documentation identifies the following outcomes for CCE/CC:

> Increased number of community initiatives for prevention, home-based care, change in harmful traditional practices, reduction of stigma and discrimination, support for orphans, and voluntary counselling and testing.
>
> Women, Women, men, girls, boys, local authorities, people living with HIV and others are increasingly involved in decision-making processes that affect their lives.
>
> Decision-making processes affecting the lives of these various groups increasingly reflect the concerns of communities through a process of active communication.
>
> Increased number of non-governmental and community-based organizations using Community Conversations to stimulate and scale up social change and to address other issues, such as governance, health, environment, agriculture and peace-building.
>
> Increased number of community decisions brought into the public domain by artists and media professionals.

Additional details on the guiding principles for CCE and the intended approaches to partnership and training are at Annex 7.2.

The contractual arrangements for implementation of CCE and other areas of the work of the National AIDS Authority are included as Annexe 7.4.

3.2 Evaluation purpose and methods

This report focuses on the CCE pilot projects and their achievements and potential. The pilot projects have been studied in the context of other initiatives of UNDP, NAA and other HIV&AIDS focused projects and programmes.

3.2.1 *Purpose of Evaluation*

The terms of reference for the evaluation are at Annex 7.1. In summary, the objectives are to:

specify the results achieved in the pilot CCE program

assess benefits in the light of results achieved and inputs required

identify lessons learned towards ownership and sustainability of CC

identify community and stakeholder's views of the CCE program and the CC process

identify partners that may support CC at community level and link it to commune planning processes

develop recommendations and strategy to scale up and replicate CCE with links to decentralisation of government mechanisms.

Challenges to CCE success previously identified[2] include:

Weak linkages between communities and Commune Councils

HIV&AIDS not integrated into development plans of Communes and Districts

Lack of monitoring and evaluation to assess CCE impact and quality

There are six steps described for full completion of the commune conversation cycle (diagram 1):

The challenges already identified (see above) suggest that the steps of Action and Reflection and Review are incomplete. This evaluation therefore focuses on these two steps. Recommendations are given that should enable communities to complete the expected CCE cycle.

[2] Terms of Reference for evaluation, annex 8.1

The evaluation also examines the planning, implementation and management, reporting, monitoring costs and benefits and effects of all stages of the CCE pilot programme in Cambodia.

The report includes the results of the following steps of the evaluation:

a review of literature and documentation including available reports, information on local government structures in Cambodia

design of field study and interview methodology

field study visits to three of the seven provinces in which CCE has been piloted – Battambang, Kampot and Svay Rieng

interviews with key beneficiaries and relevant stakeholders

analysis and formulation of recommendations, reporting, and feedback to stakeholders.

3.3 Literature review

3.3.1 *Internal reports*

Programme and report documentation for CCE is listed at Annex 7.5 Large numbers of reports submitted from the 7 participating provinces could not be located at NAA or at UNDP offices. According to the CCE implementation plans and letter of agreement the responsibility for monitoring the programme was planned to move from UNDP to NAA when the latter developed the capacity to undertake this function. As there was no clearly stated point in the programme when this transition took place there was a lack of understanding on who should receive and file copies of project Reports. Efforts were made to obtain as many missing reports as possible from the implementation teams in the Provinces. In some cases this required requesting photocopies be made at the Provincial offices.

To overcome the difficulty of missing report information, a questionnaire was developed to obtain key information. This was distributed to all CCE teams in the pilot provinces to collect basic data such as CC frequency and attendance figures, CC tools used at conversation sessions etc. See Annex 7.6.

3.3.2 *CCE Evaluation Ethiopia*

A preliminary evaluation of CCE pilot implementation in Ethiopia was completed in 2005[3]. This study was undertaken by a team of researchers and assistants in two target areas. The time available for both quantitative and qualitative field work was approximately 2 to 3 times longer than was allocated for the current Cambodia evaluation. Therefore, more in depth investigation was possible for the study.

The summarised findings of the Ethiopian evaluation are as follows:

> *….the CC methodology has been instrumental in bringing to the reality HIV&AIDS related behavioural change processes and outcomes that had not existed in the target communities prior to its introduction. The change indicators, evidenced by the qualitative and quantitative components of the research data, go to substantiate the practical significance of the CC methodology, besides calling for its up scaling and replication as a worthy initiative to embark upon.*

As for Cambodia, the Ethiopian evaluation team identified the lack of baseline information against which to measure changes attributable to the CCs.

Clear instructions appear to have been provided to the CCE implementation trainers and facilitators in Ethiopia to target a consistent group of community members

> *A focal centre is a site where fifty residents, 25 men and 25 female, engage in community conversations within the pilot project. The CC participants, numbering four hundred in all, are drawn from different community groups such as elders, traditional and religious leaders, women and youths. This figure is multiplied to about two thousand by a sub-group of another five participants, who an individual CC participant is supposed to bring the conversations to.*

This contrasts with the situation in Cambodia, where CCs were conducted with widely varying numbers of participants and with frequent changes in the composition of the groups from one

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[3] Ayalew Gebre and Yeraswork Admassie Assessment of the Community Conversations (CC) Methodology in the Pilot Project Areas of Yabello and Alaba. A Study Undertaken for the United Nations Development Program (UNDP), Addis Ababa, Ethiopia. Department of Sociology and Social Anthropology, Addis Ababa University

conversation to the next, thus preventing the build-up of knowledge and capacity by a core group of the communities. See later.

As in Cambodia, no quantitative or qualitative baseline data was available for the Ethiopian evaluation team to use. The Ethiopian evaluation states:

> *……no quantitative baseline data on the pre-intervention situation has been collected by the two NGOs or for that matter by any one else. Moreover, it has been learnt that no epidemiological data is available at the NGO offices or the Health Departments of the respective Woredas. This means that there is no quantitative base line data against which current changes can be measured.*

The Ethiopian evaluators therefore had to rely on before and after questions to CC participants and stakeholders. In focus groups and interviews. In our Cambodia study it has been necessary to use similar methods to determine the effects of CCs. The Ethiopian study divided groups into those who had participated in CCs and those who had not. For Cambodia focus group discussions were organised in villages where CCE had not been active to obtain comparative information. For both Ethiopia and Cambodia the issue of attribution of changes at community level to CC is an issue. In Ethiopia there were few identified alternative sources of knowledge and information on HIV&AIDS available to the communities. In Cambodia the situation is very different. There are many possible means by which information is available to communities. These include radio and television broadcasts, health department led initiatives for awareness raising, several HIV&AIDS focused NGOs active in the provinces, and the work of focal points for health, women and children supported by UNICEF and others at commune and village levels. These sources of information and support were frequently named by villagers in Cambodia.

The Ethiopian evaluation focused largely on changes at community level before and after the CCE pilot period. The evaluation contains relatively little information on the conduct of community conversations by facilitators. There are few mentions of the methods used and the perception of facilitators and community participants of the value of different tools. The usefulness or otherwise of the training and implementation manuals for conversations is not assessed although there are strong recommendations to implement the CCE program more widely.

3.3.3 *Other CC related programmes*

The CCE methodology is strikingly similar to the Stepping Stones programme developed by Action Aid International and implemented over the past 10 years in many countries, including Africa and Asia.

> *Stepping Stones is a UNAIDS-recommended resource for community mobilisation and has proved popular around the world: more than 2000 organisations in over 100 countries have received the package[4].*

The strategic and implementation literature for CCE is strikingly similar to available descriptions of Stepping Stones. Some of the key CCE description is included in this report as Annex 7.3. What follows here are some of the points from Stepping Stones literature relevant to the CCE learning process. This analysis should help enrich the experience gained from the pilot CCE program in Cambodia.

Stepping Stones has been reviewed and evaluated in many countries. A key review of these evaluations[5] enables the CCE programme of UNDP to be compared with Stepping Stones. Many of the challenges experienced are similar for both Stepping Stones and CCE.

For example, experience with Stepping Stones shows that the size of group worked with at community level needs to be carefully specified. Stepping Stones also has identified the need to work with specific groups with out too much change of participants for the duration of the Stepping Stones equivalent of a set of Community Conversations, as undertaken for CCE. It will be shown later that the CCE programme has experienced considerable difficulties in Cambodia to maintain continuity of participation of community members over a period of conversations. Stepping Stones experience verifies the importance of facilitating the development of thinking and capacity of a core group of community participants:

> *The training programme is lengthy and spread over many sessions, each one building on the one before enabling real behaviour change to happen and be supported during the process. It involves people working in separate age and sex groups, to encourage openness and discussion; it is designed*

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[4] Tina Wallace for Action Aid International. Evaluating Stepping Stones, a review of existing evaluations and ideas for future M&E work. Action Aid June. 2005

[5] *ibid*

> *to enable women and men and the wider community to decide how to promote respect, listening and communication between sexual partners and within families, and how best to care for those living with HIV&AIDS. While people work essentially within their peer groups, there are periodic community meetings held to share issues and, at the end, present 'special requests', which involve asking others to change their attitudes and behaviour on specific, locally identified issues*[6].

A search of the literature on the CCE, including strategic and instruction manuals, has not revealed instructions on the formation of groups for community conversations in any detail. It will be shown in this evaluation that the lack of instructions or understanding on group formation and continuity resulted in most participants in CCs only attending between one and three Conversations.

Stepping Stones literature further defines the participatory development process as follows:

> *The training is conceived as a journey, building up confidence over time to enable people to learn how to negotiate and cope with HIV&AIDS, through self- realisation, learning, sharing, and caring for those most affected. Behaviour change, because it is difficult, is best achieved through individual change, peer support and wider community changes, which includes rethinking negative social and cultural norms together*[7].

Stepping Stones reviews have identified the need for a dynamic approach to developing training and facilitation manuals:

> *Once the training started it quickly became apparent that the manual would need to be constantly adapted for use in different cultural contexts; to be relevant the training has to be properly rooted in local understandings of sex, sexual behaviour, gender and family relationships, age hierarchies, and cultural beliefs and practices*[8].

Several CCE team member informants in focus group discussions for this evaluation identified the need to review and revise the CCE

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[6] ibid
[7] ibid
[8] ibid

manuals. They pointed out that the manuals do not fit the Cambodia context in many respects. They were designed apparently for the culture and context of Africa.

In common with CCE in both Cambodia and Ethiopia, reviews and evaluations of Stepping Stones have faced the same difficulty of the lack of baseline information and adequate monitoring during implementation, attribution of observed changes to Stepping Stones has also been a challenge, as follows:

> *The lack of a baseline made it difficult for the reviewers to assess the reported changes, e.g. in the rising use of condoms, or try to understand what might be attributed to Stepping Stones directly*[9].

The Overall Assessments of Stepping Stones are largely positive, although appear be based on subjective assessments by stakeholders:

> *Those that have visited communities where Stepping Stones has been undertaken talk of real changes in people's lives: the growing assertiveness and confidence of the women, better inter-generational communication, more openness about discussing sex, less stigma and more care for those with HIV&AIDS, and a willingness of PLWHA to be open. The written and verbal feedback from NGO observers, trainers and facilitators is consistent and positive*[10].

Work with Stepping Stones has taken place across a range of NGOs and agencies such as UNICEF, yet the available documentation and learning is poor.

More information useful in contrasting Stepping Stones approaches with those of CCE Are at Annex 8.3.

3.4 Stakeholder meetings

The majority of meetings with stakeholders have taken place in the three Provinces studied for this evaluation. As there are few stakeholders outside of the teams and departments implementing CCE and the beneficiaries of the programme, it was agreed not to use limited available time for the evaluation to interview more than one or two selected stakeholders in Phnom Penh. These included his Excellency Leng Vy Deputy Director in the Department of Local

[9] ibid
[10] ibid

Authorities (DoLA), Ministry of Interior. Adviser to DoLA Paddy Roome.

In addition, correspondence enquiries were made to the HIV&AIDS umbrella NGO KHANA, the UN AIDS Cambodia office.

The Ministry of interior is responsible for design and implementation of the Decentralisation and the Deconcentration programme of the Royal Government of Cambodia. As will be seen this program presents the strongest opportunity to mainstream CCE widely across Cambodia, and to link it to village and community planning processes.

3.5 Field work

3.5.1 *Provinces Evaluated*

After some discussion, it was decide that three Provinces would be included in field work. Battambang, Kampot and Svay Rieng. Given the time available, it was agreed that sufficient depth of study could be obtained in these three provinces. Battambang was selected, as the prevalence rate has not dropped as much as the national average despite a number of programmes implemented there. In addition, there has been relatively complete reporting on CCE from the Provincial team.

Kampot has limited CC to three communities, all in one Commune and offered the opportunity to study all three relative to changes in a nearby control village.

Svay Rieng is a high prevalence Province with high levels of population mobility as it borders Vietnam. The province also has been at a location for a number of HIV&AIDS's health and non-health led responses.

It was recognised and agreed that there are likely to be wide differences between CCE undertaken across the 7 pilot Provinces, but that detailed study of three Provinces would be more useful than covering all Provinces superficially. The analysis of data from reports and questionnaires administered by NAA staff to other Provinces where reporting is incomplete would enable a degree of comparative analysis to be undertaken.

4 to 5 days were allocated to Battambang and Svay Rieng and 3 days to Kampot (there are only 3 CCE sites in Kampot). The fieldwork was completed between 11th and 29th September 2006.

3.5.2 *Focus Group Discussions and Interviews*

Focus Groups were organised in the three provinces as follows:

- Focus Groups of approximately ten villagers in each of the CCE target communities comprising specified representatives of different community groups. These included: women at home, students, farmers, business man or woman, motorbike taxi driver, focal point for village women, employed workers, youth, older Persons, focal point for children.

- Focus Groups of up to 10 villagers in one or more communities not included in the CCE pilot program. These were selected from the following: chief of village, respected older person, women at home, students PLHA, Monk or pagoda person, a teacher, farmer, village healthcare person, business person, volunteer in village, child focal point, women focal point.

- Focus Group Comprising NGOs working in CCE target villages and those working on HIV&AIDS outside of CCE target villages.

- Focus Group Comprising the CCE trainers and facilitation teams for each province

- Focus Group Comprising the Village Chiefs, focal persons and commune chiefs or assistance for the CCE villages

- Focus Group with approximately 10 PLHA drawn from CCE and other villagers

- Focus Group of provincial offices from Provincial Departments who work on the response to the HIV&AIDS epidemic.

In addition a meeting was held with the Senior Provincial Program Advisor for the Partnership for Local Government (SPPA-PLG) for each province.

3.5.3 *Check lists and conduct of focus groups*

Check lists were prepared and used for all focus group discussions. Annex 7.8. The checklists were used as a guide for the conversations with each focus group. Additional probing questions were asked as appropriate.

Where focus groups were large and comprised members with different degrees of power and capacity to talk within the full group, the focus group was divided into subgroups. Membership of the subgroups comprised women, younger people, village level leaders, commune level leaders, men, respected elders. In this way it proved possible to increase greatly the participation of group members who might feel inhibited from contributing in the larger focus group.

The ratios of men and women participants in focus groups across the three provinces is given in the table below:

PROVINCE	CCE team		PLG Advisor		Provincial Officers		Villagers		PLHAs		Private Sector		NGO's staff		Tot-als
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Battambang	4	1	1		1	2	46	44	3	7	2	4	3	5	123
Kampot	4	2	1		4		38	18	1	9			4	1	82
Svay Rieng	3	1	2		3		74	50	5	5	3	7	4	2	159
Totals Male	**11**		**4**		**8**		**158**		**9**		**5**		**11**		206
Totals Female		**4**		**0**		**2**		**112**		**21**		**11**		**8**	158
Total F & M															**364**

More men than women participated in the evaluation focus groups. This contrasts with information from CCE reports and villagers information that shows that community conversations were normally conducted with 70 to 80% female participants. It may be that for the evaluation to fulfil the focus group compositions, see above, it was necessary to identify more men than women. An additional explanation may be the attractive fee paid to village participants for attending a focus groups, whereas CC participants only receive snacks. That this may be the case is evidenced by the experience at one village where pre-organisation of focus group participation had not been arranged. In this village far more women than men assembled at the last minute for the focus group.

3.5.4 *Interviews*

The interviews held with the three SPPA-PLG in each province provided updated information on the operation of decentralisation and the concentration support and planning processes in the provinces. This information is used in the following analysis and recommendations for the future of CCE.

4 Findings

4.1 Documentation, Reports, Feedback, Training and project management

4.1.1 *Documentation and Reports*

A documentation process that includes verbatim reports accompanies each step of this process. Photos, maps and other community-designed illustrations such as songs and drama are also used, deliberately respecting modes of documentation that are preferred by the community. Documentation is an ongoing part of this approach. ***It must be conducted in a rigorous way starting from the first visit.*** It is a process that provides information on activities, outcomes, (including decisions and changes) and outputs, including community maps and timelines. Community Conversations require that documentation be in the form of a 'thick description'. A thick description is not about observing processes superficially. *CCE Documentation*

The above statement, drawn from CCE documentation used for training purposes, defined the level of reporting appropriate for CCE. While there are quarterly reports listing community conversations held, names of participants, also used at the conversation and financial information, very little detailed information of a kind described above is evident in most reports. Some reports include photographs of conversation meetings in progress and examples of mapping and taken and if you are the outcomes of the conversations. There are a very few if any reports with what might be described as "a thick descriptions" that detail the results and potential impact of the conversations.

A difficulty expressed by facilitators of CCE in understanding what reporting is required of them is the lack of feedback on reports submitted. All team members stated that they had had no feedback on their reports, and that there had been only limited contact with UNDP and NAA staff managing the program. This lack of feedback, they stated, limited their understanding of the content required to in reports of conversations. Apart from quarterly reports, very few, if any, annual reports with outcome and impact analysis have been written.

4.1.2 *Training and refresher meetings*

CCE team members in all cases stated they required both more training at the outset of the program and more support during its implementation. There were opportunities for CCE teams of trainers and facilitators to meet and review progress with conversations on at least two occasions (in Phnom Penh).

According to the CCE Strategy Manual training and ongoing support should be provided as follows:

There will be two sessions implemented:

- *Skills-building session for trainers (10 days)*
- *Skills-building session for community facilitators (6 days)*

Depending on the availability of participants, the first session could be followed by six weeks of practice in Community Conversations by the trainers themselves before the training of facilitators begins. The content of the sessions will take into account specific aspects of the society and culture, the nature of the epidemic as well as the ways in which community responses to HIV have been addressed, and relationships among communities and organizations. The methodology used during the workshops will be based on experiential learning and participatory processes including interactive presentations, group work, facilitation by participants, role playing, exercises, simulations, 'teach backs', field work and practice, debriefing and application by all participants.

After Community Conversations have been implemented for one year, a three-day facilitated experience-sharing workshop will be held in each country. The participants will come from all organizations that have been involved in the approach. This is an opportunity for stocktaking, capitalization of outcomes, setting up direction for scaling up the and expansion of partnerships. The overall documentation of the approach will be presented. Participating communities will be represented.

According to CCE team members met in focus groups, the initial training provided was for 5 days only for trainers. No one could identify a total of 15 days of training for trainers and facilitators, although UNDP and NAA state staff identify that training was provided over two weeks.

The above description of a review process is recognised by CCE team members. However, they say that they have not been engaged in substantive discussions for scaling up and expanding partnerships for the program. They were also unable to identify that community participants in the community conversations were present at the review events. The views of the three CCE teams given in focus group discussions are summarised in the table below.

Staffing and training CCE Teams			
	Battambang	Kampot	Svay Rieng
# in team	7	6	2003-2005 - 6. Late 2005 - 4.
# of team at Focus Group	5	6	4
# of women	1	2	1
# of men	4	4	3
# of gov. departments they come from	3: Health, Planning, POLA. NGO	3: Health, Education & Tourism	3: health, women affairs & culture
Any trainer or facilitator from Health Y/N	Y-1	Y -2	Y - 4
(Average) # of days of training for Trainers	There was 1 training for trainers - 5days.	There was 1 training for trainers - 5 days.	There was 1 training for trainers - 5 days.
# of refresher events or study visits made	3 times	2 times	3 times

External visits from the international coordinator for UNDP of CCE have taken place, and visits were made by him to some of the pilot programme sites[11]. There is, though, no clear evidence that the recommendations and observations in these notes were used by those in UNDP and NAA managing the program. As a consequence of these monitoring visits, the following statement was included in an updated version of the CCE strategy published by UNDP:

[11] CCE Brief Report June 2005 – June 2006, also TOR for this Evaluation. 2006

Community Conversations have begun in seven pilot provinces in Cambodia. Although the programme is still in the early stages, positive results have already been observed. Villagers have discussed their concerns about HIV&AIDS; for many people, this is the first time they have talked about these issues openly. Some common concerns included husbands travelling away from home for business, where they often become infected with HIV, young women travelling to work in garment factories, poverty, natural disasters such as floods, a lack of adequate treatment for people living with the virus, alcoholism and drug addiction, illiteracy and widespread unemployment. They also discussed prevalent attitudes about HIV&AIDS, including the general taboo against speaking openly about it, and various myths, including the notion that condoms contain the virus that causes AIDS. The next phase of Community Conversations in Cambodia will focus on community decisions and actions related to the above concerns. – *Updated Strategy Document of CCE – UNDP 2005*

The expected focus on community decisions and actions relating to concerns identified are not so far well developed in the pilot villages. It is not clear whether or how this focus was conveyed to the trainer and facilitation teams. The CCE Strategy emphasises that:

> *There are three key components that make CCE such a successful programme:*
>
> ❑ *Its unique methodology*
>
> ❑ *The quality, dedication, mindset and values of trainers and facilitators*
>
> ❑ *The values of the community-based and civil society organizations that implement the programme*

No NGO and CBO partner organisations were identified to help implement the CCE programme. In Focus group discussions with NGOs almost none had heard of CCE even though some are working with the same communities on HIV&AIDS. Thus the third of the above success factors is not being met.

As has been stated above, the agreement between UNDP and NAA did not clarify who should take responsibility for direct management of the program at different stages. Consequently, neither organisation has been clear on its role. Furthermore, the contractual arrangements for financing the community conversations were between UNDP and each of the implementing

provinces. This understandably resulted in NAA staff being unclear about their management role.

4.1.3 *Monitoring and Evaluation*

As reported in UNDP review visits[12] there has been a *"lack of Monitoring and Evaluation systems to assess the impact of the project interventions and to ensure quality control of the CC and facilitation skills"*.

No baseline was established for levels of HIV&AIDS awareness and response. There were apparently inadequate instructions to CCE teams on providing "thick descriptions" and using other monitoring and reporting tools to show how things are changing in CCE communities. Perhaps most significant of all has been the lack of feedback and guidance to CCE team members on the reports they have submitted. No team member could recall receiving feedback after submission of their quarterly reports on the quality of the CCs.

4.1.4 *Project and Community Conversation organisation and managment*

From the perspective of the CCE implementing teams in each province, the program has lacked continuity. The initial contract awarded each province was for a short one month phase. Further phases and contracts were signed for periods varying from three months to one year. In most cases, if not all, this resulted in Community Conversations stopping and starting according to the existence or not of a contract. The lack of continuity in contractual arrangements and consequent lack of medium to long-term planning clearly prevented the development of a continuing relationship between the facilitation teams and the communities with whom they worked.

This may have led to the lack of clarity and confusion in the minds of villagers between CCE and other projects in their areas. In focus group discussions with CCE villages considerable uncertainty and confusion was expressed in identifying when the community conversations were held, their frequency and when they started and finished. There were clear instances where community conversations were being confused with other projects and programmes operating in the village. For example, participants described sessions in which questions and answers on HIV&AIDS were asked and rewards of soap and other items given for correct answers. This is a program of PSI, not CCE, designed to check and

[12] ibid

monitor levels of awareness. Again, focus group participants in villages described meetings held since the end of community conversations that were clearly the work of other agencies.

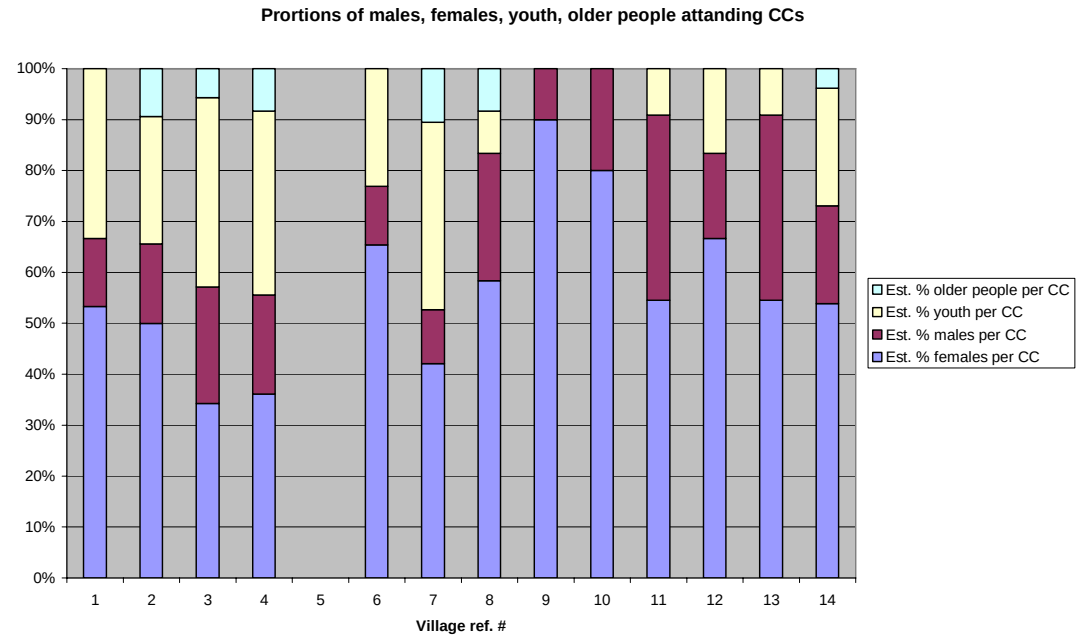
To identify when villagers were describing community conversations activities we had to ask check questions, for example, the day of the week on which the Conversations took place. Most if not all Conversations took place at weekends. Unfortunately, quite often villagers are not clear on which day of the week Conversations were held. Given that few villagers attended more than 2 or 3 Conversations it is unsurprising that they would not remember details. See next section also.

4.1.5 *Gender and ages of CC participants*

The average number of conversations attended by focus group participants in each CCE village ranged between one and six. Most focus group participants had attended only between one and three community conversations each. The average for some villages is higher because the village chief, when present at the focus group, reported having attended most of the conversation meetings himself (we met no female Village Chiefs).

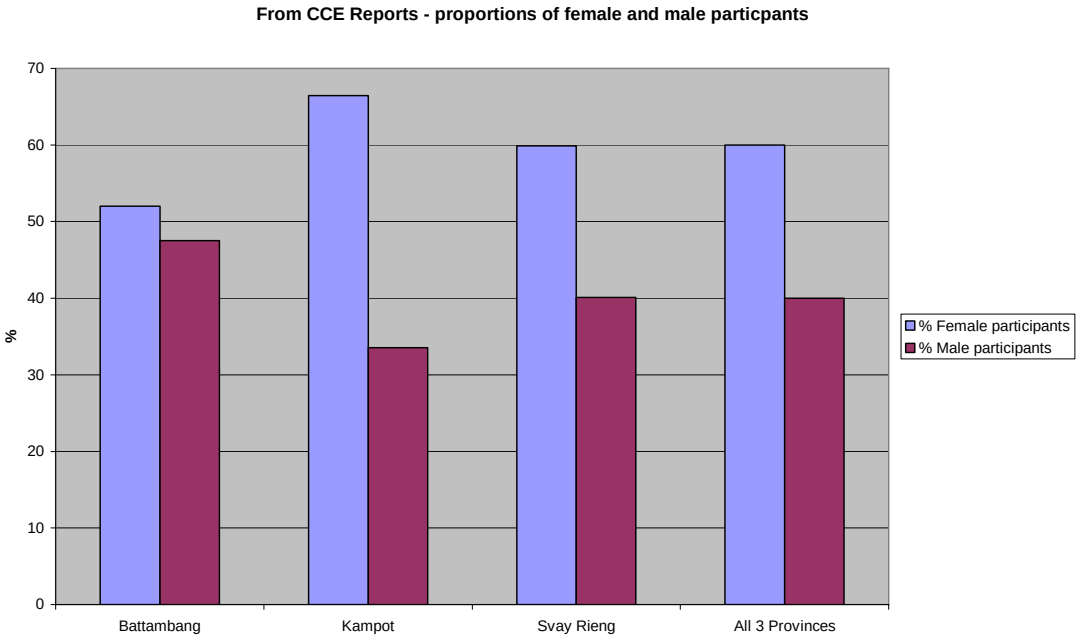
The reason that few people attended more than a small number of conversations is that all village and commune leaders understood their responsibility to be to ensure as large a number of representatives of village families had the opportunity to attend a Conversation. Furthermore, in several villages, Community Conversations were held at a number of different sites on each day the CCE Team came to their village to facilitate Conversations. The number of sites per village at which Conversations were held ranged from two to seven. According to UNDP[13] on review and support visits they made to villages, large numbers of CC participants assembled to meet the review team. In fact, Focus Group participants explained that this was because for those special visits the participants from all sites where CCs were held assembled together to meet the visitors. The following table shows the proportions of men, women youth and older people reported to have attended community conversations at the villages where these figures are remembered.

[13] Meeting with Renato Pinto and file note on field visits with Daouda



Village 5, Toul Ta Ek, Battambang, did not achieve consensus on the proportions of people attending their conversations.

Analysis of available CCE Reports for the three provinces studied provides the proportions of male and female participants in conversations



On average, Community Conversations were attended by 60% women to 40% men according to the reports submitted by CCE teams in the 3 Provinces. Given that more young women than young men attended conversations, these proportions are

consistent with the focus group records. CCE Reports did not provide information on proportions of youth, older people and other sections of the community as was determined in the evaluation focus group discussions at most villages.

4.1.6 *Observations on CCE training, management and CC conduct*

It has to be concluded that the quality of community conversations has depended on the initial training, reflection and review meetings, and the quality, motivation and initiative of the members of each of the provincial teams. There has been very limited coordination and central guidance and management of the program by either UNDP or the NAA for the reasons given above. The lack of clear instructions – in CCE Manuals and apparently in the training provided – resulted in most conversations being attended by different people. This absence of continuity has prevented the building of a core capacity in villages with an in depth understanding of CC tools and methods to pass on to others in the villages, or even neighbouring villages. This contrasts with the experience in Ethiopia, where group formation was clearly defined for what were termed "Focal Centres". Consistent numbers and attendance at Conversations was planned, and a pattern of outreach to further community members built up, see box:

> A focal centre is a site where fifty residents, 25 men and 25 female, engage in community conversations within the pilot project. The CC participants, numbering four hundred in all, are drawn from different community groups such as elders, traditional and religious leaders, women and youths. This figure is multiplied to about two thousand by a sub-group of another five participants, who an individual CC participant is supposed to bring the conversations to. These engage in extension CC sessions which take place in informal circumstances like the home, cattle camps and water points, with CC members forming the core of the pilot project sharing the information they receive with fellow residents. – Assessment of the Community Conversations (CC) Methodology in the Pilot Project Areas of Yabello and Alaba. Ethiopia 2005. UNDP

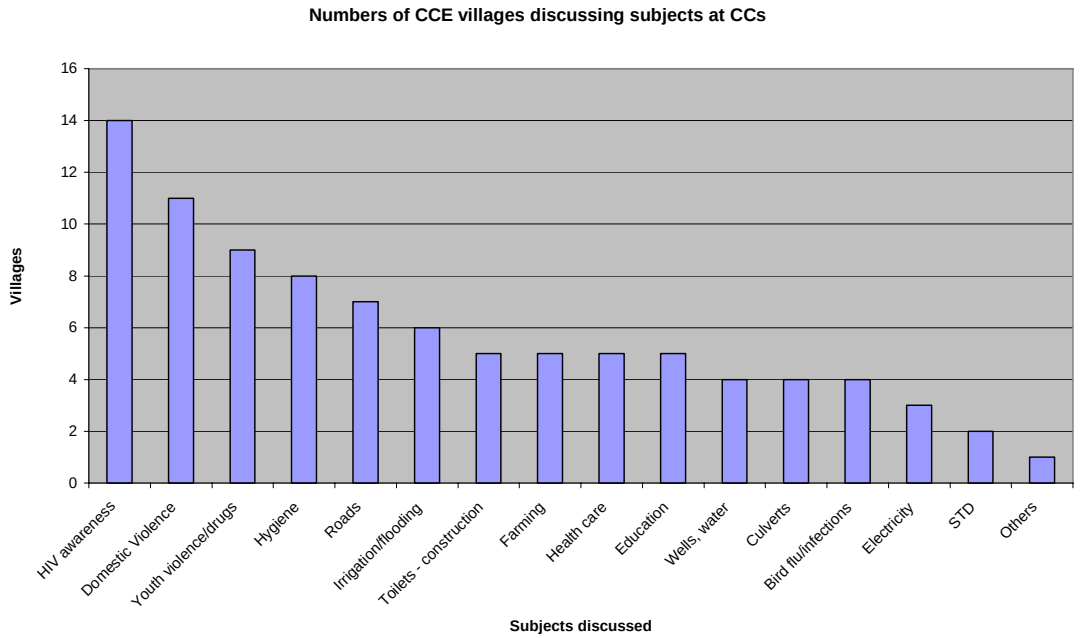
4.2 Contributions of CCE to community H/A response and development challenges

4.2.1 *Community Conversation discussion content*

Attribution to specific initiatives is extremely difficult to establish for improved HIV&AIDS awareness in villages where there has been considerable efforts made to provide information by a number of organisation, different programmes, and the availability of TV and Radio programmes on HIV&AIDS. By holding focus groups in both community conversation villages and those who have not participated, the evaluation has been able to confirm that confidence and ability to discuss a wide range of subjects has resulted from conversations. The level of knowledge on HIV&AIDS and other subjects is not significantly different between villages with and without CCs. What is observable is an increase in the level of participation of marginalised community members.

Annexe 7.10 provides a list of the subjects discussed in CCs in order of the frequency with which these were mentioned by Focus Group participants. HIV awareness, prevention etc was discussed in all villages. This is unsurprising given that the CC facilitators are all appointed by the Provincial AIDS Committee or Secretariat (PAC or PAS). Domestic violence is ranked second and was discussed in 11 of the 14 CCE villages. Security and problems of violence were discussed in 9 of 14 villages. Other subjects discussed are largely related to development concerns, especially infrastructure (roads, wells, culverts), livelihoods and services. it was clear from the discussions that the level of detail and sensitivity with which the first three ranked subjects are being discussed is high, with women especially able to assert both their concerns and ideas for solutions to many of the issues addressed.

The chart below shows the subjects discussed at community conversations by more than one village, and the number of times the subject was mentioned:



The “other” subjects mentioned by one of the 14 village included: mobility, people digging land to find treasures (ancient artefacts, gold hidden by Khmer Rouge etc), village planning, karaoke, illegal fishing and HIV&AIDS services. “Hygiene” discussions included the cleaning of the village environment. “Farming” includes cropping rice, livestock management and the production of organic fertiliser. The Community Conversations thus included a mix of social issues such as domestic violence and youth problems resulting from lack of employment opportunities alongside infrastructure and service provision subjects.

As focus groups comprised both Community Conversation participants and those who had not participated it was possible to identify differences in the knowledge and understanding of subjects between those who had participated in CCs and those who have not. For example, in one Community Conversation focus group a man who had not participated asked if it is true that the condoms available may be the cause of HIV infection.

The most striking change and initiative taken by women in most Community Conversation villages is to insist that their menfolk take condoms with them when they travel away for work or any other reason. Most families state that they do not use condoms within the family, other than for birth spacing purposes., They believe they are protected from infection if men choosing to have sex with sex workers and others use condoms. Some villagers still say that HIV&AIDS comes from towns and is not endemic in rural areas. Most PLHA focus group discussants who shared their history had become HIV+ through sexual relations with soldiers or ex soldiers,

or are ex soldiers themselves thus reinforcing the perception that HIV is brought into the village from outside.

In Battambang, on the edge of the city, a single male CC participant in his mid thirties stated that he does not use condoms and that he does not consider himself to be at risk of infection. The local stores do not stock condoms. These, people say, are available only in sex work places such as brothels and karaoke bars and from pharmacies. If small shops and stalls stocked condoms they would be used as balloons by children, one group suggested.

4.2.2 *PLHA – Stigma and Discrimination*

A total of 12 PLHAs were reported to have attended CCs across 5 of the 14 sampled CCE villages. 4 of these villages are in Battambang and one in Kampot. No village in Svay Rieng identified PLHAs as attending their CCs, though they acknowledged that participants might be positive but not sharing this information outside their immediate family.

Eight of the 14 villages stated that PLHAs are not "coming out". They explained that PLHAs may seek support and treatment from health and other services, but this information is kept confidential and many PLHAs fear to share their status due to risks of loss of livelihood support and stigma. This contrasts strongly with the claims made at all villages that stigma and discrimination has reduced now that transmission and infection is understood. This information appears in Annexe 7.10 and the edited table that follows:

PROVINCE	Battambang					Kampot			Svay Rieng					
COMMUNE	Tout Ta EK					Prey Khmum			Svay Toeur			Sang Khor		
VILLAGE[1]	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Do PLHAs "come out" in village - Y/N	N		N					N		N	N	N	N	N
# PLHA in village	8		15			5	4							
# PLHA known to attend CCs	1	4	2	3			2							

[1]See Annexe 7.10 for names of villages 1 to 14. No entry indicates question not clearly answered by focus group.

Triangulation of information provided by village focus groups, CCE team Reports and meetings with other focus groups confirmed that many PLHA are reluctant to "come out" and declare their status. The PLHA focus group participants in particular were clear that,

while there is less discrimination than three years ago, they are still very reluctant to come out. They state that there is serious risk to their livelihoods if their status is known. For example, one female PLHA whose status is known and who sells food says that she must sell her food in markets where her status is not known and not to her neighbours. Another mother of three children, who is not "out" says that she fears if her status is known her neighbours may stop her children collecting water from their wells, which they currently depend on.

The information provided by PLHAs contrasts greatly with that provided by Village focus group participants. Villagers declare awareness of HIV&AIDS risks and that they know they cannot be infected through social interaction. Yet this information is not translating into actual behaviour to any great extent, if we listen to the experiences and fears of PLHA. Little difference was found between the situation of PLHAs who attended CCs or lived in CC villages and those who do not. There are gaps between increased awareness and putting this knowledge towards action plans that will change the situation for HIV&AIDS affected people.

The CCE strategy, as was noted in visits made by the CCE UNDP Advisers to Cambodia[14] "*…weak linkages….and…limited participation of local authorities in the CC hinders action to address the issues raised by the communities"*. There is little evidence that this situation is changing. Considerable changes are needed to the structures of CCE in Cambodia for community awareness to be translated into actions, and for these actions to be reviewed, assessed and a culture of lesson learning and progress to develop.

4.2.3 *OVCs*

Orphans and vulnerable children (OVCs) known to be the children of people who have died of or been affected by HIV&AIDS are claimed to be getting more help than in earlier years as a result of people understanding transmission and infection. Focus groups in both CCE and non CCE villages state that they are more ready to contribute to the funerals of PLHAs who die and then provide support to their surviving dependants. The distinction made in CCE and non CCE villages was not greatly significant. While CC participants had a more accurate understanding of transmission and infection risk, those from non CCE villages have obtained sufficient information from non CCE sources to act with compassion towards OVCs. Typically, pagoda committees and Monks are introducing

[14] CCE Brief Report June 2005 – June 2006, also TOR for this Evaluation. 2006

collection boxes and using the funds to support OVCs attend school as well as make the funds available to PLHA to travel for tests and treatment. Pagodas and Monks are clearly seen as the main means of support for OVCs (as they tend to be for old and destitute people). CCs should be used to encourage communities to decide if this is the most helpful and best way to care for OVCs, many of whom may prefer to live with families, despite the obvious compassion extended to them in pagodas.

In discussions with PLHAs, the situation was less positive. For example a single mother had removed two of her three children from school to farm as she had too little community support to meet the family's livelihood costs.

4.3 Benefits in relation to CCE inputs

4.3.1 *Costs*

The cost estimates that follow are approximations based on the information available from the 3 Provinces included for field study in this evaluation. There may be wide variations from these figures due to differences in numbers of villages targeted and frequency at which Conversations were held. Also, some Provincial CCE teams added more villages to the initial numbers targeted. Although the costs arrived at are approximations, they do give some indication of the cost of running the CCs on the current basis. They also enable comparisons to be made with alternative approaches to running CCs as will be described.

The cost of initial and refresher training of CCE teams members, the cost of any monitoring and support visits from UNDP and NAA, the administrative overheads of these organisations are NOT factored into the following cost estimates. Given that there are now teams trained and experienced in conduct of CCE some of these costs may be considered a capital investment that does not need to be repeated. This will be the case if alternative cost effective means can be developed to pass facilitation skills to community levels. See Recommendations.

Community Conversations are implemented by CCE teams contracted directly through the Government Provincial Aids Secretariat (PAS) on behalf of NAA at a rate of approximately US$3000 per 3 months of Conversations. Assuming there to be 2 CCs per month in each of up to 6 villages – a total of 36 Conversations, the cost is **US$83.3 per Conversation.** These costs include incentive payments to CCE team trainers and facilitators – each of whom receives $50 per month, transport costs, costs of preparing materials for Conversations, snacks for participants.

The number of villagers targeted per Province differs. The numbers of participants attending Conversations also differs widely from Village to Village.

The average number of participants for Battambang for the entire pilot period was 52 per conversation. The cost per participant is therefore **$1.6 per participant per conversation**.

135 Conversations were held in Battambang in a total of 5 villages, although two villages started later than the others. The *average* number of Conversations per village is therefore 27. So assuming each participant had attended all Conversations – that is completed the entire course of pilot Conversations, the **cost per participant per course of 27 CCs is $43.3** over a period of 3 years,

The Conversations were not held continuously due to breaks in contracting Provincial teams. In three years at 2 Conversations per month there would have been 72 Conversations per Village. In fact in Battambang 3 villages held 31 Conversations and two villages held 21 Conversations over the (nominal) 3 year pilot period.

Calculations for other Provinces would provide similar results, but due to gaps in information it is difficult to provide even clear average figures.

4.3.2 *The value of Benefits*

It is impossible to make more than guesses at the monetized value of the benefits resulting from the Conversations with the time, information and resources available for this evaluation. Proxy indicators would need to be identified and values ascribed. For example, it might be possible to calculate the savings in care costs for a given number of HIV affected OVCs accepted into families in place of being cared for in orphanages or at Pagodas. If this change in OVC care arrangements is attributable to the changed attitude and behavior of CC participants then the cost of providing CCs can be equated with the costs saved in caring for the OVC – over the period of childhood of the OVCs.

A more useful exercise is to compare the costs of CCs with that of other awareness and empowerment approaches. Alternatively, if there is the will to continue with CCs the costs of alternative means of implementing CCs is a useful exercise. The alternatives suggested by some focus group participants and also by CCE team members are now presented.

4.3.3 *Projected costs of implementing CCs using community members as facilitators*

CCE village focus groups were asked to estimate how much it would cost for them to facilitate CCs in their communities. Most villages proposed having three facilitators. Estimates for payment to each facilitator ranged from $2.5 to $5 per day on which they conducted CCs. The size of groups they proposed for each CC averaged approximately 30. CCs, on average, should run for about 12 months with two CCs per month. A total of 24 CCs. Funds would also be needed for snacks at CCs and for materials for conducting CCs. This would cost approximately $20 per CC. The villagers mostly considered that they would need initial training (this should be 10 days according to the UNDP CCE Manuals and Strategy) and some ongoing support from the Provincial team. This could be provided through a month of the time of one team member spread over the 12 month period and provided across up to 6 villages. Say $50 for salary supplement and $20 per village for transport. The cost estimates are shown in the table below.

Course of 24 CCs with Village facilitators				Current costs
Facilitator fees and incentives at $2.5 per day			*Costs*	
10 days training for 3 village level facilitators provided by Province trainer or PFT/DFT	30	2.5	75	
24 one day CCs, 3 facilitators	24	7.5	180	
CC related costs				
Materials and snacks	24	20	480	
Monitoring and support - 1 month per year from Province for 5 Villages 50/5			10	
Transport for support per village			20	
Cost per CC			**31.9**	**83.3**
Cost per participant per CC for 1 year (52 participants now, 30 as proposed by villagers)			**25.5**	**43.3**
Cost per participant per Conversation			**1.06**	**1.6**
Cost for of CC for 1 year per village 27 now, 24 with village facilitators			**765**	**2,249**
Cost to run further year of CCs in ALL 41 Pilot Villages		765	**31,365**	92,209

All Costs are US$.

These figures show that moving facilitation from Provincial level to Village level could reduce the costs of running a series of CCs by approximately 2/3rds, from $2249 to $765 per village. If all current the 41 CCE target villages are to transfer to this system then the approximate **total cost will be US$31,365.** Based on the existing Provincial CCE team continuing the approximate cost will be US$92,209 These cost estimates do NOT include administration costs, M and E by UNDP or NAA, costs of training village facilitators if this is not done locally. See recommendations.

4.4 Community ownership and mobilization

The CCE Village focus groups all said they value Community Conversations and many of the participants presented their ideas for improving and continuing them. Some villages expressed concern that the benefits of CCs has not extended to all families in their village. Their ideas for further CCs is based on the need to develop village level capacity so the messages and lessons from CCs can be shared with all of their community.

Villagers perceive the benefits of CCs to be primarily to improve the social relationships of community members. They value the opportunity to gain accurate information on health and other issues, including, but not only, HIV&AIDS. Most villages when asked to prioritise their health and social concerns listed common diseases such as diarrhoea, dengue fever, the need for children to be vaccinated, TB, domestic and youth violence ahead of HIV&AIDS.

CC participants recognise that the CCs provide opportunities to discuss village development plans and some participate in Commune Investment Planning meetings as well as CCs.

Knowledge of the tools used in CCs is generally low. Village focus groups were only able to list a few of the tools and methods used as stated in CCE Team Reports. This may be partly because most villagers only attend a very few CCs. It may also be that CC participants are not always aware of the tool they are being helped to use by facilitators. If a group of CC participants is to assist other villagers use CC tools and methods they need to understand what the tools are and be able to apply them as needed. Villagers are proposing that CCs are held with a consistent core group of participants who will attend all, or most, CCs. Then they will be able to share the CC learning and methods with others. The numbers of tools identified as used in CCE Reports and by focus group participants are shown in the table below:

VILLAGE[1]	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Number of CC Tools used - from Reports	22	22	23	23	23	9	9	9	13	13	13	13	13	13
Number of CC Tools used - from Focus Groups	3	6		3	3	4	3	3	3	3	5	3	4	4

[1]See Annexe 7.10 for names and locations of Villages

4.5 Partnerships for sustainability of CCE and CC tools

The choice of partner organisations for implementation of CCE being the National Aids Authority and the Provincial Aids Secretariats (PAS) has influenced the spread of information on CCE. Only persons and organisations associated with the implementation of CCE are aware of the programme. The Provincial AIDS Committees (PAC) and similar structures at District and Commune level should work across Government Departments and Civil Society sharing information of HIV&AIDS. These structures are generally very weak and in many cases rarely meet.

Focus groups with NGOs in the three Provinces revealed that almost no civil society organisations are aware of CCE. A notable exception was found in Battambang where one Pagoda Monk who is a member of the CCE team and also runs a NGO “Home for Children” is deeply engaged in building services for OVCs. NGOs also pointed out that the number of coordination meetings they are invited to attend by Government is too high for them to be present at all but a few.

Seila-PLG staff met also are unaware of the CCE programme, but expressed interest and enthusiasm to learn more about CCE and readiness to engage with the programme in future. Village and Commune level programmes such as CCE are invited to participate in the Commune Investment Planning processes (CIP) and, in particular, to attend District Integration Workshops (DIW) at which decisions on CIPs are made and resources are allocated. Clearly, CCE as a programme that aims to help villagers plan their development actions and projects should be represented at these Seila-PLG managed meetings and processes.

The pilot phase of the programme has not included the development of links with civil society and other actors. This makes it difficult to identify and recommend additional or alternaytive partners for future support, dissemination and management of the CCE work.

Had NGOs working in CCE villages been aware of the pilot Conversations it would have been possible to discuss the inclusion of CCE tools and methods in their own work with villages.

The strongest links to local structures exist where CCs have been attended by Village leaders, local focal points (for example for health and women and children) and Commune Council Members.

4.6 Partners for implementation and links to development planning

Future sustainability of the CCE programme and its dissemination to new areas will therefore depend on the development of three key partnerships and actors:

1. **Building a core of facilitators at community level to run CCs with 20 to 30 villagers over one year who can develop social development projects for Commune Investment Plan (CIP).**

2. **Civil Society organisations and Commune Sangkat fund or its successor to provide financial and implementation support to social projects included in CIPs.**

3. **DoLA of Ministry of Interior to include CC training in curriculum for training village level facilitators.**

1. CCE Villages are clear on the value of CCs in improving their capacity to engage with the Commune Planning system. They recommend training village level facilitators to work with a core of CC participants (approximately 20 to 30). These people can be effective in developing social programmes for the village to implement. They can ensure that all families are engaged in planning processes, they can mobilise resources within the village, and they can link their social needs into the Commune Planning process. (see next section).

2. As there has been little or no linking of CCE in Cambodia with civil society (CS) organisations – NGOs mainly, any further CCE project work will have to develop these links. CPN+, the PLHA network in Provinces, is the best placed organisation to link CCE to civil society. This is because CPN+ takes a multi sector position on HIV&AIDS and also includes on its staff only PLHAs. While there are other CS organisations addressing social and livelihood HIV&AIDS issues most are working from a health sector perspective. In focus groups with PLHAs we found PLHA participation in CCs limited.

	Battambang	Kampot	Svay Rieng
PLHAs in Focus Groups			
Total	10	10	10
Women	7	9	5
Men	3	1	5
CCE Participation			
Know about CCE Y/N	Y	Y	N
PLHA invited to attend CCs Y/N	Y		
Do they live in a CCE village Y/N	Y		
PLHAs who attend CCs	7	4	
Average number of CCs they attended	3	1	

In only 2 of the three Provinces studied were PLHAs attending CCs. In one Province, though PLHAs attended CCs they had not been invited specifically to do so. A key indicator of a reduction in stigma and discrimination towards achieving sustainable impact of the CCs must be the inclusion of PLHAs in community life. If they are being invited to participate in CCs and other community meetings, and they feel able to declare their status, then CCs will be achieving a real reduction in discrimination.

3. The decentralization of Government to local levels[15] is moving forward in Cambodia. Many Government and donor supported pro-poor development programmes are linking to the Local Government systems. They use these systems to plan their projects and to provide support to local people to plan and decide their priorities for development action. For CCE to have a sustainable impact the programme must integrate with the local government systems and establish itself as a valid means to improve community participation in community development.

Focus groups with Commune and Village leaders demonstrated that there is awareness of CCE. In several villages Village Chiefs and Commune Council members attend CCs, although others stated they are too busy to do so. Most Commune Council CC participants were women, with focal point responsibility for health or women and children. In meetings with the Seila Principal Provincial Advisers

[15] D and D, PLG, Seila, PFTs, DFTs, PRDC, ExComm, DIW, CIP etc – see abbreviations and acronyms list in this report

(SPAA) in the three Provinces in all cases advice was given to integrate CCE with the D and D Local Government system. See next section.

4.7 Potential for scaling up and integrating CCE with decentralization of governance

Feedback from the SPAA staff in the three Provinces is summarized in the table below. In addition, SPAA's gave examples of social projects supported through the CIP/DIW 11 Step Planning process. Whilst infrastructure and service development projects still dominate the CIPs, there is genuine effort being made to encourage villages to plan social projects. Furthermore, donors, and Government, are "earmarking" funds for social programmes, including HIV&AIDS. UNICEF, GTZ, ADB and the PLG (supported by several donors) are all providing funds for social as well as infrastructure and service development local projects. SPAAs have provided lists of planned and supported CIP projects and these verify that social programming is getting increasing support.

	Battambang	Kampot	Svay Rieng
Know about CCE Y/N	No	No	Yes A little. It is activities on H/A prevention & providing information on H/A & PLHAs services.
Summarise any advice given on integrating CCE with D and D	Should integrate CCE in existing government system. Commune councils have low capacity on administration, finance & planning. NGOs work effective in small areas. Need a good coordination work between government & NGOs.	Include CCE tools in training program for PFT & DFT.	CCE should be integrated in D&D through Excom/PRDC & work at community level with facilitation of district & commune council. Should integrate CCE tools in training program for PFT & DFT.

In meetings with senior DoLA staff in Phnom Penh Ministry of Interior[16], CCE partnership with DoLA and D and D was strongly advised. The mechanisms for this are clear and similar to those

[16] HE Leng Vy, Deputy Director Min of Interior, Paddy Roome, TA to Dola and drafter of Organic Laws.

recommended for the Multi Sector HIV&AIDS response, now piloting in 3 Provinces[17]. It should be noted that the Organic Law currently being debated by the RGC may alter over time the structures and mechanisms for Decentralising and Deconcentrating government in Cambodia. The steps proposed in the draft law are positively aimed at increasing responsibility and accountability to local levels. If these changes are implemented then programmes like CCE that empower community members to plan and mobilise resources to meet their needs will be of increasing importance.

5 Recommendations

5.1 Future of CCE in pilot Provinces

This section provides recommendations for follow up to CCE implementation in the target villages in the seven Provinces where CCE has been piloted since 2003. CCE village focus groups were asked for their views on next steps with CCE. Most villages had answers to this question and were quite specific with their advice so the recommendations include this advice. In addition, CCE trainers and facilitators gave their views on the future of CCE. No other focus groups expressed views as in most cases they claimed to have had little or no exposure to the CCE pilot, or to know of its existence.

Recommendations for rollout of the CCE Programme to more Provinces of Cambodia are also provided, but it is strongly proposed that dissemination is implemented only after further experience is gained from the pilots in the 7 current Provinces as described in this report. The existing structures for CCE are not achieving sufficient results to justify extension without changes.

5.1.1 *Trainers and facilitators*

The next stage for all villages must be to identify facilitators within the community and provide them with adequate training, support and a level of compensation or incentive for them to facilitate a further period of Community Conversations. The purpose of continuing Conversations will be for:

- Village communities to take ownership of the tools and methods used through facilitators holding conversations with groups of villagers so that communities can identify

[17] A Platt, Kong Vutheary et al Multi Sector Response Research Study, June 2006. National AIDS Authority Royal Government of Cambodia

problems, mobilise resources, and seek outside assistance when needed.

- Participating groups to then spread the ideas and information on CC to all corners of the village.

- CC participants to become leaders in village level planning processes, engaging in CIP/DIW 11 Step Village Development Planning and encouraging and empowering others to join in too.

- Where requested, facilitators to conduct Conversations with groups in neighboring villages

There should be three facilitators for an average village. At least one must be female, and probably a focal point for health, women or children in the community. If he or she has time, another facilitator should be the Village Chief or their assistant.

Facilitators should receive support and their progress be monitored by one current CCE team member from Provincial level. This may change if introduction of the Organic Law defines different responsibilities for Provinces, Districts and Communes.

5.1.2 *Organisation of CC groups in villagers*

- Each group for Conversations should comprise 20 to 30 participants. Participants must commit to attending as many Conversations as possible over fixed period of time

- Group participants must come from a cross section of the community and include women, younger people, no group may be left out.

- Representatives from each of these sections of the community should be selected for the respect in which they are held and for their leadership potential.

5.1.3 *Dissemination within pilot Provinces*

CCE villages, when confident to do so, may accept invitations from neighboring villages to assist them develop CCs. This should be facilitated by Commune Councils working across the villages of the Commune. Commune Councils should be assisted and supported by the DFT, PFT and Provincial and District structures, when these are directed and trained to support CCE (see below on Roll Out of CCE to other Provinces),

5.1.4 *Costs*

CCs should be operationalised in existing villages as described in Section 4.3.1 at approximately one third of the current costs. This should be a first call on remaining UNDP CCE budget lines.

Any remaining budget should be used to establish a project fund to support CC designed social initiatives. As it is too late this year to contribute these funds through the Commune/Sangkat fund that supports CIP projects, these funds should be released for well designed pilot activities designed by CCE communities for which community resources are inadequate. This will build confidence that CCs can lead to action and will help support activities planned locally that can then be reviewed by CCs and lessons learned.

5.1.5 *Management, monitoring and reporting*

Monitoring of CCE should be built into Community Conversations. Tools are included in the CC methods to enable this to be done by Conversation participants.

A challenge for facilitators drawn from communities will be to report and monitor CC progress, for example where they are not sufficiently literate. However, illiteracy should not be made a bar to selection as a facilitator. There will be CC participants with adequate literacy to record the results of CCs and compile the basic reports required. It is requested by villagers that support is provided from provincial level and it is proposed that one current CCE team member per 5 or 6 villages be appointed to support the village facilitation teams. While accountability needs to be assured, the focus of this support must be on monitoring changes achieved though the year of CC implementation.

The extension period must start with establishing a few basic indicators which the community feels are important and which it can monitor change. Indicators could include:

- The numbers of OVCs affected by HIV&AIDS that are out and in school.
- The number of OVCs in the care of the pagodas,, and the number accepted into families (that are or are not related to the OVC).
- The number of men who travel from the village whose wives or female partners have persuaded them to travel with or agree to use condoms.

The baseline for these indicators and any others the community chooses must be measured through surveys at the beginning of the

new phase of CCs. Then at regular intervals agreed in the CC changes can be measured through repeat surveys, using CC tools.

With this level of responsibility established at the village level, management and monitoring by the Provincial, District or Commune should follow the same procedures well established for other monitoring programmes, such as the 100% Condom Use programme. These programmes have established routines and standard forms that enable essential management information and project data to be collected. It may be possible to integrate the CC management and monitoring with the systems used for existing projects[18]. Management and monitoring linked to the release of funds for CCs should help ensure that reports are provided. Feedback on reports must also be given and feedback forms must be devised and used to ensure that this feedback is provided.

Consideration should be given to producing a short "newsletter" for groups of villages through which the reports plus feedback comments from and to all villages is shared. Such a newsletter could also list any successes with gaining Commune/Sangkat and other support for social projects, as well as describing projects villages have resourced without external assistance.

5.2 Roll out of CCE to other Provinces

The roll out of CCE nationally or even to Provinces additional to seven pilot Provinces is premature at this stage and should await results of the extension to the current pilots recommended in the above section. This is because there is insufficient evidence to show that CCs have operated effectively and according to the strategies and principles defined by UNDP.

It is therefore recommended that dissemination and rollout of the CCE methodology on Cambodia is delayed for about one year, or until clearer evidence of the value and impact of the programme is established.

Future roll out of CCE therefore needs to be through the decentralizing Government structures and it is through partnership with those that plans can be developed.

The long lead times to negotiate and draw up agreements with different levels and arms of Government make forward planning

[18] In our field work visits we noted that commune and provincial officers were collecting information from focal points in villages as we toured the CCE sites.

essential. Therefore to start CCE across Cambodia in a year's time requires planning to start now.

The Seila Task Force is the obvious place to negotiate support to roll out of training on CCE to Decentralised Government levels. Seila is ending and will be replaced by a Ministry of Interior Commission. This is not yet fully defined nor operational, so UNDP and NAA will need to track progress with this and establish appropriate contacts. UNDP Governance staff should be able to advise and assist.

Once the National structures for DoLA are clear, UNDP/NAA should agree that a training curriculum is developed and put in place so that trainers of trainers are identified and available to train Provincial and District Facilitation Team members. These staff – currently working for Seila – will then be able to include CCE in the support tools they use at Commune level, and to plan and introduce CCE through the Commune Councils, who direct the activities of the Village development teams in their communes.

5.3 Integration of CCE with Commune Plans and D and D

If CCs are implemented at village level through the SEILA/DoLA/PoLA structures as described in the previous sections then villagers will be able to participate more effectively in village and commune planning. This increase in power of CC participants (even though most attend only a small number of CCs) has been demonstrated in the existing CCE pilot programme. There should be no further action required other than to use the SEILA/DoLA/PoLA management and monitoring systems to track that CCs are taking place and to monitor their progress, quality and impact (see above sections and recommendations on managing and monitoring against baselines and sharing learning).

5.4 Links to Civil Society

As has been noted, CCE has not so far been linked to NGOs. It is recommended that during the extended pilot phase of CCE in the existing 7 Provinces emphasis is placed on working closely with NGOs active in those Provinces and specifically in targeted villages.

This can include running joint sessions at which CCs and awareness raising meetings of NGOs are combined and the tools of CCE and the NGOs are discussed and used together. This should make possible cross learning at the local level. UNDP and NAA will need to meet with National and Provincial staff of NGOs to discuss joint working. If this is not done, CCE tools and methodologies will stand alone instead of being integrated with the work being done at

community level by others, as is intended and described in CCE strategy documentation.

6 Conclusions

CCE in Cambodia has already demonstrated the potential to be one of the programmes able to help empower communities. It has shown its value at Village and Commune level in solving one of the main problems faced by the decentralisation and deconcentration of Government – that of achieving sufficient levels of participation of communities in defining and working out solutions to solving their development and poverty reduction needs.

With greater decentralisation of the CCE programme it could become the programme of choice for ensuring the inclusion of the poorest and most marginalised in local development. If its potential can be demonstrated through a further period of piloting with adjustments to the way it is implemented and monitored then rollout of the programme to further Provinces will be justified and worthwhile.

Dissemination and sustainability of the CCE approach is possible with low levels of funding if a core of communities are helped to acquire understanding and skills in the methods so these can be passed on with minimal additional investment. This investment is probably affordable and worthwhile to provide through the D and D systems Government is steadily introducing through the Organic Laws. Without programmes like CCE at local level S and D will not achieve the pro-poor development progress for which it aims.

7 Annexes

7.1 Terms of Reference

TERMS OF REFERENCE

The Community Communications Enhancement Programme (CCE) is a package of participatory approach techniques developed by UNDP, known as Community Conversations (CC). The main objective of the CC is to generate a response to HIV&AIDS that integrates individual and collective concerns, values and beliefs and address individual and collective attitudes and behaviours embedded in social systems and structures.

As part of a global initiative, Cambodia was one of the first pilot countries to implement the CC, as part of the joint NAA/UNDP project "Support to the HIV&AIDS Response". Fifty individuals were trained as facilitators/Trainer of Trainers (ToT) in March 2003. These were selected on the basis of their HIV knowledge, their position as local leaders (i.e. commune councillors, PAS, PAC) and from 7 provinces with high HIV&AIDS prevalence rate, namely Siem Reap, Beantey Meanchey, Battambang, Pursat, Kampot, Svay Rieng and Sihanoukville.

Based on the quarterly reports and monitoring visits, anecdotal evidences show that CC has been successful in addressing stigma and discrimination against PLWHA and taboos around sexuality. However, these also show limitations in enabling the communities to take action despite the very encouraging initiatives, e.g. extending the traditional practice of "chol bon", contribution for funerals to AIDS patients. The programme has been commended for targeting a more comprehensive population sector (in opposition to the 100% condom use campaign which is focused on high risk

behaviour population). However behavioural change or actions resulting directly from CC sessions are not necessarily visible or easily attributed to the CCE.

Furthermore, the major challenges for the CCE have been identified, as follows:

 Weak linkage between communities/villages to Commune Councillors.

 No mechanism to integrate HIV&AIDS in the development planning at the commune

level/District Integration Workshops.

 Lack of Monitoring and Evaluation system to assess the impact of the project interventions and to ensure quality control of the CC and facilitation skills.

Objectives

UNDP is seeking a suitably qualified team of consultants to design, and conduct a evaluation of the CCE in order to reflect on the experience of the CCE, over the duration of its pilot period, as means to:

 Specify the results achieved in the CCE programme in terms of its contribution to energising communities' response to HIV&AIDS as well as broader development challenges;

 Assess the benefits gained in the light of results achieved and inputs required;

 Identify lessons learned for optimizing the benefits achieved in terms of community

mobilization, ownership and sustainability of the CC.

 Identify community and related stakeholders' perspectives of the CCE programme and CC process.

 Identify potential individuals or organizations capable to function as a depository of the CCE tools at the community level to ensure sustainable continuation of the CC.

 Identify potential organizations and development partners able to support the

implementation of CC at the community level and to link it to development planning process at the commune level.

 Develop way-forward recommendations and strategy on how to scale-up and replicate the Programme's benefits in the light of current deconcentration and decentralization (D&D) process underway in Cambodia, through linking CCs to existing decentralizing mechanisms (DOLA, DIW, Commune Councillors).

Tasks

Evaluation will be conducted over a period of one month. Under the overall supervision of the UNDP and in consultation with the National AIDS Authority, the incumbent will:

- Draft workplan for the evaluation in consultation with NAA and UNDP.

- Carry out a desk review of all documents, reports and other available written materials on HIV and AIDS and D&D specific challenges and opportunities.

- Conduct field visits to selected sites.

- Carry out interviews with project partners, beneficiaries and relevant stakeholders (e.g. government and non-governmental organizations) in Phnom Penh and selected provinces.

- Organize consultative workshop/meetings, as needed, with NAA, PAS, MoI (DOLA,

community councillors), related stakeholders (NGOs, SEILA), and community members, to discuss the findings of the evaluation and to develop way-forward recommendations.

Qualifications

The consultant team should possess the following qualifications and experience:

 Extensive experience in community mobilization, HIV&AIDS response, and the Decentralization and Deconcentration process;

 Extensive experience in undertaking consultancies in Cambodia;

 Proven track record in designing, and conducting evaluations;

 Proven research capacity and analytical skills;

 Excellent communications skills in oral and written English and Khmer;

 Willingness to travel to project sites.

7.2 CCE Guiding Principles

Guiding Principles for CCE (from UNDP CCE strategy documents)

The following ways of working are fundamental to the enhancement of community capacity:

❑ Sensitivity to local, family and community experiences – working by invitation and commitment, not imposition;

❑ Facilitation rather than intervention of 'experts';

❑ Gender sensitivity, a focus on the participation and inclusion of women and girls, and addressing gender issues;

❑ Mutual learning (facilitators with community, community with facilitators, community with community, among community members, organization to organization);

❑ A grounding in universal human rights;

❑ Participatory approaches with space for listening, inclusion, agreement, and expressions of concerns;

❑ Team formation at the organizational and community levels for implementation;

❑ Respect for differences, mutual trust;

❑ Belief that communities have the capacity to identify needed changes, 'own' these changes and transfer change to other communities;

❑ Facilitation of Community Conversations as spaces for interaction, change and transfer;

❑ Working in partnership with non-governmental and community-based organizations;

❑ Willingness of facilitators to engage in a process of self-development.

Partnership and Training (from UNDP CCE strategy and Implementation documents)

The Community Conversations methodology goes much further than simply involving civil society organizations, community-based groups and other partners. Rather, it enhances the managerial and leadership competencies of these organizations and furthers their development. Moreover, it grounds these organizations, which will be implementing the CCE programme, in community-level action.

There are guidelines for choosing the organizations with whom UNDP will work – guidelines that are based on core human rights principles. The choice of community-based and civil society organizations should involve three criteria. First, they should be organizations that have worked with and have shown sensitivity to communities. Second, they should be organizations that are gender sensitive and have worked on issues related to women and girls. Finally, they do not need to have worked on HIV&AIDS issues before. But they do need to have worked on issues relating to the epidemic's underlying causes. There are three key components that make CCE such a successful programme:

Its unique methodology

The quality, dedication, mindset and values of trainers and facilitators

The values of the community-based and civil society organizations that implement the programme

Community Capacity Enhancement is an approach that strengthens the capacity of non-governmental and community-based organizations to move beyond awareness-raising. It provides these organizations with the tools and competencies to facilitate community decision-making processes from within. Key partners will be NGOs with national coverage working with community-based organizations in specific locales. The UNDP country office will prepare the first visit of community development specialists by briefing them on the Community Conversations approach.

The CCE programme explicitly focuses on strengthening the capacity of civil society and community-based organizations - the groups that will be implementing the programme. There are guidelines for choosing organizations with whom UNDP will work – guidelines that are based on core human rights principles. These principles include, but are not limited to, the demonstrated capacity to work sensitively with communities, taking into account gender-related issues. Choose two to three anchor organizations (NGOs) with national or sub national coverage working on HIV&AIDS or on development issues with an HIV component, and six to nine local implementing organizations (community-based organizations) that will participate in the process; There will be two sessions implemented:

Skills-building session for trainers (10 days)

Skills-building session for community facilitators (6 days)

Depending on the availability of participants, the first session could be followed by six weeks of practice in Community Conversations by the trainers themselves before the training of facilitators begins.

CCE Strategy Documentation. 2005

7.3 Stepping Stones methodology – summary

Stepping Stones manuals are specific on the composition and formation of community level groups that will participate in the programmes and on the training of Facilitators. The following descriptions drawn from Stepping Stones documentation illustrates the point:

Training of facilitators –

- Project staff/facilitators are trained in the tools
- Reorientation of the facilitators in the tools after one pilot training
- Training of the facilitators on participatory tools, gender etc on a regular basis
- Regular meetings of the facilitators to share experiences, challenges and good practices

Participants

- Participants are divided in peer groups (gender, age, marital status) of 20 – 25 as per the community need
- Special groups in the community like sex workers, disabled etc get representation or form separate groups
- Participants are selected in such a way that different social groups in the community find representation

Place and time of Stepping Stones

- Sessions take place in a place recommended by the participants
- Sessions take place at a time suggested by the community. Frequency of the training is also finalized after community consultations
- The place where sessions take place is private and big enough for groups to sit

Process - guidance for ensuring Stepping Stones is monitored throughout is provided by Bhattacharjee and Costigan, SCF UK, 2005. Monitoring and Evaluation Framework for Projects Implementing Stepping Stones:

• Advocacy with the power structures in the community done to ensure their support

• Session wise time table is prepared in consultation with the community • Pace of the session is maintained as per the pace of the peer group

• Groups work separately for any sessions

• Join periodic meetings are organised to share ideas and thoughts after completion of every theme

• Theme wise sequencing is maintained with adaptations as per the community needs

• Emphasis on WE and US and not on THEY and THEM

• Participatory techniques like drawings, role plays etc are used in sessions • Sitting together in circles to ensure everyone is equal

• Participation of the facilitators in the sessions to ensure that everyone is equal • No competition between peer groups

• Ensuring the participants get time after the session to think about the session and practice

• Ensuring the participants share each session with friends and family • Ensuring facilitators have information about other services related to HIV like STI clinics/ VCTC/condoms

• Ensuring that participants get positive reinforcement for their changed behaviour

• Good session wise documentation Post Stepping Stones

• Develop post SS plans with the groups

• Develop plans to undertake SS with Volunteers for other groups • Support linkages of the groups with services

7.4 NAA/UNDP partnership and Programme Support Document

The CCE pilot project is one of a number of initiatives described in the Programme Support Document approved and signed in

October/November 2003 by UNDP and the National Aids Authority[19]. This document identifies a range of the areas of support from UNDP and its partners to the Royal Government, largely through support to the National Aids Authority.

Specifically, the first objective included that. *the NAA's structure and capacity will be strengthened in areas of human resources, institutional organisation, planning and implementation, financial procedures, monitoring evaluation mechanisms; and thus enabling it to better perform its functions at central and provincial level.* A research study into the performance and strategy for the multisector, decentralised response to HIV&AIDS was commissioned and completed for The National Aids Authority in April 2006[20] this study identified strengths and weaknesses of the response to date as coordinated by the National Aids Authority. Specifically, it proposed integration of the decentralised response with the local level government structures pioneered by the Seila/PLG programme across all provinces of Cambodia.

The second objective of the support by UNDP included: *Nationwide Capacity Development through leadership dialogues and community conversations between leaders at national and provincial government levels, civil society, towards a new paradigms of empowering and facilitated leadership to support the response to HIV&AIDS at the local level.* Furthermore, objective three is to create an *enabling environment for greater involvement of infected and at affected people in the national response to the epidemic.* Finally, objective 4 aims for an *innovative use of information and communication strategies at central and decentralised levels increasing the visibility of the epidemic while the increasing the stigma associated with HIV&AIDS.*

7.5 Documentation

LIST OF DOCUMENTS

A. English documents

CCE Facilitator Notes. UNDP. English & Khmer.

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[19] UNDP Support to Cambodia's Response to the HIV&AIDS Epidemic CMB/03/007/01/99. United Nations Development Programme and Royal Government of Cambodia.

[20] Platt A, Kong Vutheary et al. "Operational research study on Decentralised Multisectoral Response to HIV&AIDS@. Report to National AIDS Authority, April 2006

Evaluating Stepping Stones. Tina Wallace for Action International. June 2006.

UNDP. Community Capacity Enhancement Handbook. 2005.

UNDP Project document: UNDP Support to Cambodia's Response to the HIV&AIDS Epidemic.

US/CDC-GAP. Guide for Implementation of Empowerment Community to Respond HIV&AIDS. Jan 2005.

B. Khmer reports

1. Banteay Meanchey province

Monthly report, March 2004, Boeung Raing, Phnom Touch Tbong & Phnom Touch Choeung village, Phnom Touch commune, Monkol Borey district. PAS Banteay Meanchey.

Monthly report, Feb 2004, Boeung Raing, Phnom Touch Tbong & Phnom Touch Choeung village, Phnom Touch commune, Monkol Borey district. PAS Banteay Meanchey.

Commune Conversation report, Jan 2004, Boeung Raing, Phnom Touch Tbong & Phnom Touch Choeung village, Phnom Touch commune, Monkol Borey district. PAS Banteay Meanchey.

Commune Conversation report, Nov 2003, Boeung Raing & Phnom Touch Tbong village, Phnom Touch commune, Monkol Borey district. PAS Banteay Meanchey.

Financial report, Jan-Mar 2003, PAS BMC.

2. Battambang province

Monthly Reports, Oct-Dec 2005 & January 2006, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 27-32. Battambang CCE Team.

Monthly Reports, May-July 2005, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 21-26. Battambang CCE Team.

Monthly Reports, Oct-Dec 2005 , O Ta Korm 1 & Dangkor Teab village. Round 17-21. Battambang CCE Team.

Monthly Reports, Aug-Dec 2005, O Ta Korm 1 & Dangkor Teab village. Round 17-21. Battambang CCE Team.

Monthly Reports, Dec 2004 & Jan-Feb 2005, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 15-20. Battambang CCE Team.

Monthly Reports, Jul-Aug 2004, O Ta Korm 1 & Dangkor Teab village. Round 1-4. Battambang CCE Team.

Monthly reports, Jul-Aug 2004, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 12-14. Battambang CCE Team.

Monthly reports, Jun-Jul 2004, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 9-11. Battambang CCE Team.

Monthly Report, Dec 2004 & Jan-Feb 2005, O Ta Korm 1 & Dangkor Teab village. Round 5-10. Battambang CCE Team.

Monthly Report, Jul-Aug 2004, O Ta Korm 1 & Dangkor Teab village. Round 1-4. Battambang CCE Team.

Monthly Reports, Mar-Apr 2004, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 7-8. Battambang CCE Team.

Monthly Reports, Feb 2004, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 5-6. Battambang CCE Team.

Combine Monthly Report, Jan 2004, O Ta Korm 2, O Ta Korm 3 and Toul Ta Ek village. Round 3-4. Battambang CCE Team.

Monthly reports, Jan 2004, O Ta Korm 2, O Ta Korm 3 & Toul Ta Ek village. Round 3-4. Battambang CCE Team.

Monthly reports, Jul-Aug 2003, O Ta Korm 2, O Ta Korm 3 & Toul Ta Ek village. Round 1-2. Battambang CCE Team.

3. Kampot province

Quarterly report for May-July 2004, PAS Kampot.

4. Pursat province

Quarterly report, March-May 2005, PAS Pursat.

Quarterly report, Sept-Nov 2004, PAS Pursat.

Quarterly report, May-July 2004, PAS Pursat.

Monthly report, January 2004, PAS Pursat.

5. Siem Reap province

Financial report, Oct-Dec 2005, PAS Siem Reap.

Quarterly report, Oct-Dec 2004, PAS Siem Reap.

Quarterly report, Jun-Aug 2004, PAS Siem Reap.

Financial report, Jun-Aug 2004, PAS Siem Reap.

6. Svay Rieng province

Quarterly report for Oct-Dec 2005, PAS Svay Rieng.

Financial report, September 2004, PAS Svay Rieng.

Quarterly report for May-July 2004, PAS Svay Rieng.

Monthly report of 3 villages, Bak Ronors, Tanor & Khosarng village. January 2004. PAS Svay Rieng.

7. Sihanoukeville

7.6 Questionnaire to collect report data

Khmer language document – available on request.

7.7 Focus Group Checklists

Checklist for CCE villagers/beneficiaries

Participants present their names & job

A. CCE activities

1 What do you know about CCE project? When did CCE start in your village?
2 What are CCE project activities?
3 How often were CCs conducted? (# of CC per month/year)
4 Did you attend CCs in your village? how many times did you attend CCs?
5 Usually, how many people participated in each CC? (women? Youth? Elder? PLHAs? NGOs? Other?)
6 What did you do when you participated in CCs?
7 What have you gained from CCs? (HIV&AIDS info, check used tools)
8 What have been documented? By whom? (community & facilitator walls, plan, etc)

B. Achievements

1 What are the achievements of CCE project? Please describe.
2 What are benefits that villagers received from CCE project: as individuals? as whole village?
3 What are the positive changes on H/A responses occurred in the period of 2003-2006? List them H/A awareness, stigma & discrimination, prevention, care, treatment, counseling, OVC, etc
4 Did villagers conduct CCs within the periods that CCE project was pending and in 2006?
5 Do villagers discuss on health, H/A, sexual behavior, gender, domestic violence? When did it start?
6 What activities have villagers been able to agree & plan to do as results of their conversations?
7 Which of these ideas & plans are implemented? Who is doing this? How much progress is being made?
8 Have HIV&AIDS, health & gender issues been discussed in CIP formulation meetings? Have they been included in CIP priorities? Were these activities received support to implement?

C. Perspectives on CCE project

1 What do you think about CCE project?

2 What are the strong points of CCE?
Tools, which tools are most useful for response to H/A? for response to other village issues?
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others

3 What are the weak points of CCE?
Tools
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others

4 How useful is CC for you, your family & your village/community?

5 Should CCE be continued?
If yes, what improvement should be made for better H/A response?
How long should CCE be continued?
What activities be conducted next step?
Who should be CCE focal persons/partners at provincial, district & commune level?
Who should be the implementers at village level?

If no, please explain the reason.

D. Other HIV&AIDS players

1 List names of HIV&AIDS NGOs who worked/work in CCE villages in 2003-2006. What are their activities? Did they attend CCs?

2 Which HIV&AIDS NGOs are currently providing good services in CCE target villages or in your province?

3 In CCE villages, how many projects on HIV&AIDS were/are implemented by provincial depts, donors & other institutions, in 2003-2006? What are the activities of those projects? Are they still on going?

4 Commune council role on H/A response?

5 PLHAs network?

6 OVC network?

7 Women and children committees/focal persons?

8 Village associations exist?

9 Pagoda?

E. Leadership

1 How many people of your village attended leadership course? List their names and titles.

2 How have they involved in CCE activities and HIV&AIDS services?

3 What differences they have made?

G. GIPA Project (for Bat)

Do you know about GIPA project activities?

H. Other comments and suggestions

Checklist for non CCE villagers

Participants present their names & job

1 What do you know about CCE project?
2 What do you know about HIV&AIDS, its spreading, prevention, care, etc ?
3 Who provide H/A services such as awareness, prevention, counseling, care, treatment, OVC, etc?
4 How do you get info on H/A? NGOs, TV, radio, relatives, neighbors, meetings, provincial depts, etc.
5 Did you receive H/A trainings? Who organized these trainings?
6 How many H/A NGOs work in your village? What are their activities?
7 Do provincial depts have some H/A projects in your village? What are their activities?
8 How do you see things change in your villages regarding stigma & discrimination, awareness, care,
counseling, treatment, OVC, etc.
9 Did you attended leadership course?
10 How have you involved in HIV&AIDS activities?
11 Do you know about GIPA project activities?
12 Commune council roles on H/A?
13 What are the participations of village chiefs & focal points (on OVC, Health, women & children, etc) in H/A services?
14 Village associations exist?
15 Pagoda?
16 Others?

Other comments and suggestions

Checklist for CCE team

A. Staffing

1 Participants present their names & title of their full time jobs & their role in CCE project.
2 When did they join CCE? How they were selected as CCE team members?
3 Were they trained on CCE tools before conducting CCs?
4 How many refreshments, trainings, study tours were organized by CCE project in the period of 2003-2005? How many trainers & facilitators from each target province attended these events?
5 What are benefits that trainers & facilitators received from CCE project: personally? for work/job?

B. Outputs

1 How many CCs were conducted in each target village, in the period of 2003-2005? (fill in the table of CCE activities for Bat, KPT & SVR).
2 How many tools were used in the CCs? List used tools.
3 How many participants involved in each CC? Women? Range of ages if possible.
4 How many kinds of villagers involved in each CC? Farmer, housewife, elder people, village focal
persons (for women & children, health, development, etc), PLHA, businessman/woman, worker,
student, teacher, youth without job, reporters, etc…)
(Will not ask the questions 1-4 if the team already filled the table of CCE activities)
What monitoring, review & evaluation were carried out?
5 Did you use Workshop Evaluation framework? If so do you have examples?
6 Did you use "thick description" as a means to document CCE?
7 Did you organize "Program to Program Visits"? (villages within a province, province to province)

8 Did you participate in field visit to other countries for sharing CCE experience ? What did you learn from this?
9 Did you attend the Annual Resource Network Meetings for CCs?
10 Did you attend the Annual National Review, Reflection & Scaling up Meetings?
11 Did CCE expert visit your province? What happened/changed after the visits?

C. Financial info

1 How much was the expenditures for each CC?
Materials
Snacks
Travel
Reporting
Others
2 What is the salary for trainers & facilitators?
3 How many month did you receive CCE salary?
4 Other expenditures?
(Will not ask the questions if the team already filled the table of CCE financial info)

D. Achievements:

1 What are the achievements of CCE project? Please describe.
2 What are benefits that villagers received from CCE project: as individuals? as whole village?
3 What are the positive changes on H/A responses occurred in the period of 2003-2006? List them (H/A awareness, stigma & discrimination, prevention, care, treatment, counseling, OVC, etc)
4 Did villagers conduct CCs within the periods that CCE project was pending and in 2006?
5 Were HIV&AIDS issues included in CIP?

E. Perspectives on CCE project

1 What do you think about CCE project?
2 What are the strong points of CCE?
Tools, which tools are most useful for response to H/A? for response to other village issues?
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others
3 What the weak points of CCE?
Tools
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others
4 What are your difficulties in implementing CCE project? (HR, capacity, time, communication, materials, transportation, reporting, etc)
5 Should CCE be continued?
If yes, what improvement should be made for better H/A response?
How long should CCE be continued?
What activities be conducted next step?
Who should be CCE focal persons/partners at provincial, district & commune level?
Who should be the implementers at village/community level?

If no, please explain the reason.

F. Other HIV&AIDS players

1. List names of HIV&AIDS NGOs who worked/work in CCE villages in 2003-2006. What are their activities? Did they attend CCs?
2. Which HIV&AIDS NGOs are currently providing good services in CCE target villages or in your province?
3. In CCE villages, how many projects on HIV&AIDS were/are implemented by provincial depts, donors & other institutions, in 2003-2006? What are the activities of those projects? Are they still on going?
4. What are the current HIV&AIDS services in your province?
5. Commune council role on H/A response?
6. PLHAs network?
7. OVC network?
8. How have these organizations/departments/committees/networks worked at community level?
9. Village associations exist?
10. Women and children committees/focal points?

G. Leadership

1. How many people of your province attended leadership course? List their names and titles.
2. How have they involved in CCE activities & HIV&AIDS services?
3. What difference has been made?

H. GIPA project (for Bat)

I. Other comments and suggestions

What media links with CCE, if any, have there been?

Checklist for Private Sector

Participants present their names & job

1. What do you know about CCE project?
2. What is HIV&AIDS?
3. How does H/A spread from PLHAs to normal people?
4. How do you prevent HIV&AIDS?
5. Who provide H/A services such as awareness, prevention, counseling, care, treatment, OVC, etc?
6. How do you get info on H/A? NGOs, TV, radio, relatives, neighbors, meetings, provincial depts, etc.
7. Did you receive H/A trainings? Who organized these trainings?
8. Have H/A NGOs visited your places? If so how often?
9. Do you know other H/A projects of NGOs & provincial depts in your village? Your province? What are their activities?
10. How do you see things change in your villages regarding stigma & discrimination, awareness, care, counseling, treatment, OVC, etc.
11. Did you attended leadership course?
12. How have you involved in HIV&AIDS activities?
13. Do you know about GIPA project activities?
14. Commune council roles on H/A?
15. Village chiefs & focal points involvement in H/A services?
16. Village associations exist?
17. Pagoda?
18. Others?

Other comments and suggestions

Checklist for PLHAs

Participants present their names & job

A. CCE activities

1 What do you know about CCE project? When did CCE start in your village? End?
2 What are CCE project activities?
3 How often were CCs conducted? (# of CC per month/year)
4 Did you attend CCs in your village? If so how many times did you attend CCs?
5 Usually, how many people participated in each CC?
6 What did you do when you participated in CCs?
7 What have you gained from CCs? (HIV&AIDS info, check used tools)

B. CCE Achievements

1 What are the achievements of CCE project? Please describe.
2 What are benefits that villagers received from CCE project: as individuals? as whole village?
33 What are the positive changes on H/A responses occurred in the period of 2003-2006? List them (H/A awareness, stigma & discrimination, prevention, care, treatment, counseling, OVC, etc)
4 Did villagers conduct CCs within the periods that CCE project was pending and in 2006?
5 Were HIV&AIDS issues included in CIP?
6 Do you know who provide what kind of services? How & where can you get services?

C. Perspectives on CCE project

1 What do you think about CCE project?
2 What are the strong points of CCE?
Tools, which tools are most useful for response to H/A? for response to other village issues?
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others
3 What are the weak points of CCE?
Tools
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others
4 How useful is CC for you, your family & your village/community?
5 Should CCE be continued?
If yes, what improvement should be made for better H/A response?
How long should CCE be continued?
What activities be conducted next step?
Who should be CCE focal persons/partners at provincial, district & commune level?
Who should be the implementers a

If no, please explain the reason.

D. Other HIV&AIDS players

1. List names of HIV&AIDS NGOs who worked/work in CCE villages in 2003-2006. What are their activities? Did they attend CCs?
2. Which HIV&AIDS NGOs are currently providing effective services in your villages or in this province?
3. In your villages, how many projects on HIV&AIDS were/are implemented by provincial depts, donors & other institutions, in 2003-2006? What are the activities of those projects? Are they still on going?
4. Commune council role on H/A response
5. Involvement of village chiefs in H/A response
6. PLHAs network
7. OVC network
8. Village health focal person
9. Women and children committees/focal persons
10. Village association
11. Pagoda

E. Leadership

1. How many PLHAs attended leadership course? List their names and titles.
2. How have they involved in CCE activities and HIV&AIDS services?
3. What differences they have made?

G. GIPA Project (for Bat)

1. Do you know about GIPA project activities?

H. Other comments and suggestions

Checklist for provincial departments

Participants present their names & title

A. CCE

1. Do you know about CCE project? (if not brief on CCE project activities.)
2. How CCE activities contributed to H/A response?
3. What are the achievements of CCE project? Please describe.
4. Did you see any weak points of CCE activities?
5. Do you think CCE should continue? If so what are your suggestions to CCE project for better H/A response?

B. Department activities on H/A

1. What H/A activities/projects do your department have ?
2. Do your department have plan to integrate H/A activities in the projects of your sectors? Please describe.
3. Do other provincial departments provide H/A services?
4. What are the positive changes on H/A responses occurred in the period of 2003-2006? List them (H/A awareness, stigma & discrimination, prevention, care, treatment, counseling, OVC, etc)

C. NGOs

1. Which NGOs have played critical role on H/A services? What are their activities?
2. PLHAs network? CPN+?

D. Leadership

1 How many staff of your departments attended leadership course? List their names and titles.
2 How have they involved in CCE activities and HIV&AIDS services?

E. GIPA Project (for Bat)

1 What do you know about GIPA project?

F. Other comments and suggestions

Commune council role on H/A response?
Village associations exist?
OVC network?
Women and children committees?
Pagoda?
Others?

Checklist for PLG/Seila

A. PLG/Seila

1 Does H/A integrated in sector activities of the Seila program?
2 Can commune councils use the commune fund in H/A activities?
3 What is the current status of Seila program?
4 When does D&D start? What is the new strategy for D&D?

B. H/A Activities

1 Do provincial departments have H/A activities/projects?
2 Do they have plan to integrate H/A activities in projects/programs of their sector plan? Please describe.
3 Which NGOs have played critical role on H/A services?
4 Who are the best H/A services providers?
5 PLHAs network?
6 OVC network?
7 Commune council role on H/A response?
8 What are the positive changes on H/A responses occurred in the period of 2003-2006? List them (H/A awareness, stigma & discrimination, prevention, care, treatment, counseling, OVC, etc)
9 What do you know about CCE project? (if not brief him on CCE project activities.)
10 What do you think about CCE activities?
11 Do you think CCE should continue? If so who are the appropriate partners for CCE at local level?

D. Leadership

1 How many Seila/PLG staff attended leadership course? List their names and titles.
2 How have they involved in CCE activities and HIV&AIDS services?
3 How does they applied leadership in their job?

E. GIPA Project (for Bat)

1 Do you know about GIPA project activities?

F. Other comments and suggestions

Village associations exist?

Women and children committees?
Pagoda?

Checklist for NGOs

Participants present their names, titles & organizations.

A. CCE activities

1 Do you hear about CCE project? When did CCE start in your village?
2 What are CCE project activities?
3 How often were CCs conducted?
4 Did you attend CCs in your target village?
Usually, how many people participated in each CC? (women? Youth? Elder? PLHAs? NGOs?
5 Other?)
6 What did you do when you participated in CCs?
7 What have you gained from CCs? (HIV&AIDS info, check used tools)

B. Achievements

8 How do you think CCE project contributed to H/A response?
9 What are the achievements of CCE project? Please describe.
10 What are benefits that villagers received from CCE project: as individuals? as whole village?
11 What are the positive changes on H/A responses occurred in the period of 2003-2006? List them (H/A awareness, stigma & discrimination, prevention, care, treatment, counseling, OVC, etc)
12 Did villagers conduct CCs within the periods that CCE project was pending and in 2006?
13 Were HIV&AIDS issues included in CIP?

C. Perspectives on CCE project

1 What do you think about CCE project?
2 What are the strong points of CCE?
Tools, which tools are most useful for response to H/A? for response to other village issues?
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others
3 What are the weak points of CCE?
Tools
Activities
Work plan
Management (coordination, technic, finance, administration & reporting)
M & E
Partnership with other players
Others
4 Should CCE be continued?
If yes, what improvement should be made for better H/A response?
How long should CCE be continued?
What activities be conducted next step?
Who should be CCE focal persons/partners at provincial, district & commune level?
Who should be the implementers at village level?

If no, please explain the reason.

D. Other HIV&AIDS players

1 Brief describe of participant's H/A activities.
2 List names of HIV&AIDS NGOs who worked/work in CCE villages in 2003-2006. What are their activities? Did they attend CCs?
3 Which HIV&AIDS NGOs are currently providing good services in CCE target villages or in the province?
4 In CCE villages, how many projects on HIV&AIDS were/are implemented by provincial depts, donors & other institutions, in 2003-2006? What are the activities of these projects? Are they still on going?
5 PLHAs network (CPN+)?
6 OVC network?
7 Commune council role on H/A response?
8 Women and children committees/focal points?

E. Leadership

1 How many NGOs attended leadership course? List their staff names and titles.
2 How have they involved in CCE activities and HIV&AIDS services?

G. GIPA Project (for Bat)

1 Do you know about GIPA project activities?

H. Other comments and suggestions

Village associations exist?
Pagoda?
D&D?

7.8 CCE Trainer and Facilitator team Data

	Battambang	Kampot	Svay Rieng
Staffing CCE			
# of team	7	6	2003-2005 - 6. Late 2005 - 4.
# of team at Focus Group	5	6	4
# of women	1	2	1
# of men	4	4	3
# of gov. departments they come from	3: Health, Planning, POLA. NGO	3: Health, Education & Tourism	3: health, women affairs & culture
Any trainer or facilitator from Health Y/N	Y-1	Y -2	Y - 4
(Average) # of days of training for Trainers	There was only 1 training for trainers - 5days.	There was only 1 training for trainers - 5 days.	There was only 1 training for trainers - 5 days.
# of refresher events or study visits made	3 times	2 times	3 times
# of support and monitoring visits from NAA and UNDP	3 times (Renato, Dr. Wantha, Dr. Navuth-NAA)		
List in the next 3 columns the locations visited for training and visits and the number of the team who attended	Sihanoukville: Mar 03 PP/Le Royal 2004-2d PP/Cambodiana 2005 - 2.5d BMC CCE/CDC 2005 -2d	Sihanoukville: 12-21 Mar 03-3Ts, 21-27 Mar 03 - 3Ts & 3Fs. PP/Le Royal 2004 - 6p/2d PP/Cambodiana 2005 - 3Ts/3d	Sihanoukville - 3Ts/10d, 3Fs/5d. PP/Le Royal 2004 - 4p/2d PP/Cambodiana 2005 - 3p/2d BMC CCE/CDC 2005 - 4p/2d
Names of any trainers remembered, or where they came from	Daouda (3 times), Barbara,		Daouda & Severine
In next 3 columns write names of organisations or individuals who have visited CCE	Daouda, Indonesian group, Leadership team, Australian youth		Daouda
How were CCE Ts and Fs selected: PAO, Health Department, PAC, PAS, volunteered, Nominated by own Department Head etc		NAA letter on establishment of 6 member CCE team (3Ts & 3Fs) including 2 members from Seila to PAC KPT. PAC appointed the 6 members of CCE team.	

	Battambang	Kampot	Svay Rieng
# months in each year 2003, 04, 05 were there contracts to do CCE		2, 8, 6	3, 3, 6
CCE tools and methods			
What instructions were given to Communes and villages on forming groups for CC			Invite 30-50 participants for each CC. In a target village, CCs are held in 3 places with 3 different groups of villagers.
Were groups expected to stay the same Y/N		N	N
Average CC group size	70	Most of participants are women.	25p. They are elders, housewives & children.
Was CC group divided and worked with in different parts of the village Y/N and add # of subgroups if known		Y	Y, 3
List tools mentioned by CCE team as used in CCs	**Mentioned tools** 1. Concern/problem exploration. 2. Social capital analysis & H/A 3. Story telling 4. Community conversation & analysis. 5. Five friends of planning 6. Strategic questioning. 7. Transect walk. 8. Mapping	**Important tools:** 1. Strategic questioning. 2. Problems exploration. 3. Community conversation & analysis. 4. 5 friends of planning. 5. Future plan for community.	1. Concern/problem exploration. 2. Social capital analysis & H/A 3. Historical timeline. 4. Social-cultural dynamics & H/A 5. Story telling 6. Community conversation & analysis. 7. Change & language 8. Creating a vision of future 9. Five friends of planning 10. Strategic questioning. 11. Active listening.

	Battambang	Kampot	Svay Rieng
CCE Results			
List the benefits given by CCE team of CCs in 3 columns. E.g. Women and girls can talk about sex, Women get men to use condoms when travelling, villages can take part better in CIP etc.	**CCE team:** Improved capacity in organize meetings & discussion with people. CCE tools are applied by commune council & village chiefs in CIP/Seila. NGO-HOC also use CCE tools in their project activities.	**CCE team:** Get new knowledge on CCE tools. Get experience on team work. Improve leadership skill. Manage works in a better & faster way. Increase skills on H/A education. Gain experience from other provinces & teachers through refreshment workshops. Use leadership skills in H/A activities. Forward knowledge on leadership & H/A to colleagues in education sector-teachers & students. Integrate H/A & leadership in ILO/IPEC- Child Labour project.	**CCE team:** Received new knowledge on CCE tools & team work. Share CCE experience with other CCE provinces & with CDC project. Received monthly salary.

	Battambang	Kampot	Svay Rieng
	Villagers: Improve involvement of people in discussion on village issues & H/A & find solutions. Increase people knowledge on H/A, drug, DV, health & security. Women/girls/youth discuss on prevention, sexual attitude & condom use. Some youth quitted drug. Better participation of villagers in CIP meetings & more social activities were included in CIP. Strengthened commune planning committee on CIP formulation. Commune council & village chiefs involved in CCs & linked CCs with CIP. H/A & gender activities were included in CIP & got some supports from NGOs. Toul Ta Ek commune has been selected as a target commune of Pact-local administrative reform support program.	***Villagers:*** Understand on H/A transmission & prevention & forward message to others. Use condom. Reduce H/A transmission. Change youth attitude to less going out at night & stop visit brothels. Test blood before married. Reduce stigma/discrimination. Improve participation in CCs. Change wrong believes of people e.g. if husbands go to work in forest/mountains they will not get H/A. People understand what are community needs.	***Villagers:*** Wives ask husband to use condom. CCE reports were distributed to CCE communes. Commune council integrate H/A in their meetings. H/A activities were included in CIP.
		Monks raise fund through charity boxes to help OVCs, PLHAs & poor.	

	Battambang	Kampot	Svay Rieng
Future of CCE			
Summarise proposals from Team for next steps with CCE - more training, decentralise to village, spread to more sites - in beyond communes, Districts, Provinces, Integrate with D and D, work with NGOs, integrate with USCDC, improve participation of Com chiefs, village chiefs	CCE should continue and expand to 2-3 more communes. CCs should be integrated in CIP & managed by commune council & village chiefs. A cycle of CCE in each target area is 2 years. Have good coordination between national & provincial level on planning, implementation, reporting, info flow & feedback. Have better financial rule to release budget on time for implementation.	CCE should continue & expand to remote areas where there is no NGOs. Should decentralise CCE to local level & manage by provincial team. ***Training/meeting:*** Should meet with other CCE provinces before continue. CCE teams of all provinces should meet quarterly to share experience. Should have study visit to other provinces.	***Create CCE structure***: provincial team work on M&E; commune chief & commune council member responsible for women & children are trainers; and village chief & a village focal person are facilitators. CCE network should link with health centre. ***Incentive:*** commune level-$3/d; village level-$2/d. ***Training/meeting:*** Should have quarterly meetings to share experience with other CCE provinces.
Does the documentation - manual etc need changing? And why	Update tools according to Cambodian context & actual situation of each target area.		Need to simplify tools since villagers have low education. Need to include H/A law in CC.
What problems have there been with implementing CCE	Budget release late/delayed.	No coordination between provincial & national level. Do not know who is focal person for CCE at national level. Not clear roles on who does what and how information flows	
Who should manage and coordinate CCE in the future	NGOs can implement CCE if there is fund support.	NAA should play coordination roles between UNDP & provinces.	

	Battambang	Kampot	Svay Rieng
Any suggestions on reducing costs, raising money for CCE			Create charity boxes & place them in pagodas & commune offices to raise money for OVC/PLHAs.
Additional materials needed		Lack materials to explain to people. Villagers like to learn through pictures.	

7.9 Non – CCE Village Data

	Battambang	Kampot	Svay Rieng		
Name District	Battambang	Kampot	Kampong Ro	Svay Teab	Rumdoul
Name of Commune	Ratanak	Thmey	Svay Toeur	Sangkhor	Kampong Chork
Name of Village	Ratanak, Rumchek3 (R3), R4, R5, Sophy2	Wat Po	Ta Chor	Chambok Peam	Chok, Prey Keav, Svay Roong & Lakreachea
Participants					
# men	5	10	7	11	9
#women	10	3	10	4	6
# total	15	13	17	15	15
Close to CC village Y/N	Y		Y	Y	N
% who know about CC	15	0	0	0	0
H/A knowledge Y/N, 3/2/1 High Medium Low					
Transmission	Y	Y	Y	Y	Y
Prevention	Y	Y	Y	Y	Y
Condom use	Y	Y	Y	Y	Y
Reduce stigma and discrimination	Y	Y	Y	Y	Y
# of PLHA choose to come out	48/commune	22/commune	1	0	3
Support and information sources for H/A					
Pagoda	Y	Y		Y	
Commune Council	Y	Y		Y	
NGOs				Y	
Posters				Y	
Health Department/OD/Health centre	Y		Y	Y	Y
RHAC	Y				
H/A education group				Y	

	Battambang	Kampot	Svay Rieng		
Name District	Battambang	Kampot	Kampong Ro	Svay Teab	Rumdoul
Name of Commune	Ratanak	Thmey	Svay Toeur	Sangkhor	Kampong Chork
Name of Village	Ratanak, Rumchek3 (R3), R4, R5, Sophy2	Wat Po	Ta Chor	Chambok Peam	Chok, Prey Keav, Svay Roong & Lakreachea
Khmer Development Vision	Y				
PLHA			Y		
TV & radio	Y	Y	Y	Y	Y
School program	Y	Y	Y	Y	Y
Student peer education		Y		Y	
Village chief/focal point/volunteer/villagers	Y	Y	Y	Y	Y
UNICEF - Feedback info committee				Y	Y
UNICEF - Youth Association			Y		
CHC					Y
Information dept		Y			
MPK	Y				
Padek					Y
Women's Affairs Dept	Y				
RACHA		Y			
Khmer Youth Association			Y		
CDA	Y				
CRC	Y	Y			
PSI		Y			
Religion and Cult/UNICEF		Y			
Social dept/UNICEF	Y				
WVC	Y				

	Battambang	Kampot	Svay Rieng		
Name District	Battambang	Kampot	Kampong Ro	Svay Teab	Rumdoul
Name of Commune	Ratanak	Thmey	Svay Toeur	Sangkhor	Kampong Chork
Name of Village	Ratanak, Rumchek3 (R3), R4, R5, Sophy2	Wat Po	Ta Chor	Chambok Peam	Chok, Prey Keav, Svay Roong & Lakreachea
CIP	Social activities include H/A, drug, PLHAs have been included in CIP. Some activities were supported by NGOs & WA dept.	DV, gender, health, edu & PLHAs issues were included in CIP. Some activities received fund supports.			Social activities (I.e. edu, health, agriculture, gender & DV) have been included in CIP. H/A was not in CIP since it was in low priority needs.
Needs	1. Counselling service. 2. Food support to poor PLHA families when they use ARV.	Food & study materials for PLHAs families.	1. Job for youth & villagers 2. Cropping & livestock skills 3. DV edu 4. Educate dropped school youth to continue their study. 5. Info on bird flu, dengue & H/A. 6. Road, canals, toilets	1. Water source 2. Good rice seed 3. Fish pond 4. Toilet	1. Water source 2. Irrigation system 3. Cropping & livestock skills 4. Food for PLHAs 5. Health service at night. 6. Village association to help each other.

7.10 CCE Village Data

PROVINCE	Battambang					Kampot			Svay Rieng					
COMMUNE	Tout Ta EK					Prey Khmum			Svay Toeur			Sang Khor		
VILLAGE[1]	1	2	3	4	5	6	7	8	9	10	11	12	13	14
CC attendance														
# of Families	300	725							166	122	300	202	185	139
Average CC group size - FGD	60	60	65	65	45	35	50	50	55	45	28	45	45	35
# of CCs held - reports	21	21	31	31	31	21	19	40	30	22	30	30	22	22
CCs held per month- FGD		2	2	2					2	2	2			1
Max # CCs attended per FGD participant	15				6	3	15	2		20	7	3	10	10
Average # CCs attended per FGD participant	3				1	1	1	0		6	3	2	4	2
Est. % females per CC	80	80	60	65		85	80	70	90	80	60	80	60	70
Est. % males per CC	20	25	40	35		15	20	30	10	20	40	20	40	25
Est. % youth per CC	50	40	65	65		30	70	10			10	20	10	30
Est. % older people per CC		15	10	15			20	10						5
Do PLHAs "come out" in village - Y/N	N		N					N		N	N	N	N	N
# PLHA in village	8		15			5	4							
# PLHA at CCs	1	4	2	3			2							
CC organisation and tools														
Length of CC Max (hours)				3							3		3	3
Length of CC Min (hours)											1		1	
# of sites in village where each CC held									3	2	4	7	3	
The same participants at all sites - Y/N										N	N	N	N	
Sub-groups formed A=Always, B=Some, C=No	A	A	A	A	A	B	B	B	A		B	A	B	A
# of CC Tools used - from Reports	22	22	23	23	23	9	9	9	13	13	13	13	13	13
# of CC Tools used - from FGD	3	6		3	3	4	3	3	3	3	5	3	4	4
Rank	***Subjects discussed at CC (in order of mentions)***													

	PROVINCE	Battambang					Kampot			Svay Rieng						
	COMMUNE	Tout Ta EK					Prey Khmum			Svay Toeur			Sang Khor			
	VILLAGE[1]	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
14	HIV awareness, prevention etc	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
11	Domestic Violence/gender/child rights		Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	
9	Bong Thom - youth violence/drug/thieves/gamble	Y	Y	Y	Y	Y	Y					Y		Y	Y	
8	Roads	Y		Y	Y			Y	Y			Y	Y		Y	
8	Hygiene - includes cleaning environment		Y	Y	Y	Y		Y	Y	Y			Y			
7	Toilets - construction							Y	Y		Y	Y	Y	Y	Y	
7	Agriculture-cropping/livestock/fish pond						Y	Y	Y		Y	Y		Y	Y	
6	Irrigation - canals/ponds	Y			Y			Y	Y		Y	Y				
6	Health center service-mother & child care						Y	Y		Y	Y	Y		Y		
6	Education	Y				Y		Y			Y	Y		Y		
5	Wells, water							Y	Y			Y	Y		Y	
4	Environment		Y		Y	Y								Y		
4	Culverts				Y			Y		Y		Y				
4	Bird flew/dengue/malaria/typhoid/TB						Y	Y	Y				Y			
3	Electricity				Y	Y		Y								
2	STD				Y					Y						
2	Mobility									Y				Y		
1	Under ground ancient things										Y					
1	Planning			Y												
1	Karaoke		Y													
1	Illegal fishing													Y		
1	HIV&AIDS Services								Y							
	Totals	5	6	6	10	7	6	13	9	7	8	11	6	10	7	111
															Av.	7.9

	PROVINCE	Battambang					Kampot			Svay Rieng					
	COMMUNE	Tout Ta EK					Prey Khmum			Svay Toeur			Sang Khor		
	VILLAGE[1]	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	Agencies given as active in villages - Y/N														
10	Pagoda	Y	Y	Y		Y	Y		Y	Y	Y	Y	Y		
9	Commune Council	Y	Y		Y	Y	Y		Y			Y	Y	Y	
6	Health/HR/HIV- NGOs				Y			Y		Y		Y	Y	Y	
5	Health Department/OD/Health center						Y			Y	Y		Y		Y
5	RHAC	Y	Y	Y	Y	Y									
5	TV & radio		Y		Y				Y			Y		Y	
5	Village chief/focal point/volunteer/villagers		Y						Y			Y	Y		Y
4	Department of Rural Development/Dstrict		Y					Y						Y	Y
4	UNICEF - Feedback info committee									Y	Y		Y	Y	
3	Pact/Amara	Y			Y	Y									
3	RACHA						Y	Y	Y						
2	AS		Y			Y									
2	CDK		Y		Y										
2	IPM											Y	Y		
2	Khmer Youth Association											Y			Y
1	Agricultural Department														Y
1	CGA/CHHE							Y							
1	CDA			Y											
1	CHET			Y											
1	CRC													Y	
1	Child Protection Network					Y									
1	CRS										Y				
1	Education department									Y					
1	Licadho													Y	
1	NGO - Theang Thnot					Y									

	PROVINCE	Battambang					Kampot			Svay Rieng						
	COMMUNE	Tout Ta EK					Prey Khmum			Svay Toeur			Sang Khor			
	VILLAGE[1]	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
1	PSI						Y									
1	PRASAC											Y				
1	Religion and Cult										Y					
1	SEILA/PLG	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
1	Suboros -NGO					Y										
1	UNESCUP					Y										
1	UNHABITAT					Y										
1	WVC		Y													
1	WFP		Y													
1	Women Prosperity					Y										
1	Village drama				Y											
	Totals	5	11	5	8	11	5	5	6	6	6	9	8	8	6	99
															Av.	7.1

Key for Village Numbers

Ref #	Village	Province	District	Commune
1	Dang Kor Teab	Battambang	Battambang	Toul Ta Ek
2	Ou Ta Korm 1	Battambang	Battambang	Toul Ta Ek
3	Ou Ta Korm 2	Battambang	Battambang	Toul Ta Ek
4	Ou ta Korm 3	Battambang	Battambang	Toul Ta Ek
5	Toul Ta Ek	Battambang	Battambang	Toul Ta Ek
6	Prey Khmum	Kampot	Kampot	Prey Khmum
7	Prey Tum	Kampot	Kampot	Prey Khmum
8	Wat Ang (N, S, E)	Kampot	Kampot	Prey Khmum
9	Khorsang	Svay Rieng	Kampong Ror	Svay Toeur
10	Svay Toeur	Svay Rieng	Kampong Ror	Svay Toeur
11	Tanor	Svay Rieng	Kampong Ror	Svay Toeur
12	Bak Ronors	Svay Rieng	Svay Teab	Sang Khor
13	Preah Tonle	Svay Rieng	Svay Teab	Sang Khor
14	Thlok	Svay Rieng	Svay Teab	Sang Khor

7.11 NGO Data

	Battambang	Kampot	Svay Rieng
Links to CCE			

	Battambang	Kampot	Svay Rieng
# who know of CCE			
List NGOs represented	CPN+, CWPD, CDK, BFD, RHAC, MPK, HOC	KWCD, Generous, CGA, CRC	UNICEF, RHAC, REDA, CPN+, CRS
# present # men # women	8, 3, 5	5, 4, 1	6, 4, 2
Results of CCE and other H/A work			
Briefly summarise areas of work for each NGO present. Use separate row fro each NGO	***1. CWPD:*** ***Target areas:*** karaokes, massages, guest houses, brothels in 7 communes. ***Beneficiaries:*** 950 people - direct & indirect sex workers, include 22 PLHAs. ***Activities:*** educate on prevention of H/A & STD, condom use; counseling; vocational training; send patients to receive services; establish SHGs; staff capacity building & peer leader training.	***1. CGA:*** ***Target areas:*** 5 villages (2 villages are overlap with CCE) in 3 communes & 2 districts. ***Activities:*** educate on health (include H/A prevention) & agriculture, credit, water filters & toilets.	***1. UNICEF/Health-H/A:*** There are 4 health support projects in SVR. 1. VCCT - support to 4 health centers. 2. PMTCT - support provincial hospital. 3. Children health care at provincial hospital. 4. Capacity building to health staff & material support.
	2. CDK: ***Target:*** 3 communes, 2 Districts. ***Activities:*** decentralisation, HR, scholarships, health education & transportation for patients.	***2. CRC:*** started 2002-present ***Target areas:*** 4 schools in 3 districts of Kampot, Kampong Bay & Chhouk. ***Activities:*** peer education in school & out school youth, 2 drama group to play H/A education drama.	***2. RHAC:*** work on H/A education, prevention, HBC, birth spacing with 17 health centers (HC) in 2 OD of Romeas Heik & Chiphou. Another H/A project work with out school youth.

	Battambang	Kampot	Svay Rieng
	3. BFD: ***Target:*** 5 HCs ***Beneficiaries:*** 110 PLHAs & 140 OVCs ***Activities:*** counseling, establish SHGs, food, small credits, find services for PLHAs, find step parents for OVCs.	***3. KWCD:*** have 3 H/A projects. 1. Work with sex workers on prevention of H/A, STD, drug. 2. HBC is implemented with 149 PLHAs & 3 HCs. 3. OVCs - prepare official letters for OVCs to receive family properties after parents died.	***3. REDA:*** ***Target areas:*** 14 HCs in 2 OD of Romeas Heik & Svay Rieng. ***Beneficiaries:*** 1409 OVCs, PLHAs-35 SHGs (10-17PLHAs in each SHG). ***Activities:*** HBC, OVCs, monthly food support to PLHAs, travel cost to get OI & ARV, vocational training, SHGs, raise fund for PLHAs & OVCs & prepare official letters for OVCs to receive family properties after parents died.
	4. MPK: ***Target:*** 55 villages, 9 communes, 4 districts. ***Beneficiaries:*** 336 PLHAs - 12 SHGs ***Activities:*** 4 projects: 1) child center, 2) street children, 3) community & 4) H/A - prevention, HBC, OVC & PLHAs support, small credit, food.	***4. Generous:*** support to 68 PLHAs on travel cost for blood testing, OI & ARV, food, housing; established 2 SHGs; & support school materials for OVCs. This project was end in Sept 2006. They look for a new partner.	***4. CPN+:*** Establish SHGs, advocacy & forward info to PLHAs. There are 770 PLHAs in network of 45 SHGs. 52 PLHAs work as volunteers & 3 PLHAs are NGOs staff.

	Battambang	Kampot	Svay Rieng
	5. CPN+: ***Target:*** 7 districts. ***Beneficiaries:*** 1463 PLHAs in Bat. ***Activities:*** work with PHD, hospital & NGOs; find support from communities; advocacy; find solutions for PLHAs; create SHGs; create PLHAs network; raise fund to support PLHAs;		***5. CRS H/A project:*** ***Target areas:*** 3 OD of Romeas Heik, Svay Rieng & Chiphou. It is a new project started mid 2006.
	6. HoC: ***Target:*** 30 villages, 6 communes, 2 districts of Sangke & Ek Phnom. ***Beneficiaries:*** 92 OVCs ***Activities:*** 3 projects: 1) education, 2) care & 3) income generation.		
	7. RHAC: ***Target:*** 11 schools & 16 villages in 5 districts. ***Beneficiaries:*** ***Activities:*** reproductive health, drama, concert, counseling, library, vocational training, create youth network, clinic for blood testing, health care for elder people.		

	Battambang	Kampot	Svay Rieng
Summarise any proposals for next steps with CCE or other HIV&AIDS programming or projects		CCE team train Village team. Then village team train villagers. Members of village team should be village chief, a commune member, village health focal point & a PLHA.	

7.12 PLHA Data

	Battambang	Kampot	Svay Rieng
Participants of FGD			
# total	10	10	10
# women	7	9	5
CCE Participation			
Know about CCE Y/N	Y	Y	N
PLHA invited to attend CCs Y/N	Y		
Do they live in a CCE village Y/N	Y		
# attend CCs	7	4	
Average # of CCs they attended	3	1	
# of CC tools they remember using	1. Story telling 2. Transect walk 3. Social capital 4. Concern issues		
What are the improvements over 3 years? score 3/2/1 High/Medium/Low and add C if due to CCE			
Reduced stigma and discrimination	1C	1C	1
Condom use understood	2C	1C	
Condoms being used	2C	1C	
Know where to get services	3	1	
Testing service improved	2		
Improved treatment services for PLHA	2		1
Counselling services	1		
Assistance with travel	1		
Assistance with food	1		1
Support to OVCs	1		
PLHA have volunteer jobs	1		
PLHA have full jobs	1		
PLHA can get credit and other support for livelihoods		2	
Future of CCE			

	Battambang	Kampot	Svay Rieng
Want CCE to continue Y/N	Y		
Want to train and work as facilitators or similar role Y/N	Y		
Other support to PLHA			
Health Centre/referral hospital			Y
RHAC	Y		
AS	Y		
CRC		Y	Y
RIDA			Y
TV/Radio			Y
UNICEF-Feedback info committee/equity fund			Y
PLHA network	Y		
Pagoda/Monks		Y	
Village health person		Y	
Commune Council		Y	
Village Chief		Y	
Needs			
	1. Job	1. Job 2. Small credit 3. Service info 4. Travel support to get ARV	1. Job 2. Food support 3. HBC 4. Water source 5. Blood test service at health centre. 6. Connection with CPN+

7.13 Local Authority Data

	Battambang	Kampot	Svay Rieng
CC frequency information etc			
Start date for CCE - Earliest date given		Late 2003	
Start date for CCE - Latest date given			
# CCs per month	8CCs/month/5villages	4-5times/month/4villages	2
Length of each CC 1/2/3/ hours			2
Most CCs held at weekends Y/N	Y	Y	Y
# of Trainers and facilitators that go to each CC		5-6 T/F divided in 2 groups & conducted 2 CCs at the same time.	2 or 3
Average number of participants in CCs	75	50	40. At beginning many people jointed CCs. Then, less & less people attended.
Same participants invited to all CCs Y/N		N	N
CCs held at more than one place in each village Y/N		Y. 2-10 places	Y. 2-4 places
Chiefs aim for ALL villagers or families to attend a CC Y/N		Y	Y
Average % of CCs attended by Village chiefs			
Average % of CCs attended by Commune Councillors			All CCs were attended by a representative of commune council.
% of women attending CCs		70	80
% of men attending CCs		30	20
% of youth attending CCs	75	20	20
Average # of PLHAs in Village		5 families	
Average # of PLHAs in Commune			
PLHAs attend CCs Y/N		Y. 2 or 3	
Clear on difference between CC and other Village projects Y/N	N	N	
Achievements of CCs 03 to 06 score 1/2/3 -Low/Medium/High; X - increased/improved.			
Awareness increased	X	X	X

	Battambang	Kampot	Svay Rieng
People getting knowledge and from CC facilitators		X	X
People understand H/A transmission, prevention, condom use	X	X	X
People know where to go for tests and services	X	X	X
More people visited VCCT		X	
Women participate in discussions and planning			X
Drug use is reduced	X		
Youth violence less	X	X	X
Security has improved - fewer robberies etc			
Domestic violence is reduced	X	X	X
More villagers take part in Commune Planning process	X		X
Villagers able to identify development needs and projects	X		X
More social development projects included in village plans	X	X	X
PLHA are coming out	1		1
Reduction in stigma and discrimination	X	X	X
OVCs/PLHAs cared for better	X	X	
More people use health centre service			X
People talk & discuss on H/A transmission & condom use	X	X	
Suggestions for future of CCE			
Should CCE be continued Y/N	Y	Y	Y
Should village level people be trained as CC facilitators Y/N	Y	Y	Y
Should Province continue to facilitate Y/N			
Should Province continue to MANAGE CCE Y/N	Y		
# facilitators needed per village	2	3	2
Should Village/commune heads be trained for CC Y/N		Y	Y
Should women be trained for CC Y/N	Y	Y	Y
Should PLHA be trained for CC Y/N		Y	
Should young people be trained for CC Y/N	Y		
NGOs involved in CCE Y/N	Y		
# of CCs held per month		2	1

	Battambang	Kampot	Svay Rieng
Recommended size of CC groups		50	30
# months CCE should continue	24	12	6
Daily payment to facilitators - $US		2.5	2.5 - 5
Should Pagoda/Monks participate in CCE Y/N			
Links to D and D planning and NGOs			
Has CCE improved participation in CIP processes Y/N	Y	Y	Y
Are there more social and HIV&AIDS projects in Village plan Y/N	Y	Y	Y
Have these projects got support through CIP/DIW Y/N/S(ome)	S	S	S
# of NGOs active on H/A and social projects in area	7	3	2
Do the NGOs and CCE work together Y/N	N	N	N
UNICEF	Y- OVC network exists in all villages		Y- feedback info committee exists in all 6 CCE villages
UNFPA	Y		
WFP	Y		

7.14 Provincial Department Data

7.15 Private Sector Data

	Battambang	Kampot - No PS FGD	Svay Rieng
Participants			
#W #M from Karaoke	3, 1		7, 3
#W #M from beer halls			
#W #M from guest houses	1, 1		1
#W #M from brothels			
#W #M other - state where from present			
List any changes in behaviour over period 03 to 06 and why they have happened	Use condom, reduce stigma/discrimination, blood test.		Use condom, reduce stigma/discrimination, blood test.
List any problems that still exist with behaviour	A karaoke girl has no job after knowing that she is a PLHA.		Sometimes clients do not want to use condom. Karaoke owners do not accept PLHA girls.
Results of CCE and other H/A work			
Summarise areas of H/A knowledge	Awareness, prevention, care, condom use, service, stigma/discrimination,		Prevention, transmission, services, condom use
What programmes have changed behaviour			
List organisations that have helped improve H/A situation (POT, Govt Departments, CC, NGOs etc)	Women Association, CVD, Women Vision, TV, radio, Health dept, RHAC,		NGOs, police, health dept, POT
List any training received	Awareness, prevention, care, condom use, service		Monthly training for karaoke girls. Quarterly meeting for karaoke owners.
Who provided this training	Women association, CVD, Women Vision,		NGOs, POT
Future of CCE and other HIV&AIDS work			

	Battambang	Kampot - No PS FGD	Svay Rieng
Summarise any proposals for next steps with CCE or other HIV&AIDS programming or projects	Continue H/A education activities by NGOs. Improve HIV&AIDS activities in all government levels - province, district, commune & village. Create village youth network for HIV&AIDS education. Support OVCs.		Need update info on HIV&AIDS issues & services 2 times/month.

7.16 Seila Data

	Battambang	Kampot	Svay Rieng
Name, title	Mr. Kong Sokhuntho, SPPA	Mr. Roeun Sophanna, SPPA	Mr. Seng Pho, SPPA Mr. Hing Sokunthy, Local Adm Adv.
Know about CCE Y/N	N	N	Y-little. It is activities on H/A prevention & providing information on H/A & PLHAs services.
Summarise approach to supporting social village and Commune level projects	At provincial level, Seila fund is divided by 2 kinds - Provincial Investment Fund (PIF) & Commune/Sangkat Fund (C/sF). Part of PIF has been used for H/A activities by provincial level to support CIPs project implementation.	From 2003-2006, more social projects have been raised in CIPs. Some projects (ie. DV, trafficking, nutrition, vocational training, drug, Bang Thom education, H/A, gender) were supported by provincial depts (WA/IFAD/Seila, Social/PIF) & NGOs (CISE, HEK, CHC, RACHA, FHI, FHP).	

	Battambang	Kampot	Svay Rieng
Describe special programme to use C/s Fund to support social programme	In 2006, Seila has allocated 30% of C/sF to pilot social projects (including H/A) in Kok Krolor district since those social projects were in the high priority of CIPs.		This year, Seila has allocated part of C/sF to pilot social projects (including H/A, health , DV, edu) in a district of Svay Rieng.
Is SPPA in favour of integrating CCE into D and D Y/N and state reasons given			
Summarise any H/A projects SPPA described	# of H/A projects in CIPs is increased, see DIW reports in Seila website. There are many H/A activities in BAT i.e. integration of H/A in all meetings, TV program, awareness raising, trainings, flyers/posters distribution & stick in shops & along roads, OVCs support, etc. RHAC is the largest H/A NGO in BAT.		UNICEF/Set Koma support services, including hot phone service for PLHAs at district level.. NAA project on OVCs.
Summarise any advice given on integrating CCE with D and D	Should integrate CCE in existing government system. Commune councils have low capacity on administration, finance & planning. NGOs work effective in small areas. Need a good coordination work between government & NGOs.	Include CCE tools in training program for PFT & DFT.	CCE should be integrated in D&D through Excom/PRDC & work at community level with facilitation of district & commune council. Should integrate CCE tools in training program for PFT & DFT.