

Improve the Quality of Life of HIV/AIDS Infected and Affected (I/A) Children



*["HIV-related stigma and gender inequalities disempower people, making it difficult for them to reduce their risk of infection or access to HIV-related services"]
– 2001 Declaration of Commitment on HIV/AIDS Progress Report]*

**Lift the stigma and discrimination against the
HIV/AIDS (I/A) Children in
Sen Sok, Phnom Penh, Cambodia**

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EXECUTIVE SUMMARY

Acquired Immunodeficiency Syndrome (AIDS) is a disease of the human immune system caused by the **Human ImmunoDeficiency Virus (HIV)**. AIDS is now the world's leading cause of premature death among both men and women aged 15 to 59 and the combat of AIDS has been identified as one of the Millennium Development Goals (MDGs) by the United Nations (UN) in 2000.

In 2007, 2 million children are living with HIV and every hour, around 31 children die as a result of AIDS.

According to the UN, the most understated impact of HIV/AIDS are the effects it has on the protection of children's basic human rights, specifically the rights to;

- Survival, development and protection from abuse, neglect and economic exploitation;
- Participate in decision making in matters concerning them;
- Have their best interests as the primary consideration;
- Be free from discrimination.

Children who are themselves living with HIV/AIDS, or have lost one or both parents to HIV/AIDS, often experience discrimination and exclusion from the community as a result of stigma. HIV/AIDS stigma and gender inequalities continue to increase the vulnerability of the groups most at risk of HIV. Children living with HIV have many practical and material needs, but they also have social, psychological and emotional needs. Addressing their emotional needs has positive outcomes on individuals and communities.

As quoted by UN Secretary-General, Mr Ban Ki-Moon: "'Stigma remains the single most important barrier to public action. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world". Hence, the project aims to lift the stigma and discrimination against the HIV/AIDS (I/A) children as the starting point to improve their quality of life. The pilot site was chosen as Sen Sok Community, Phnom Penh, Cambodia as the country still has the second highest HIV prevalence rate in Asia, with 0.9% of the adult population infected and in a Cambodia Sentinel Survey conducted in 2007 in Phnom Penh City, the results indicates that the potential for stigma and discrimination of PLHA (People Living with HIV/AIDS) continues to exist.

Participatory approach was adopted as the overall method for this project. The 'Fish Bone' diagram was used as the method to identify and analyze the problems, as well as their causes and effects to the Community where the project is to be piloted. Logical framework was used as an analytical tool to plan, monitor and evaluate the project. The project timeframe and budget plan are also tools that ensures the successful planning and implementation of the project.

Three major project components were identified to achieve the pilot project goal and objective:

- (a) Improved awareness of target group (family, peers and community) about the rights of HIV/AIDS (I/A) children;
- (b) Enhance HIV/AIDS (I/A) children's role in the community and their involvement in HIV/AIDS prevention; and
- (c) Sustainable community involvement in developing programs and activities for the betterment of HIV/AIDS (I/A) children.

The above project components are strategic thrusts which if successfully implemented will greatly improve the quality of life of HIV/AIDS (I/A) children in Sen Sok, Phnom Penh, Cambodia (pilot site).

I. THE OVERALL BACKGROUND OF THE PROJECT

1.1 Why is there a need to improve the quality of life of HIV/AIDS (I/A) Children?

In 2007, 33 million people are living with HIV, out of which 2 million are children. In Asia, out of an estimated 5 million people living with HIV in 2007, about 147,800 are children. Hundreds of thousands of children across the world become infected with HIV every year and without treatment, die as a result of AIDS. Once a child is infected with HIV, they face a high chance of illness and death, unless they can successfully be provided with treatment. Sadly, the vast majority of children who could be benefiting from this therapy – an estimated 90% – are not receiving it. A major problem is that few appropriate drugs are available. Every hour, around 31 children die as a result of AIDS. In addition, millions more of children, who are not infected with HIV, are indirectly affected by the epidemic, as a result of the death and suffering that AIDS causes in their families and their communities. In most cases, HIV/AIDS (I/A) children faced discrimination and encounter hostility from their extended families and community, or be rejected, denied access to schooling and health care, and left to fend for themselves. Hence, the project aims to improve the quality of life of HIV/AIDS (I/A) children where these children are entitled to the rights of a child, in accordance to UNICEF's *Convention on the Rights of the Child* and have a normal, happy and carefree childhood like any other children.

1.2. Identification of key factor which contributed to the current poor quality of life of HIV/AIDS (I/A) Children?

Many factors contributed to the poor quality of life of HIV/AIDS (I/A) children but the project team recognize that the key factor is that of 'HIV/AIDS related stigma and discrimination towards the HIV/AIDS (I/A) children that undermines the access to their basic rights and the opportunity to improve their quality of life. This point is also strongly reinforced in the progress report of the 2001 Declaration of Commitment on HIV/AIDS which indicated that 'HIV-related stigma and gender inequalities disempower people, making it difficult for them to reduce their risk of infection or access to HIV-related services'.

1.3. How does lifting the stigma of HIV/AIDS help improve the quality of life of HIV/AIDS (I/A) Children?

The project team believed that by lifting the stigma and discrimination against the HIV/AIDS (I/A) Children, it would drive behaviour changes (within the HIV/AIDS (I/A) children, their families and the Community) and these children (or their parents/guardians for child aged below 12) would be more willing to come forward to be tested, disclose their HIV status and seek treatment, knowing that they would no longer be discriminated by their family and community. There will be better support from the community towards the emotional needs of these children who are affected by HIV, including those who have lost parents or relatives to AIDS. There are particular stages of an HIV-positive child's life when meeting these needs can be particularly important: the times when they are first diagnosed, start to receive treatment, have to deal with discrimination, experience problems adhering to drugs, or have to deal with end-of-life issues.

1.4. Why did we choose Sen Sok Community in Phnom Penh, Cambodia as the pilot site?

Despite its achievements in reducing its HIV prevalence rate, Cambodia still has the second highest HIV prevalence rate in Asia, with 0.9% of the adult population infected. In addition, in a Cambodia Sentinel Survey conducted in 2007 in Phnom Penh City, the results indicated that the potential for stigma and discrimination of PLHA (People Living with HIV/AIDS) continues to exist. The project team decided to pilot the project at the Sen Sok Community, which is the largest relocation site in Phnom Penh with about 3,017 families, out of which 50 families have been infected or affected by HIV/AIDS and there are about 300 HIV/AIDS (I/A) children. Most importantly, one of the team members who is from Cambodia has close network with Mary Knoll Lay Missionaries, an HIV/AIDS faith-based NGO working in Sen Sok community to pilot the initiatives.

II. THE SPECIFIC CONTEXT OF THE STUDY

2.1. COUNTRY BACKGROUND - CAMBODIA

HIV Prevalence Rate	0.9% ¹
People with HIV	71,000 ²
Adults	67,200 ²
Women	34,944 ²
Children	3,900 ²
New infections	1,350 ²
AIDS deaths	16,000 ³
Specialized Sexually Transmitted Infection clinics	30 (in 21 provinces) ⁴
Voluntary & Confidential Counseling and Testing sites	190 ⁴
People receiving anti-retroviral therapy	
Adults	21,933 ⁴
Children	1,938 ⁴
HIV support groups	685 (in 14 provinces) ⁴

¹ Cambodia Country Profile on AIDS 2006-2007; NAA; August 2007

² A Situation & Response Analysis of HIV/AIDS in Cambodia 2007 Update; NAA; October 2007

³ <http://www.unaids.org/en/CountryResponses/Countries/cambodia.asp>

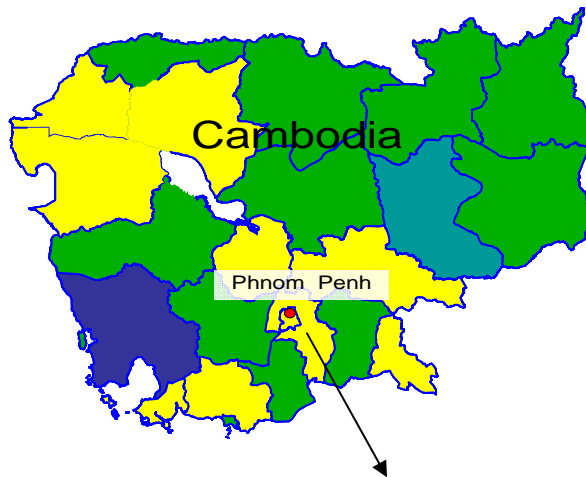
⁴ NCHADS Quarterly Report; NCHADS; September 2007

Cambodia's HIV epidemic can be traced back to 1991. After an initial rapid increase, HIV infection levels declined after the late 1990s, and have reached a steady level in recent years. Despite its achievements in reducing its HIV prevalence rate, Cambodia still has the second highest HIV prevalence rate in Asia, with 0.9% of the adult population infected. Ongoing concerns include low levels of condom use among MSM, an increase in sex work occurring outside of

brothels (making it harder to reach sex workers with interventions), and mother-to-child transmission of HIV – around one third of new infections occur through this route. HIV is mostly transmitted through heterosexual sex in Cambodia, and almost

half of those infected are women. Please see below table for the HIV/AIDS related data in Cambodia for 2007.

2.2. BACKGROUND OF THE TARGET AREA



**Pilot Project Site
Sen Sok Community**

Quick Facts

Community Name: Sen Sok

Commune: Khmoun

District: RuseyKeo

Municipality: Phnom Penh

Ethnic group:

95% Cambodian and
5% Vietnamese.

Population: 3,017 families with
total 17,500 populations,

Infrastructure conditions:

Children faced difficulties access
to school and health center during
rainy season (flood) and only
about 10% of the residents can
access to running water and
electricity. There is no proper
drainage system.

Sen Sok is the largest relocation site in Phnom Penh which comprises of more than 3,471 plots and a population size of 17,500 people, with about 3,017 families which were relocated from the bank of Bassac River in Nov 2001. At the time of relocation there were no amenities on the site except the demarcation of plots. To date, about 50 families and 300 children have been infected or affected by HIV/AIDS.

2.3 SOCIAL ECONOMIC BACKGROUND OF TARGET AREA

Cambodia is a predominantly rural society, with 84.3% of its 14 million estimated population living in rural areas. The remaining 21% urban dwellers live predominantly in Phnom Penh, which has an estimated population of about 1.3 million in 2008 and is about 16 times the size of the second largest city, Battambang. The population in Phnom Penh grows at a faster rate than in the country overall, with an estimated 8% per annum made of a 3% in-migration rate and a 5% natural increase. The country has one of the lowest Human Development Index (HDI) in Asia (HDI ranking : 131 in 2007 globally), with a life expectancy of 62 years (2006), an adult literacy of 75% (2006), and a yearly gross national income per capita of

\$1,550. Conversely, it ranked 85th position globally in the Human Poverty Index (2007), with a high level of mortality and child malnutrition, and a limited availability of public services.



Although the HDI is 21% higher in cities than in the countryside, cities are also where disparities are most marked. In Phnom Penh low income settlements, indicators of health, access to education and living standards are thus worse than in rural Cambodia with 56% of houses made of bamboo and leaves, only 17.3% with access to water distributed by the governmental water supply authority, and 33% without access to storm drainage (Fallavier 1999 :56; Slingsby 2000; Squatter and Urban Poor Federation 1999). Most heads of households are unskilled construction workers or vendors, and find work on nearby construction sites and markets. They earn an average of \$10 to \$15 per week. Within poor communities, the most vulnerable families live on public land where private owners cannot claim property rights and evict them. This is also where living conditions are the harshest: in makeshift shelters under the level of flooding for a large part of the year, in areas very difficult to reach, in the alleys and corridors of dilapidated buildings, or on their rooftops.

III. PROBLEM, CAUSES AND EFFECTS

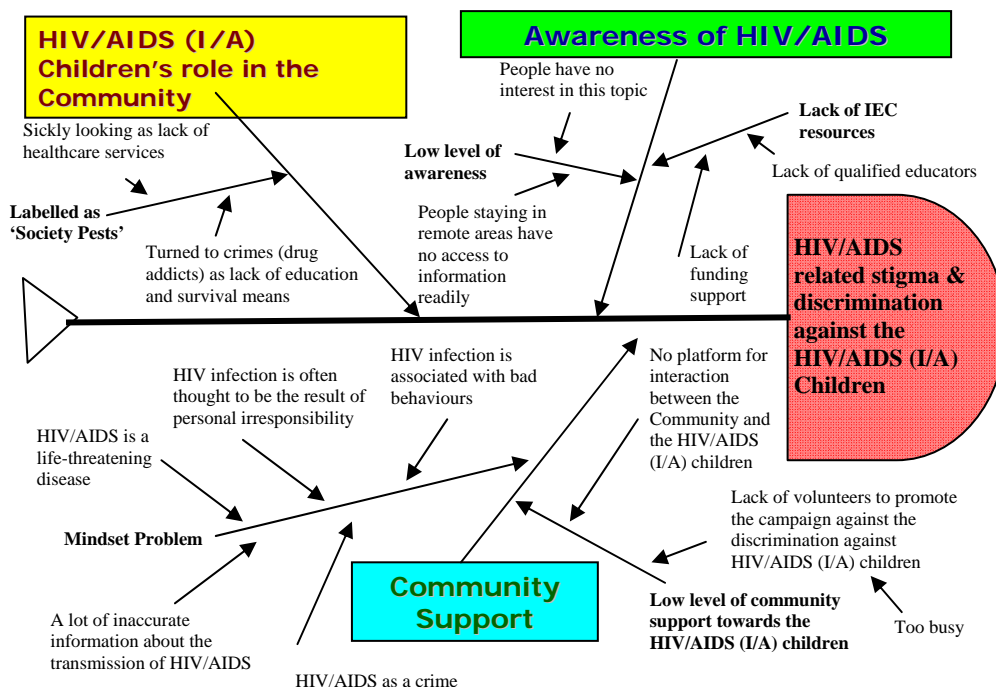
3.1 PROBLEM STATEMENT

The project team aims to address the issue of 'HIV/AIDS related stigma and discrimination against the HIV/AIDS (I/A) children in Sen Sok, Phnom Penh, Cambodia to improve their quality of life and lead the life as that of a normal child and have full access to their basic rights (i.e. education, proper healthcare services and not to be discriminated, etc)

3.2. CAUSES & EFFECT

Causes

Using the fish-bone diagram, three major causes were identified contributing to the situation of 'HIV/AIDS related stigma and discrimination against the HIV/AIDS (I/A) children in Sen Sok, Phnom Penh, Cambodia' and undermines the access of these children to their basic rights. Please refer to the fish-bone diagram below.



Effects

There are three main effects of HIV/AIDS related stigma and discrimination against the HIV/AIDS (I/A) children which include (i) HIV/AIDS (I/A) children or their parents/guardians (for dependent children) are reluctant to be tested, to disclose HIV status or to take antiretroviral drugs and reduce their chance of survival further, (ii) HIV/AIDS (I/A) children encountering hostility from their extended families and community, or (iii) be rejected, denied access to schooling and health care, and left to fend for themselves.

IV. METHODOLOGY

4.1 OVERALL APPROACH

Participatory approach was adopted as the overall method for the project as it maximizes (i) the participation of all the Group Study team members in the discussions, research and design of the project proposal and (ii) the participation of major stakeholders in the justification, implementation and evaluation of the project cycle.

Participatory approach has been widely adopted for grassroots/community-based projects in a wide variety of areas such as HIV/AIDS prevention, gender equality, rural development and poverty reduction. The success of participatory approach is confirmed based on the literature gathered from project reports and studies in many ASEAN countries (*Advocating for Sustainable Livelihoods and Environmental Justice in Indonesia*. 2005; Maria-Celeste H. Cadiz and Lourdes Margarita A. Caballero. 2006; *Localized Poverty Reduction in Vietnam-Project Reports and Lessons Learned*. 2005).

Within the project proposal scope, participation is assumed to be both as a tool to ensure the sustainability and feasibility of the project and as an end which reflects the empowerment of the target groups.

4.2 PROJECT DESIGN, MONITORING AND EVALUATION TOOL

Logical Framework was used by the team as an analytical tool to plan, monitor and evaluate the project. Logical Frame (LogFRAME) links the ends (overall objective/goal and specific purpose/objective) of the project with the means to achieve that end (activities), and the tools to monitor and evaluate whether the ends are achieved or not [expected output, objective verifiable indicators (OVI) and means and sources of verification (MOV)]. It also presents assumptions based on which the whole project is developed and implemented (assumptions).

V. PROJECT OVERALL OBJECTIVE, STAKEHOLDERS, PURPOSE AND COMPONENTS

5.1 OVERALL OBJECTIVE AND PROJECT PURPOSE

The overall objective of the project is to improve the quality of life of HIV/AIDS (I/A) children in Sen Sok village (Pilot Site).

The purpose of the project is to help HIV/AIDS (I/A) children in Sen Sok to live a normal childhood by lifting the stigma of the disease amongst their family, friends and the community.

5.2 PROJECT TARGET GROUPS

Primary: The major stakeholders of the project are AID/HIV infected/affected children, their families, peers, and the general population of Sen Sok. The project also aims to empower them so they can take the lead in communicating about the disease and propose interventions that can lessen the stigma against them.

Secondary: Non-affected children between 0-18 years old and vulnerable groups (girls, street children, in/out of school children within Sen Sok, who are considered the high risk groups who can obtain HIV/AIDS. Pregnant women and mothers are also secondary stakeholders who have a tendency contract HIV/AIDS transmitted from men/husbands.

Corollary: The academe, healthcare centers, care and support groups and volunteers who are active in the area and can assist in implementing project activities and events.

5.3 PROJECT COMPONENTS

The project has three components, which are:

1. Improved awareness of target groups (family, peers and community) about the rights of HIV/AIDS (I/A) children.
 - Conduct meetings with local community decision makers and potential volunteers to get support and participation for the project.
 - Assess awareness level and implement awareness raising program for the target groups.
 - Reduce HIV/AIDS-related stigma and discrimination and enhance community participation through awareness raising and educational activities, events and materials in local language, that can provide safer and supportive environment for HIV/AIDS (I/A) children (Table 5.2.A).
 - Assess capacity level and implement capacity building opportunities for community volunteers such as training of trainers to enable them to conduct basic orientations regarding Gender Sensitivity, and *Act Responsible, Live Safe*.

Table 5.3 A. Message Packaging (Awareness Raising Program)

<i>Knowledge</i>	<ul style="list-style-type: none"> • How HIV/AIDS is transmitted • Ways to prevent infection (<i>Prevention messages are always linked to the country's National AIDS strategy.</i>) • <i>Healthy attitudes that reduce stigma and discrimination</i> • How to respond assertively to peer-pressure • Feeling compassion for people with HIV/AIDS
Skills*	<p>*Sports and play will be the methodology to develop and teach life-skills during capacity-building activities and meetings for HIV/AIDS (I/A) children.</p> <ul style="list-style-type: none"> • Decision-making • Problem solving • Critical thinking • Negotiation

2. Enhance HIV/AIDS (I/A) children's role and involvement in HIV/AIDS prevention in their community.
 - Development and implementation of interventions by/from the HIV/AIDS (I/A) children such as a *Speak Out Forum*, child-friendly orientation about HIV/AIDS, and a Kid's Club (Table 5.2B).
 - Make information and learning fun and enriching by employing many interactive sharing/teaching methods, including sports/play, group-work and role-playing.
 - Relevant information, education, and communication (IEC) materials are produced using the local language in terms of language and disseminated in available and preferred communication channels.

Table 5.3. B Kid's Club

Target	HIV/AIDS (I/A) children and non AIDS children
Objectives	1. To provide venues/forums for HIV/AIDS (I/A) kids and non

	<p>AIDS children to meet each other.</p> <ol style="list-style-type: none"> 2. HIV/AIDS kids will be able to share and help each other. 3. To support kids' activities.
Venues	A local school / playground / community center (<i>depends on activity</i>)
How to become a member	<ol style="list-style-type: none"> 1. Visit a local community center, sign up for free. 2. Members will be given a friendship band to wear. 3. After joining more than 5 activities organized by the club, they will get a small token (sticker, small toy, etc.)
Activities	<ol style="list-style-type: none"> 1. Peer counseling 2. Music Therapy 3. Story-telling by the older children and volunteers. 4. Toy playing/ Red Ribbon Origami making 5. Drawing 6. Meditation 7. Playing sports (i.e: HIV Tag, Don't Trust Your Eyes) 8. Voluntary work

3. Sustainable community involvement in developing programs and activities for the betterment of HIV/AIDS (I/A) children.

- Identify existing HIV//AIDS programs in the community and work towards modifying them to become child-friendly programs.
- Establish new 'child friendly' programs through partnerships with relevant institutions such as schools, healthcare centers, and care and support groups.
- Provide venues that enhance community interaction and supplemental income for households through community garden plots and One-Village-One-Product inspired products.
- Install a toll-free hotline for HIV/AIDS prevention, counseling and support.

Table 5.3 C AIDS Prevention Module for Schools

Target	Primary and secondary school students
Objective	<p>Primary and secondary school students are acknowledged of the risk of AIDS and prevention through learner-based center approach.</p> <p>It can be a supplemental learning session in the Moral class, Physical Education, and Social Studies. It can also be informally taught by a faith-based individual or AIDS volunteers one hour per month in a school hall or in a club class.</p>
Content	<ul style="list-style-type: none"> - The current situation of AIDS worldwide and Cambodia - Learning from AIDS affected volunteer - AIDS awareness - Preventions

Facilitator	School teachers, faith-based individuals (monks), HIV/AIDS affected volunteers
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Within the third component, providing venues such as playgrounds and community garden plots can significantly enhance community interaction between those who are HIV/AIDS (I/A) individuals, including children, and the general population.

Community Garden Plots to Encourage Interaction

The project will work closely with local authority leaders to seek their support and involvement on the community garden plots. The project will engage community leaders through community associations and microfinance institutions to allocate sufficient land or funds in their area to establish a model community garden plot since it will be the community that will benefit from the harvest. This initiative is expected to augment household income and participants in the program will be offered basic home gardening training programs.

After the initial orientation, succeeding capacity-building activities/trainings will be conducted. For example, Basic Financial Management training, will improve their ability to manage their own financial resources, through basic budgeting, saving and financial planning for the future.

The community garden plot also aims to address food security and any produce surplus can provide supplemental income to families.

Social Enterprises: One Village, One Product-Inspired Products

The project will seek the experiences of OVOP from Japan and other regional OVOP projects that have been implemented well in Thailand. In terms of product design and development, the project will seek local or regional fashion designers who are active in supporting causes related to children. For example, Rajo Laurel, a top fashion designer in the Philippines has created the idea of “Rags to Riches”—turning ordinary floor rags into hip and functional bags for women.

The choice of the product will be range of handicraft products made from textile that include bags, clothes and household decorative items. Cambodia is one of the textile producers with an average growth of 9% annually, the products are mostly exported to Europe, the U.S. market. The Sen Sok products, in the local market, can also be channeled through the Angkor Wat souvenir shops, a world heritage site that attracts around 2 million tourists annually.

VI. THE LOGICAL FRAMEWORK

	Intervention Logic	Objective Variable Indicators	Means of Verification (MOV)	Assumption

Overall Objective	To improve the quality of life of HIV/AIDS (I/A) children in Cambodia	60% of the HIV/AIDS (I/A) children enjoying the same rights as that of normal children	Baseline and post surveys, Progress Reports	Current awareness about the disease is low.
Project Purpose	Helping HIV/AIDS (I/A) children in Sen Sok (Pilot site) to live a normal childhood by lifting the stigma of the disease amongst their family, peers, and the community.	100% of families (nuclear/extended) accept an (I/A) child 50% of community accepts an (I/A) HIV/AIDS child.	Baseline and post surveys, Progress Reports	HIV stigma starts within the family Peer pressure among children not to associate with HIV/AIDS (I/A) children
Expected Result 1	Improved awareness of target groups (families, peers, community) about the rights of HIV/AIDS (I/A) children.	At least 60% of the target groups understand about the right of the child Target groups participate in promoting the right of HIV/AIDS children	Pre-post survey design and reports List of participants	Reluctance of the target groups
ER 1/ Activity 1	1.1. Meeting with the community decision makers and key stakeholders to get their support for the project.	At least 70% of Community decision makers participating in project meeting	Minutes of the meeting. Lists of participants	
ER 1/ Activity 2	1.2. Assess awareness level of and implement awareness raising programs for the target groups.	Baseline survey result sharing & meeting with local community Each household at least receive two awareness materials At least 50% of HIV/AIDS (I/A) participate in 1-2 awareness raising activities Private sector Involvement for events (ie: provision of counterpart funding)	Perception Survey Results Project communication plan Meeting minutes Actual Information, Education and Communication Materials (IEC)	Community receptive and participates in the survey Reluctance of the private sector to be sponsorship
ER 1/ Activity 3	1.3. Identification and recruitment of community volunteers.	Repeat attendance of community volunteers	Attendance sheet Photos	Local volunteers provides input for the project

ER 1/ Activity 4	1.4 Assess capacity levels and implement capacity building opportunities for community volunteers.	Repeat attendance of community volunteers	Attendance sheet Training Evaluation Reports Photos	Fluctuation in commitment & interest in the project
ER 1/ Activity 5	1.5 Monitor community activities' progress & development.	Target group leader identified take the lead in awareness program activities	Name of leaders Activity Reports	Meetings may be seen as extra responsibilities Low motivation due to lack of financial incentives Conflict among leaders
Expected Result 2	Enhanced HIV/AIDS (I/A) children's role in the community and their involvement in HIV/AIDS prevention.	At least 60% (I/A) children participate in prevention programs and community projects.	Activity/Event reports	Reluctance of the HIV (I/A) children Resistance from the HIV (I/A) families children
ER 2/ Activity 1	2.1. Baseline gathering (how many of 300 (I/A)	Methodology: - interviews - collecting data from testing center - mobilize medical personnel & volunteers to collect voluntary blood samples per village	List of all the children in Sen Sok, classified if I,A, or non I/A Schedule of medication personnel dispersement and results release date	Low number of children going to the center to get their results
ER 2/ Activity 2	2.2. Development and implementation of interventions by/from HIV/AIDS (I/A) children and adolescents' to lift stigma about the disease.	HIV/AIDS Youth-led activities Repeat attendance	List of HIV/AIDS (I) youth leaders - Action plan - Minutes of meeting - Photos - Attendance sheet	Health condition of HIV/AIDS children may deteriorate Lack of Communication skills Parents of affected & non (I/A) HIV/AIDS kids don't want their kids near HIV/AIDS (I) kids

ER 2/ Activity 3	2.3. Assist in the development of a Kid's Club	Elected officers (adolescence (15-18)) Team leader An annual schedule of activities Certificates & incentives	Name of leader(s) List of members Schedule of activities Meeting Minutes/photos	Parents of HIV/AIDS (I/A) to become a member or join the club's activities Kids can't keep track of schedule
ER 2/ Activity 4	2.4. Design and Implementation of Edutainment program and IEC materials	At least 80% of children in Sen Sok participated in at least 1 edutainment activity	Reports/Photos Feedback survey IEC Dissemination Monitoring sheet	High attraction of edutainment activities among children
Expected Result 3	Sustainable community involvement in developing programs & activities for the betterment of HIV/AIDS (I/A) children.	At least 3 child friendly programs in terms of education, healthcare & s-support& leisure	List of community leaders & volunteer and their activities List of HIV/AIDS (I/A) children activities & program developed	Resistance from the families of HIV (I/A) children Low volunteerism spirit
ER 3/ Activity 1	3.1. Gather description of existing programs in Sen Sok community	At least 3 institutions directly working with HIV/AIDS in the community (NGOs, NPOs, school, monks) willing to partner with the project.	List of partner institutions HIV/AIDS program related to kids Minutes Photos	Active in the community Hesitation in adjusting the program to make it more child-friendly' because it costs money
ER 3/ Activity 2	3.2. Establish new child-friendly programs through partnerships with relevant institutions and agencies, etc.	At least 5 new partners (NGOs, NPOs, academe, faith-based)	The Memorandum of Understanding (MOU)s	Programs for HIV/AIDS in Sen Sok is not child-friendly
	3.2.1 Establish partnership with schools	At least 70% of concerned staff of partner institution (ie: medical officers, students & teachers) aware of the rights of HIV/AIDS (I/A) children	Attendance sheet	The government is open to accept the adjusted program
	3.2.1 Establish partnerships with healthcare, care and support groups		Surveys	
ER 3/ Activity 3	3.3. Develop a Multi-stakeholders children advisors for the Kid's club	At least 1 member from each key sector working directly with HIV/AIDS (I/A) children	List of advisor's name Meeting minutes	

ER 3/ Activity 4	3.4. Provide venues that enhance community interaction & provides supplemental income for households and the community	Community is 100% supportive and participates in implementing activities	Attendance sheets Photos	Community assoc. leaders are receptive & supportive of the project community because they're free (OVOP training, fairs), fun (fairs, playground), can augment their food supply (food garden) and income (OVOP & garden harvest surplus)
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VII. PROJECT TIMEFRAME

Expected Results (ER) / Activities	Project Timeframe				
	Y1	Y2	Y3	Y4	Y5
ER#1. Improved awareness of target groups (families, peers, community) about the rights of HIV/AIDS (I/A) children.					
1.1. Meeting with the community decision makers and key stakeholders to get their support for the project.					
1.1.1. Conduct Project presentation to key stakeholders in the site					
1.2. Assess awareness level of and implement awareness raising programs for the target groups.					
2.1.1. Conduct of Perception Survey to assess awareness, perception, attitude towards AIDS, and behavior towards children (I/A) by HIV/AIDS.					
2.1.2. Sharing of baseline results and Awareness Raising Program with the community.					
2.1.3. Implementation of Awareness Program modified according to community inputs.					
1.3. Identification and recruitment of community volunteers.					
1.4 Assess capacity levels and implement capacity building opportunities for community volunteers.					
1.4.1. Conduct of presentation/orientation about the Rights of a Child and state/causes/effects of HIV AIDS among the children in Cambodia and Sen Sok					
1.4.2. Conduct of Gender Training					
1.4.3. Conduct of HIV/AIDS: Act Responsible, Live Safe Training					

1.4.4. Conduct of Training for Trainers					
1.4.5. Replication of Basic Gender & 'Act Responsible, Live Safe Orientation amongst other target groups					
1.5 Monitor community activities' progress & development.					
ER#2. Enhanced HIV/AIDS (I/A) children's role in the community and their involvement in HIV/AIDS prevention.					
2.1. Baseline gathering (how many of 300 (I/A)					
2.1.1. Identify and conduct profiling of families who have HIV/AIDS (I/A) kids					
2.2. Assist in the development and implementation of HIV/AIDS (I/A) children and adolescents' interventions to lift stigma about the disease					
2.2.1. Organize a Speak-Out forum for HIV/AIDS (I) children.					
2.2.2. Design and pilot child-friendly orientation about HIV/AIDS					
2.3. Assist in the development of a Kid's Club					
2.3.1. Identify potential HIV/AIDS (I/A) youth (15-18 yrs.old) leaders					
2.3.2. Conduct peer counseling and leadership training					
2.2.3. Replication and conduct of child-friendly orientation about HIV/AIDS by the Kid's Club team leader(s)					
2.4. Design and Implementation of Edutainment program and IEC materials					
2.4.1. Design and development of materials for toy library and Reproduction of Mobile Toy Library structure.					
2.4.2. Dispersion of Mobile Toy Library around the community					
ER#3. Sustainable community involvement in developing programs & activities for the betterment of HIV/AIDS (I/A) children.					
3.1. Gather description of existing programs in Sen Sok community					
3.1.1 Extract program related to HIV/AIDS (I/A) children					
3.1.2. Conduct of Feedback meeting with relevant implemented HIV/AIDS (I/A) kids & their parents					
3.2. Establish new child-friendly programs through partnerships with relevant institutions, agencies, etc.					
3.2.1 Establish partnership with schools					
3.2.1.1 Formulate grade level-appropriate module integration/augmentation to local school curriculum/classes to include knowledge about AIDS (Moral subject, Physical Education).					

3.2.1.2 Mobilize student clubs (Theater/ drama played by teachers and students).					
3.2.1.3 Launch of community painted mural program in school/community walls					
3.2.1 Establish partnerships with healthcare, care and support groups					
3.2.1.1 Develop appropriate healthcare & support program					
3.2.1.2 Training program for health care/support volunteers					
3.2.1.3. Establish day care support for AIDS/HIV (I/A) children in the community centers.					
3.2.1.4 Install toll-free hotline for HIV/AIDS prevention, counseling and support.					
3.3. Develop a multi-stakeholders children advisors for the Kid's club					
3.4. Provide venues that enhance community interaction & provides supplemental income for households and the community					
3.4.1.Capacity building for community associations ((organization, Finance, governance, admin, leadership)					
3.4.2. Revamping of old/Establishment of new community playgrounds safe for HIV/AIDS children.					
3.4.3. Pilot of model Community Garden Plot					
3.4.3.1 Replication of Community Garden Plot					
3.4.3.2 Monitoring of Community Garden Plot(s)					
3.4.4. Launch of One Village One- inspired products for Sen Sok					
3.4.4.1 Network with local and regional designers					
3.4.4.2 Conduct of OVOP training					
3.4.4.3 Conduct of Feasibility study					
3.4.4.5 Develop private sector sponsorship for marketing and promotion of OVOP product(s).					
3.4.4.5 Monitoring of OVOP product operation.					
3.4.5. Formulation/Participation in local fairs					

VIII. PROJECT BUDGET

Items	Units	5-Year Budget		
		A		
		No. of units in contract	Unit rate (USD)	Costs (USD)
1. Human Resources				
1.1 Salaries (gross amounts, local staff)				
1.1.1 Technical				
Project Managers (1)	Per month	1	800	48,000
Project Coordinator (2)	Per month	2	700	84,000
Training and Education Specialist (2)	Per month	2	500	36,000
Communications Specialist (1)	Per month	1	600	36,000
Social and Development Action Officer (2)	Per month	2	400	48,000
Occupational Therapist/Medical officers/Community Organisers (10)	Per month	3	400	72,000
1.1.2 Administrative/support staff (10)	Per month	2	300	36,000
Subtotal Human Resources				360,000
2. Travel				
2.2 Local transportation	Per flight	30	140	4,200
3. Equipment and supplies				20,000
4. Local Office/Action costs (Vehicle, Office rent/supplies, electricity)	per year			15,000
5. Other cost, services				
5.1 Toys for Children (e.g. Occupational Therapy and recreational)		1,000	10.00	10,000
5.2 Publications				
5.1.1 Monographs	Copies	1500	4.00	6,000
5.1.2 Children Illustration books/flashcards	Copies	3000	2.00	6,000
5.1.3 Comics	Copies	3000	0.50	1,500
5.1.4 Lessons learned and best practices	Copies	1	2,500.00	2,500
5.1.5 Training manuals	Copies	3	700.00	2,100
5.3 Studies, research				15,000
5.4 Local Consultants and Advisers	Per day			40,000
5.5 Auditing costs/ financial services	Per year	5	1,800	9,000
5.6 Awareness raising activities				
5.6.1 Local Events/World Children's Day	Units	5	1,000	5,000
5.6.2 National Events (e.g. World's AIDS Day/ Children's Day)	Units	5	1,500	7,500
5.6.3. Local Fairs for HIV/AIDS (I/A) children	Units	5	1,000	5,000
5.6.4 Theater/Musical	Units	3	1,000	3,000

5.6.5 Women/mother day (quarterly community discussions)	Units	20	50	1,000
5.6.6 Community Dialogue and Sharing	Units	20	200	4,000
5.6.7 Candle Light Memorial's day	Units	5	500	2,500
5.6.8 Kid's Forum	Units	5	500	2,500
5.7 Capacity building activities (Training and Education) for key and relevant stakeholders pertaining to HIV/AIDS children (I/A) health, care & support, education, family/livelihood.				50,000
5.9 Visibility actions				
5.9.1 Info kits/flyers/posters/ red ribbon origami / official pin	Copies	30000	0.30	9,000
5.9.2 Project Brochure	Copies	30000	0.23	6,900
5.9.3 Video documentary	Units	3	1,500	4,500
5.9.4 Exhibits	Units	5	1,000	5,000
5.9.5 T-shirts/Cap	Pcs	3000	1.50	4,500
5.9.6 Billboards	Units	4	3,000	12,000
5.9.7 Information campaign through radio spots	Yrs	5	3,000	15,000
5.9.8 Information campaign through TV spots	Yrs	5	5,000	25,000
Subtotal Other costs, services				293,700
6. Other				
6.1 Surveys	Units	22	1,046	23,017
6.3 Workshops	Units	10	500	5,000
6.4 Consultations & Meetings	Units	150	50	7,500
6.4.5 Project launch activity	Units	2	1,200	2,400
6.4.6 Project completion activity	Units	1	2,500	2,500
6.6 Project Management Team (PMT) Meetings/Training	Per year	10	700	7,000
6.7 Project Evaluation (mid-term and end)	Per year	2	2,500	5,000
6.8. Community Social Enterprise/Activities	Per year	3	5,000	15,000
6.8 National Conference	Forum	1	15,000	15,000
6.9 Legal fee	Units	1	1,000	1,000
Subtotal Other				83,417
7. Subtotal direct costs of the Action (2-6)				460,534
8. Administrative costs (1)				360,000
9. Total costs of the Action (7+8)				820,534

IX. MONITORING AND EVALUATION

Project activities will be monitored throughout the project life – the Project Managers will monitor progress on a monthly basis through received reports from the Site Coordinator, the Training and Education Specialist, Communication Specialist, Social and Development Action Officer and Community Organizers. The Project Managers have the overall responsibility to monitor the progress of activities in accordance with the set objectives and avoid deviations from the Logical Framework, which might interrupt the entire project, and to better address probable problems that may

arise in the course of the implementation stage. Also, mid-term evaluation of inputs shall be utilized as bases for future improvements/modifications. An end of project evaluation will be undertaken.

Monitoring & Evaluation Schedule

Activity / Year	1	2	3	4	5	Implementing Body
Monitoring						
Project Managers monitoring project progress through monthly reporting from: <ul style="list-style-type: none"> • Site Coordinator • Training and Education Specialist • Communication Specialist • Social and Development Action Officer • Community Organizers 						Project Managers
Evaluation						
<ul style="list-style-type: none"> • Mid-term evaluation • End evaluation 						External evaluation team

X. PROJECT SUSTAINABILITY

(a) Financial and economic sustainability

In this project, sustainability is understood as the capacity of the project to maintain and extend its impacts to the target groups even after the project ends. Sustainability is one of the key factors that the project team takes into consideration for both the design and implementation of this project. At first the project sustainability is ensured by seeking possible funding sources from regular funding channel of multilaterals, bilateral and international organisations and other corporate social responsibility entities who are interested in development programs pertaining to children.

As the project progresses, it will be emphasized here that efforts will be directed to empower the local community and its members so that the income generation activities through the philosophy of One Village, One product movement of handcraft-making and community garden plots become essential self-driven activities that a majority of the community can willingly and skilfully participate in. The intention is to eventually change the composition of the project management so that initial human resources and project staff facilitation and monitoring roles are transferred to local government officials, community leaders, local associations and talented local people.

(b) Institutional sustainability

The success of this project is based on the establishment of a Best Practice model. In order to achieve this end, the technical skills of project staff, who will be

responsible for managing the project's implementation will be continuously developed over the life of the intervention. Project team members will be equipped to identify, implement, manage and monitor a comprehensive HIV/AIDS intervention and these skills will exist beyond the life of this project. Effectively then, project management skills will be institutionalised at project level as a result of this project.

This project will also facilitate the training of community volunteers, community organizers and peer educators – people who are able to effectively reach the population in an informal, accessible manner. These people will become renowned for the knowledge and dissemination skills that they will have developed as participants in this project and their abilities will outlast the intervention.

(c) Behaviour changes sustainability

This is a Behaviour Change Communication (BCC) project that is managed, implemented and monitored by country nationals. The activities will be developed as a result of outcomes from focus group discussions and training amongst members of the target groups. The project aims to change the behaviours of target group members – making them more aware of HIV/AIDS needs, access to services and methods to prevent the transmission of HIV/AIDS. The results of the project will be maximised and sustained through the active participation of target groups in all stages of development and implementation.

Furthermore, this project aims to create an enabling environment for sustained change by operating within local systems and structures, whilst also targeting a broader audience through mass media communication. The approaches of child-friendly program, by strengthening local capacity, will contribute to an improved system of care and support provision for HIV/AIDS I/A in Cambodia. This initiative, coupled with participatory BCC will gain local acceptance by utilising social linkages and local networks to disseminate information and increase awareness. In effecting sustained behaviour change to empower target groups and improve their quality of life, this project will strengthen both human capital and local social structures.

XI. CONCLUSION

This project has been designed around the framework of many existing successful project implementation by various NGOs looking into the well-being of HIV/AIDS (I/A) children in Cambodia. The project objective is to improve the quality of life of HIV/AIDS (I/A) children to live a normal life childhood by lifting the stigma of the disease amongst their family, friends and the community. The project aims to achieve the following expected results: (i) **Improve Awareness of the Target Groups** (Family, Peers, and Community) about the right of HIV/AIDS (I/A) children, (ii) **Enhance HIV/AIDS (I/A) children's role in the community** and their involvement in HIV/AIDS prevention and (iii) **Sustainable community involvement in developing programs and activities** for the betterment of HIV/AIDS (I/A) children.

The project design is simple with measurable benefits. It emphasized hugely on capacity building and sustainability of the project. The project components are strategic thrusts which if successfully implemented will greatly improve the quality of life of HIV/AIDS (I/A) children in Sen Sok, Phnom Penh, Cambodia where they will no longer encounter hostility from their extended families and Community, or be rejected, denied access to schooling and health care, and left to fend for themselves. With greater acceptance and support from the community, these children (or their parents/guardians for child aged below 12) would be more willing to come forward to be tested, disclose their HIV status and seek treatment. All these positive changes will allow the Sen Sok Community to better manage and control the HIV/AIDS from spreading further. If this pilot project is successful, the concept can be replicated in other cities as well for the benefit of its HIV/AIDS (I/A) children.

XII. POSTSCRIPT

Origin of our group

There are a total of six members in the group. The group name is ‘B. Origami’ where ‘B.’ is a notion for ‘Group B’. The inclusion of ‘Origami’ had two significance; (1) for the group to exercise the spirit of ‘Origami’ in whatever challenges faced – patience, flexibility, creativity and process-based oriented; and (2) to mark the group’s union in Japan to work on this project proposal. The group also adopted the Red Ribbon symbol of the AIDS campaign, and renamed our group as “Red Ribbon Origami”.

Challenges faced during group study

The group faced two major challenges which are (1) ‘Race Against Time and (2) ‘Members having different perspectives and areas of focus’. Members constantly find themselves torn between the group study project work and the other many commitments like submitting of other reports as well as preparation for the Cultural Exchange Day. In short, there were so many things to do yet so little time. In addition, with the members coming from different countries and cultural background, there were different perspectives on issues discussed and areas of focus. As such, the group find themselves having to spend more time to debate, clarify and better understand each other’s point of view before the group came to a consensus.

Overcoming the challenges

Holding steadfast to the significance of our group name ‘B. Origami’, we constantly reminded ourselves to be patient, flexible, creative and process-based oriented in our working style. To resolve the issue of ‘race against time’, the members exercised flexibility and agreed to have additional short meetings during the ‘free time’ period (i.e. short meeting of 1.5 hours after dinner) to close this gap.

With regards to the members having different perspectives on issues discussed and areas of focus, it helped that the members respected the views of one another and came to the meetings with an open-mind. The group also agreed by voting system

whereby members who had differing views or areas of focus were given the opportunity to sell 'their stuff' and convince the group to adopt his/her perspectives and areas of focus. Through this method, the team was able to cut short the discussion time spent on the 'narrowing of focus' phase and proceed to the next important segment of developing the concrete action plan to tackle the issue identified.

Lessons learnt from group study

One important lesson learnt is the concept of 'giving and taking'. The group recognized this concept as a critical attribute leading to the success of the group study. Although there were differing views and perspectives, all members' views were respected by one another and everyone was willing to compromise (on a valid basis) and converge. There were also times when some members were tired out by the various assignments allocated and it greatly helped when other members offered a helping hand to lighten their workload. This selfless act and team spirit made the group grow closer and stronger each day.

Another lesson learnt is 'humility'. Even though the group members came from different backgrounds and credentials, it helped that all members were open-minded and had the common objective to 'think and learn together'. None of the members made each other feel like they were more superior and that allowed active participation from all members of the group and many good ideas were developed.

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