Workshop Report

Scale-up of TB/HIV Collaborative Activities in Cambodia

August 2004

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Abstract

Cambodia is one of the countries most severely affected by tuberculosis (TB) and HIV. To combat TB/HIV co-morbidity, Ministry of Health agencies are working jointly to plan, implement, and monitor TB/HIV interventions, starting with pilot activities in four sites. The Ministry has requested Partners for Health Reform*plus* (PHR*plus*) to provide technical support to develop an information component to support the TB/HIV activities. PHR*plus* thus is standardizing the information being collected across all sites and facilitating its use in order to increase case detection and strengthen case management. A three-day workshop in August 2004 allowed participants from TB/HIV pilot sites to share information the successes, obstacles, and other experiences they have had thusfar, so that lessons learned could be used to improve pilot activities and guide nationwide scale-up. This report presents the workshop findings and recommendations.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CDC/GAP	Centers for Disease Control/Global Aids Program
CENAT	Centre National Anti-Tuberculose
CoC	Continuum of Care
CPT	Cotrimoxazole Preventive Therapy
DOTS	Direct Observed Therapy Short-term
FHI	Family Health International
HBC	Home-Based Care
HIS	Health Information System
HIV	Human Immuno-Deficiency Virus
IEC	Information, Education, Communication
IPT	Isoniazid Preventive Therapy
JICA	Japan International Cooperation Agency
MMM	*Mondol Mith Chuoy Mith* (Friend Helps a Friend)
NAP	National AIDS Program
NCHADS	National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases
NGO	Nongovernmental Organization
NTP	National Tuberculosis Program
OD	Operational District
OI	Opportunistic Infection
OPD	Outpatient Department
PAO	Provincial AIDS Office
PHD	Provincial Health Department
PHR*plus*	Partners for Health Reform*plus*
PLWHA	Persons Living with HIV/AIDS
RH	Referral Hospital
TB	Tuberculosis
USAID	United States Agency for International Development
VCCT	Voluntary Counseling and Confidential Testing
WHO	World Health Organization

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The authors would like to thank the many workshop participants for their time, effort, and valuable recommendations for scale-up of TB/HIV collaborative activity in Cambodia. We also wish to thank the chairpersons of the TB/HIV Technical Working Group as well as implementing agencies – World Health Organization, Japan International Cooperation Agency, Family Health International, and U.S. Centers for Disease Control – and their representatives for their participation and support. Thanks also to the facilitators: Dr Khun Kim Eam, Deputy Chief of Statistics in the Planning and IEC Unit of the National Tuberculosis Program; Dr Chay Sokun, TB/HIV Coordinator at the National Tuberculosis Program; and Dr Norng Kanara, Chief of AIDS Care Unit at the National Center for HIV/AIDS, Dermatology and STD.

1. Background

Cambodia is one of the countries most severely affected by tuberculosis (TB) and HIV. Adult HIV prevalence is 2.6 percent, 64 percent of the total population is infected by TB, and hundreds of thousands of people with HIV/AIDS are at risk to develop TB. In response, the Cambodian Ministry of Health has made addressing TB and HIV co-morbidity a priority: the National Tuberculosis Program (NTP) and the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) are working to jointly plan, implement, and monitor TB/HIV interventions, which started in 2002 with pilot activities in four sites.

At the Ministry's request, the Partners for Health Reform*plus* (PHR*plus*) is providing technical support to develop an information component to support the TB/HIV activities. PHR*plus* is standardizing the information being collected across all sites and facilitating its use by implementing partners in order to increase case detection and strengthen case management of TB/HIV co-morbidity.

This report summarizes the proceedings of a three-day workshop on "Scaling-up TB/HIV Collaborative Activities," held August 23-25, 2004, for representatives from the pilot sites. The workshop allowed representatives to share lessons learned from their experiences and to make recommendations for nationwide roll-out of the information activity.

The workshop, which took place at the National Center for Tuberculosis Control (CENAT), was organized by NCHADS and CENAT with financial support from PHR*plus*.

2. Workshop Proceedings

The workshop on collaborative activities on TB and HIV co-morbidity allowed participants from TB/HIV pilot sites the opportunity to share information about their successes and obstacles, and other lessons gleaned from their work on joint TB/HIV activities. Lessons learned from one pilot site are intended to be adapted to improve the operation of other sites and to serve as guidance for nationwide scale-up.

More specifically, **workshop objectives** were the following:

1. Review the Cambodia country framework to determine the current status of TB/HIV activity
2. Identify lessons learned and best practices in TB/HIV joint implementation

Expected results from the workshop included:

1. Lessons learned in TB/HIV activity implementation
2. Recommendations for TB/HIV co-morbidity policy making
3. Draft scale-up models for Cambodia

The participants presented and reviewed activities under all components of the TB/HIV continuum of Care (CoC) in order to come up with the lessons learned and best practices.

2.1 Workshop Participants

Staff responsible for TB/HIV and CoC implementation at the four pilot sites were invited to participate in the workshop, and 6-7 representatives from each pilot attended the workshop. Other organizations interested in supporting TB/HIV activities other operational districts in the future were invited to attend as observers. An average of 45 participants were present each day. Annex A contains participant lists.

2.2 Workshop Facilitators

The following Ministry of Health staff, assigned by their directors, assisted in organizing and conducting the workshop:

1. Dr Khun Kim Eam, Deputy Chief of Statistics, Planning and Information, Education, and Communications (IEC) Unit of the NTP
2. Dr Chay Sokun, TB/HIV Coordinator, NTP

3. Dr Norng Kanara, Chief of AIDS Care Unit of NCHADS

The following PHR*plus* staff were seconded to the above facilitators:

1. Dr So Phat, PHR*plus* Technical Manager

2. Mr Seak Kunrath, PHR*plus* Technical Manager

2.3 Workshop Agenda

The agenda of the workshop is attached as Annex B. The workshop was conducted in Khmer and supporting documents were provided in that language.

2.3.1 Day 1

Workshop Opening:

The workshop was officially opened by the Dr Seng Sut Wantha, the Deputy Director of NCHADS and Chairperson of the TB/HIV Technical Working Group; and Dr Mao Tan Eang, Director of CENAT and co-chairperson of the TB/HIV Technical Working Group.

Dr Seng Sut Wantha gave a background of TB/HIV activities in Cambodia. The prevalence of HIV among TB patients is currently around 12 percent, so there is a need to combat TB/HIV co-infection. Collaborative TB/HIV activities provide the opportunity to prevent new infection and help in reducing the burden of both diseases. Dr. Wantha commended the commitment and the work carried out by the staff at the pilot sites, which demonstrates that TB/HIV collaborative activities are feasible in Cambodia. However there is much to be done in terms of scaling up the activity. Within the CoC framework, infected people will benefit from available care and support services, such as treatment for opportunistic infections and antiretroviral therapy, which help to improve their quality of life. Currently there are about 65 voluntary counseling and comprehensive care testing (VCCT) facilities and 165 home-based care (HBC) teams. Lessons learn from this workshop will help us to improve our work and will guide us in the expansion plan as well.

Dr Mao Tan Eang complemented the timing of the workshop, after a year of piloting activities. He suggested that participants take a closer look at their activities in order to review and identify lessons learned so that these could be used not only for scaling up the activities in Cambodia but also for sharing with other countries in the region during the upcoming TB/HIV Mekong conference organized by the government of Vietnam and the World Health Organization (WHO) in October in Ho Chi Minh City, Vietnam. He pointed out that the experience of Cambodia was unique in the region and experiences should be shared with neighboring countries.

Dr. Eang also pointed out that a TB/HIV country framework to guide the activities exists. Previously, TB/HIV issues were discussed only in the African countries. Now TB/HIV co-infection is also a burden for Cambodia. Though Thailand has a lower prevalence rate it has a higher number of cases than Cambodia. Dr. Eang encouraged the participants to take the opportunity to discuss together to identify the problems, and help find solutions and to continue their discussions in the field.

Following the opening speeches, representatives from each pilot gave presentations on the current practices in implementing TB/HIV collaborative activities (Annex C). The presentations

covered the areas of collaboration, referral, human resources, IEC, case detection, and case management. The presenters explained how activities were carried out, the challenges faced in implementation and how some of the issues were resolved, and their recommendations for scale-up.

Dr Khun Kim Eam gave a presentation on the Cambodia Country Framework, and Dr Norng Kanara gave a presentation of the WHO's guidelines on implementing TB/HIV collaborative activities (Annex D).

The participants were divided into three groups (Annex E) for the afternoon sessions, during which they worked on importants component of the TB/HIV collaborative activity. Each group was provided facilitation guides (Annex F) to help them through the group discussions.

Group 1 discussed ***collaboration between TB and HIV/AIDS programs***. The objective of the group was to define the role of coordination at each level.

Main findings for collaboration were:

- Coordination exists at the operational district (OD) level (CoC, MMM [*Mondol Mith Chuoy Mith*, Friend Helps a Friend], TB/HIV network, TB/HIV technical working groups), but there is no official structure for coordination at the provincial level.
- Lack of official scope of work for TB/HIV activities or coordination as well as clear job descriptions with integrated responsibilities for its members, at both provincial health department (PHD) and OD levels.
- There is no official coordination mechanism at the PHD level.
- Each program has a work plan but they do not include plans for integration with the other programs.

Recommendations for scale-up were:

At the national level

- Clarify roles and develop job descriptions for TB/HIV coordinating group at all levels, as well as for staff participating in activities.
- Develop integrated work plans at all levels.
- Strengthen communication between the programs through development of a joint training curriculum, and participation in joint workshops, conferences and joint study tours.
- Hold integrated supervision visits, quarterly on the national level and monthly on provincial and OD levels; develop supervision checklists.
- Address the issue of staff motivation.

At the PHD level

- TB/HIV coordinating group at the provincial level should consist of provincial TB supervisor, provincial HIV/AIDS manager, and nongovernmental organizations (NGOs) that support the activities, and be headed by the technical bureau chief.

- Organize monthly TB/HIV meetings in order discuss technical issues.

At the OD level

- Members of coordinating group should include OD TB supervisor, HIV/AIDS manager, chief of OD technical bureau as well as referral hospital (RH), and NGO representatives.
- Organize monthly TB/HIV meetings at OD levels in order to discuss technical issues.
- Make TB/HIV coordinating groups at the provincial and OD levels responsible for developing integrated work plans for the OD.
- Make TB/HIV coordination at the OD level the responsibility of the CoC committee.

Group 2 discussed the ***TB/HIV referral system***. The discussion was about referral of clients to and from both programs and HBC including policy on referrals and follow-up, especially during care and treatment. The group also reviewed issues such as referral slips, transportation costs, client follow-up, and information-sharing and feedback between services.

Main findings for referral system were:

VCCT/HBC to TB service

- Quality of counseling skills is limited, and there is a lack of understanding on the impact of dual epidemics (TB/HIV co-morbidity).
- Some clients with severe health problems are unable to go to services.
- There are no staff or persons available to accompany HIV+ individuals for screening.
- Budget is insufficient for transportation support.
- Patients feel ashamed to go to RH or HC for screening.
- The waiting time for TB screening is long due to many clients and overburdened staff.
- The division of labor among TB staff is not clear.

TB to VCCT

- Lack of transportation support
- VCCT far from TB ward
- Information about VCCT is limited
- TB patients don't believe that they are at risk for HIV infection.
- There had been instances when health staff discriminated against people living with HIV/AIDS.

Recommendations for scale-up were:

VCCT/HBC to TB service

- All HIV+ clients should be referred for TB screening.
- There should be transportation support.
- Clients should be accompanied.
- Clear information on the location of TB screening should be provided to clients (directions, address, and telephone number).
- Poor patients should utilize Equity Fund services (esp. transportation support).
- Logs should be kept of persons being referred and those who follow through with referral.
- Counseling to clients on the importance of TB screening and treatment is essential.
- Inform the community about TB screening for PLWHA to promote referrals.
- If transportation support is not available VCCT staff should:
  - provide counseling that focuses on the importance of TB screening and treatment.
  - use referral slips that have clear addresses and information about TB screening facilities.
  - inform NGO, health center (HC) and the VSHG of TB screening and treatment.
  - bring the client to TB screening.
- Best referral mechanisms: referral slip, transportation support, peers or volunteers accompany clients to services, clear information on TB screening side.
- Mechanisms to track referrals: staff from VCCT should phone TB staff every Friday to see how many clients were received (those referred) or monthly meetings should be held so that information on referrals can be shared.
- Monthly reports should be shared with relevant people and organizations.

TB to VCCT

- TB suspects should be referred for HIV+ screening.
- All TB patients should be referred for HIV testing after registering or during TB treatment.
- Best practices for referral: use referral slip and support transportation for the poor.
- Poor patients should utilize Equity Fund services.
- Transportation support should be given at the VCCT.
- If transportation support is not available, provide additional counseling by focusing on the

importance of HIV testing and HIV/AIDS services availability. A referral slip and clear directions and address to VCCT should be provided. Inform HCs, NGOs, or community members about importance of HIV screening so that they can assist or ask TB staff to accompany client.

- Mechanisms to track referrals: TB staff should phone VCCT staff every Friday to see how many clients were received (of those referred) or monthly meetings should be held so that information on referrals can be shared.

Group 3 discussed ***information-sharing and human resources development.*** This component includes: TB/HIV IEC strategies; information-sharing between services and beyond; staff knowledge and training needs; supervision; monitoring and evaluation; and data collection, analysis, and use.

Main findings for information-sharing were:

- Best mechanisms for transmitting information: radio, television, and community networks (VHSG, PLWHA network, support groups, HBC team) and World TB or HIV Days
- TB/HIV issues can be solved in technical meetings
- Some sites share information through monthly reports
- Lack of staff to carry out TB/HIV activities
- Insufficient knowledge of existing staff
- Problems with the transfer of knowledgeable staff to other services, organizations, etc.
- Lack of training
- Lack of commitment
- Lack of clear division of labor

Recommendations for scale-up were:

- IEC materials for TB/HIV need to be developed: poster, flip chart, leaflet, billboard, t-shirts, hats, stickers, pamphlets
- IEC messages and materials should be standard (developed by the national level)
- Messages should include: HIV+ clients are at risk for TB development, timely HIV screening can prevent TB development,

Messages to be developed for the community:

- TB prevention messages among PLWHA
- Clear information on TB and HIV services available

Messages to be developed for providers

- Improve TB treatment
- Intensify TB screening among PLWHA
- Intensify HIV screening among TB patients

Main findings for human resource development were:

Some training has been provided: sensitization on TB/HIV, basic training on TB/HIV, counseling training for referrals, CoC training for children, adults, and for HBC, isoniazid preventive therapy (IPT)/cotrimoxazole preventive therapy (CPT) (before guidelines were developed) training, X-ray training

Recommendations for scale-up were:

- The following training should be provided to those involved with TB/HIV activities:
  - Basic TB/HIV knowledge to all staff involved in TB/HIV activities
  - TB/HIV counseling to all staff involved in TB/HIV activities
  - TB/HIV clinical management to all clinicians involved in providing TB and HIV/AIDS clinical care
  - X-ray reading skills to TB clinicians
  - TB/HIV Information Management
  - Additional advanced knowledge in CD4 count, biopsies, cultures, etc. to lab technicians
  - In-country and international study tours
  - General refresher training should be provided every six months
  - On-the-job training should be provided during supervision
- Staff motivation could be improved by training appropriate staff
- Recruit sufficient staff
- Provide financial support
- Develop and provide clear Scope of Work or job descriptions

2.3.2 Day 2:

During the morning session each group presented the findings and recommendations from their group work.

Following discussions about the presentations, the four pilots were invited to present their practices in TB/HIV case detection and case management. In their presentations, they reviewed

current practices for detection, diagnosis, treatment and follow-up as well as the availability of patient files that monitor patient, treatment, follow-up, etc.

All the three groups worked separately but on the same topic. Most of the points that the three groups discussed were similar in nature. Common findings and recommendations from the three groups have been grouped together. Additional points have been listed separately.

Common findings on case detection and case management from the three groups were:

Case detection

- Case detection for TB/HIV co-morbidity is carried out at the referral hospital level.
- In general case detection is delayed and this causes dropouts.

TB screening among people living with HIV/AIDS

- Record history of treatment
- Physical examination
- X-ray (facilitates quick diagnosis, provision of IPT on time, diagnosis of other opportunistic infections, etc.),
- Sputum smear examination
- Culture, ultrasound (if available), etc.

HIV testing among TB patients

- Counseling to take HIV testing
- HIV testing (per NCHADS guidelines)
- HIV status results

Case management

- TB/HIV patients must be admitted at the TB ward and separated according to diagnosis (smear positive, smear negative and extra pulmonary)
- If TB/HIV patients are admitted to the TB ward, they should receive care for both opportunistic infections and TB.
- Staff should be trained not to discriminate based on the patients' status.
- Preventive therapy protocols are available, but their dissemination is inadequate.

Cotrimoxazole Preventive Therapy (CPT)

- CPT protocols are available.

- CPT eligibility criteria are not complied with (implementation is based on symptoms only).
- CPT eligibility criteria are good liver function and a clear address of the patient
- Protocols and standards are available for laboratories.
- Patients changing HBC teams are registered in two different groups and receive CPT twice.

Ioniazid Preventive Therapy (IPT)

- IPT eligibility criteria are: absence of active TB, good liver function, agreement for treatment adherence, absence of nervous disorders, clear address, absence of TB treatment history, etc.
- IPT eligibility criteria is too strict, it is difficult to follow up clients during treatment (clients keep changing their addresses).
- IPT is provided based on either Japanese International Cooperation Agency (JICA) or Family Health International (FHI) draft guidelines.

Recommendations for scale-up were:

Management

- TB/HIV patients should be admitted to the TB ward. TB/HIV patients should not be admitted in the general ward or HIV/AIDS ward; if this happens, comply with universal precautions.
- Drug delivery could be carried out by HC or HBC.
- HBC staff could assist HC staff to implement DOTS (direct observed therapy short-term).
- If TB/HIV patients have other opportunistic infections, they should be sent to general ward or related units for treatment.
- TB staff should be given financial incentives.
- For clients who screen negative, monthly follow-up screenings should be held.
- If clients manifest symptoms, those clients can go before appointment date.
- Promote TB screening for HIV+ clients through MMM meeting, radio, and TV.

CPT

- Provide counseling on drug use, importance of treatment, and its compliance.
- Referral hospitals (opportunistic infection unit or outpatient deparment) should decide on the eligibility of receiving CPT and HCs should provide the treatment.
- Opportunistic infection unit at RH should provide CPT to TB/HIV patients after TB treatment

- HIV+ clients should access CPT at the HC located in their area.
- Clinical checklist should contain dose of drug, period of provision, and side effects.
- There should be clinical checklist for CPT.
- CPT could be provided by either RH or HC staf.

IPT

- Screening for IPT should take place at RH.
- TB staff should be responsible for IPT follow-up.
- The best method to screen for IPT is using an inclusion/exclusion criteria.
- IPT follow-up checklist should be standardized
- If client develops TB while taking IPT, IPT should be stopped and client treated according to TB treatment guidelines.
- A checklist for regular monitoring and supervision should be developed.
- Monthly IPT follow-up should be provided (weight of patients, side effects, general health check up, etc.).
- IPT should also be discussed during CoC meetings.

2.3.3 Day 3

The third day started with the presentations of the group work on case detection and case management. All three groups discussed on the same component guided by similar kinds of questions.

Following the plenary discussions on case detection and management, Dr So Phat, PHR*plus* Technical Manager, reported on the *Information Subgroup Activities* and its progress (see Annex G). The information subgroup consists of national health staff from both the TB and HIV/AIDS programs. Dr Phat spoke about how the group worked towards drafting a standard set of indicators for TB/HIV activities, information collection tools, recording and reporting systems, etc.

TB/HIV Scale-up model(s)

The afternoon session focused on:

- reviewing recommendations made by the three groups
- minimum requirements to set up TB/HIV activity
- guidelines and implementation and next steps for developing country specific TB/HIV collaborative operational guidelines

The following recommendations were made for each component:

Collaboration

- Clear scope of work for collaborative activity should be designed for each level.
- National operation guidelines should be developed for TB/HIV collaborative activity.
- Joint supervision, monitoring, and evaluation should be carried out.
- TB/HIV activity should be integrated into the vertical program plans.

Referral

- Transportation support for referral would facilitate and improve compliance.
- Counseling to clients about the importance of TB screening and treatment and HIV testing is essential. This would improve referral compliance.
- Best referral mechanism: referral slip, transportation support, peers or volunteers accompany clients to services, clear information on TB screening and HIV.
- There should be close communication between VCCT and TB staff in tracking referral compliance. Mechanisms proposed could be through telephone, regular face-to-face meetings, cross checking registers, etc.
- All HIV+ from HBC and VCCT should be referred for TB screening (not only suspects).
- All TB patients should be referred for HIV screening, except old age or severe cases. Risk assessment for TB patients?

Information Sharing

- TB/HIV IEC should be part of outreach activities
- IEC messages and materials should be standard (developed by the national level)
- Messages should include: “HIV+ clients are at risk for TB development,” “Timely HIV testing can prevent TB development.”

Messages to be developed for the community:

- TB prevention messages among PLWHA
- Clear information on TB and HIV services available

Messages to be developed for providers

- Improve TB treatment
- Intensify TB screening among PLWHA
- Intensify HIV screening among TB patients

Information systems

- Information systems should be standardized and integrated into the national health information system (HIS)
- Indicators for TB/HIV surveillance, and monitoring and evaluation should be standardized.
- Data collection tools such as forms, registers, and report formats should be standardized.

Human Resources Development

- National TB/HIV training package including training-of-trainers, etc.
- Scope of work for care providers
- Training material for treatment guidelines
- Resources for staff development
- Provider training in TB/HIV co-morbidity
- Training in data collection, analysis, and use
- Training for counselors should include specific portions on TB
- Counseling skills of counselors and other care providers should be improved.

Case Detection and Case Management

Detection

- All HIV+ clients should be screened for TB
- All TB patients should be tested for HIV (this is what the national framework states; however, there was discussion whether in terms of efficient use of resources, TB patients should be tested based on a risk assessment).
- TB/HIV clinical manual should be developed
- Should we include the model of TB screening in this section like X-ray or sputum first?

Management

- Schedule TB screening for PLWHA be fixed separately for sake of infection prevention?
- TB/HIV patients should be admitted in the TB ward. TB/HIV patients should not be admitted in the general ward or HIV/AIDS ward; if this happens, comply with universal precautions.
- Drug delivery could be carried out by HC or HBC
- HBC staff could assist HC staff to implement DOTS

- If TB/HIV patients have other opportunistic infections, they should be sent to general ward or concerned units for treatment.

2.4 Closing Ceremony

Mr Seak Kunrath, PHR*plus* Technical Manager, thanked His Excellency the Secretary of State for his presence during the closing ceremony. He also thanked the chief guests and the participants for their input in the workshop. He debriefed attendees on the activities and achievements of the workshop. The following sections contain summaries the remarks made by the chief guests.

H.E. Dr Mam Bun Heng, Secretary of State, Ministry of Health

TB and HIV diseases are partners, so we should also form partnership to fight TB/HIV co-morbidity.

From this workshop we can share experiences and formulate a joint strategy to prevent the infection of the two diseases and provide TB/HIV service to our patients. We should mobilize all resources – existing in-country and from donors – in order to cope with the diseases.

There is political support from the Ministry of Health, and there is involvement of NGOs and donors. Please collaborate with each other to provide benefits for the patients.

Dr Chak Chantha, USAID

Dr Chak Chantha described current USAID support for TB and TB/HIV activities in Cambodia. These include community DOTS; DOTS strengthening at HCs, the FHI-managed TB/HIV pilot in Battambang, the PHR*plus*-managed monitoring and evaluation activities, and a new TB Private-Public Mix program, which is at the discussion and design stage.

The future challenges are to improve accessibility to services and quality of services, expand coordination, strengthen monitoring and evaluation of the HIS system related to TB/HIV, and strengthen managerial capacity. He noted that USAID will continue the collaboration with partners and stakeholders to explore approaches for expansion of this program.

Dr Kosuke Okada, JICA

Dr Okada expressed the need for minimum requirements to be able to introduce TB/HIV collaborative work in other provinces.

- Quality VCCT center with good counselor and reliable laboratory.
- X-ray facility and capable staff for both taking and reading films. Both services should be provided in the same compound (referral hospital).
- Need for support organization like HBC teams so that people with HIV should be encouraged to visit medical facility regularly for TB screening or to continue their regular drug intake.

- Need for standardized recording and reporting system for monitoring and evaluation, which are currently being supported by URC
- Need for good DOTS practices which can lead overall public health activities in the area
- Need for TB/HIV collaborative activity operating guidelines, where the above minimum requirements are described clearly.

Dr Okada also proposed to set up a sub-working group under the auspices of CENAT and NCHADS. This group would draft guidelines for scaling up TB/HIV care in Cambodia. It would be small – not more than 10 persons – with members nominated from each pilot area and from PHR*plus*. Draft guidelines would be discussed and approved in the TB/HIV working. This subgroup, he believes, can contribute not only to developing guidelines but also to sharing financial burden of TB/HIV activities.

Dr Pratap Jayavanth, WHO

His Excellency, Dr Mam Bun Heng, Distinguished Colleagues, Honoured Guests, Facilitators, Participants, Representatives from international and national NGOs, Ladies and Gentleman.

On behalf of WHO, let me express my pleasure in having participated in this workshop which has been a very comprehensive one covering practically all the aspects of TB/HIV pilot projects and an assessment of the wide range of collaborative activities carried out.

In the Western Pacific Region, Cambodia is one of the countries where TB/HIV activities have been initiated and where lessons learnt have been documented. In this regard, Cambodia, where both prevalence of TB and HIV is high, is in a unique position to show other countries what can be done to address this dual epidemic. Two major international meetings are scheduled during September and October – the Global TB/HIV Working Group Meeting in Addis Ababa, Ethiopia, and the Conference on TB/HIV for the Mekong Countries in Ho Chi Minh City. Cambodia's presentation and participation in these meetings will be watched with interest.

With so much of information that has been systematically collected from all the pilot sites, I believe the time has now come for both the programs (TB/AIDS), to strengthen their collaboration from all levels to develop a master plan for scaling up the TB/HIV activities nationwide. It is also important that a costing exercise of the pilot projects be carried out in order to estimate the budget spent so far for TB/HIV collaborative activities. This is very much required if resources have to be mobilized for scaling up the activities to all the operational districts where Continuum of Care is fully functioning. I am glad that the TB/HIV Working Group with the assistance of major partners would be able to embark on this task without much delay.

WHO has been in the forefront to address this dual epidemic and has developed the regional framework for TB/HIV, guidelines on TB/HIV clinical care, field version of a guide for monitoring and evaluation of TB/HIV collaborative activities, while the Global TB/HIV Working Group is actively involved in providing policy, developing strategies and mobilizing resources.

I wish the organizers and participants all success in their activities.

Thank you.

Mr. Jack Spencer, Chief of Party, U.S. Centers for Disease Control (USCDC)

H.E. Dr. Mam Bun Heng, Secretary of State for Health, Dr. Chawalit Natpratan, Country Director FHI, Dr. Mao Tan Eang, Director, National TB Program, Dr. Chak Chantha, USAID, workshop participants.

I am pleased to be here this afternoon to assist in the closing of this important workshop on scaling up TB/HIV Collaboration Activities. Although I have been out of the country for several weeks and my schedule did not permit me to attend the workshop until this afternoon, it is important for you to know that the USCDC remains committed to the continuation and expansion of TB-HIV activities in Cambodia for the near and medium term.

I have said many times to many of you that the combination of TB and HIV activities can and should be one of the most cost beneficial activities for the Ministry of Health to engage in. The costs are minimal in terms of supplies and medication, the programs are already both adequately funded, at least in the pilot demonstration sites, to support the activity and the long term benefit in terms of lives saved is potentially enormous. In other words, with relatively little additional investment in terms of time or money, we can save many lives.

Over the life of the demonstration projects, you have made substantial improvements in the ability to have patients from the two disease clinics (VCT and TB) referred for testing and necessary treatment, and although we are not where we would like to be, the referral rates and the response of patients has been increasing over time. It is therefore of substantial concern to me that we are not doing better in terms of getting the essential TB therapy for prevention of active TB infection in HIV positive patients. I know that you have discussed this issue at length in this workshop and hopefully you have developed a better understanding to the need for urgency in expanding this portion of the program.

Urgency is also required for expansion and scaling up of this program to other high prevalence areas in the country. Eight months into the program, we have gathered enough data to determine what the key issues are, and as you successfully expanded and continue to scale up DOTS activities, I think it is now time to attempt to replicate the best of what has been learned from the demonstration sites to other high prevalence areas with as much haste as is possible. Many of you attended the HIV Conference in Bangkok, and heard the impassioned please of individuals such as Nelson Mandela for immediate and high priority attention to interaction of Tb and HIV. We have the data; now is the time for us to act.

From the standpoint of the USCDC, we are ready to support some of this expansion using our own funds and also using funds from our US Government partner, USAID. We would encourage other donors to take a hard look at the benefits of this program and support it as well.

Annex A: Agenda

Workshop on scaling-up TB/HIV collaborative activities

23-25, August 2004

Venue: CENAT Conference Room

Facilitators:

- Dr Khun Kim Eam, Deputy Chief of Statistics, Planning and IEC Unit
- Dr Chay Sokun, TB/HIV Coordinator, National Tuberculosis Program
- Dr Norng Kanara, Chief of AIDS care unit, National Center for HIV/AIDS, Dermatology and STD.

Co Facilitators:

- Dr So Phat, PHRplus Technical Manager
- Mr. Seak Kunrath, PHRplus Technical Manager

Objectives of the workshop:

1. Review Cambodia country framework to determine the current status
2. Identify lessons learned and best practices in TB/HIV joint implementation

This workshop will provide the participating TB/HIV pilot sites the opportunity to share successes, barriers, and learn from experiences in piloting TB/HIV joint activities. These experiences can be adapted and used to improve current pilot activities and serve as guidance for scaling-up nationwide. The participants will be presenting and reviewing activities under all components of the TB/HIV CoC in order to come up with lessons learned and best practices.

Expected results:

1. Lessons learned in TB/HIV activity implementation
2. Recommendations for TB/HIV co-morbidity policy making
3. Draft scale-up models for Cambodia

Participants: Staff who are responsible for TB/HIV and CoC implementation will be invited. There will be equitable representation from the four pilots. 6-7 participants from each of the sites will be invited to join the workshop. Organizations that have plans to start TB/HIV activities in the future are welcome to join as observers.

DAY 1: 23rd August 2004

8:00 AM Registration

8:30 AM Opening remarks

9:00 AM Break

9:15 AM Pilot presentations on the actual implementation and challenges faced

- △ Collaboration
- △ Referrals
- △ Information Sharing
- △ Human Resource Development

10:30 AM Presentation on WHO Guidelines and Cambodia Country framework

11:00 AM Discussion

12 noon Lunch Break

2:00 PM Group work

* The groups will be provided with facilitation guides to help them with group work

Group 1: Collaboration between TB and HIV/AIDS programs

(Facilitators: Dr Eam and Mr Kunrath)

- Coordination committee
- Technical Working Group (smaller group which meets to discuss technical issues

Group 2: Referral system Management

(Facilitator: Dr Kanara)

- Referral of clients to and from both programs TB patients to VCCT (policy on referrals and follow-up especially during care and treatment), review issues such as referral slip, transportation costs, etc.)
- Client follow-up
- Information sharing and feedback between services

Group 3: Information Sharing and Human Resource Development

(Facilitators: Drs So Phat and Sokhun)

- TB/HIV IEC strategies
- Information sharing between services and beyond
- Knowledge of TB/HIV co-morbidity
- Training needs
- Supervision, monitoring and evaluation
- Data collection, analysis and use
- Management skills

3:30 PM Tea Break

4:15 PM Continue Group Work

DAY 2: August 24th 2004

8:00 AM Working group presentations

- Collaboration
- Referrals
- Information sharing/Human Resource Development

9:45 AM Break

10:00 AM Pilot presentations on the actual implementation and challenges faced

- Case Detection and Management

11:00 AM Discussion

12 noon Lunch Break

2:00 PM Group Work

Group 1: Case Detection and Management

(Facilitator: Drs So Phat and Sohkun)

- Review current practices for detection, diagnosis, treatment and follow-up
- Availability of patient files that monitor patient, treatment, follow-up, etc.

Group 2: Case Detection and Management

(Facilitator: Dr. Kanara)

- Review current practices for detection, diagnosis, treatment and follow-up
- Availability of patient files that monitor patient, treatment, follow-up, etc.

Group 3: Case Detection and Management

(Facilitator: Dr. Eam and Mr Kunrath)

- Review current practices for detection, diagnosis, treatment and follow-up
- Availability of patient files that monitor patient, treatment, follow-up, etc.

3: 30 PM Tea Break

4:00 PM Continue Group Work

DAY 3: 25th August 2004

8:00 AM Working group presentations

10:00 AM Tea Break

10:30 AM Report on Information Sub group Methodology and Progress (Dr So Phat)

- Indicators
- Data collection forms
- Recording and Reporting systems

10:45 Discussion

12 noon Lunch Break

2:00 PM **TB/HIV Scale-up model(s)** (Chief Facilitator: Dr Kanara)

- Review of recommendations made
- Discussion on minimum requirements to set-up TB/HIV activity
- Discussion of guidelines and implementation and next step for developing country specific TB/HIV collaborative operational guidelines

4:30 PM Closing Ceremony

- H.E. Dr Mam Bun Heng, Secretary of State, Ministry of Health.
- Dr Chak Chantha, USAID
- Dr Kosuke Okada, JICA
- Dr Pratap Jayavanth, WHO
- Mr Jack Spencer, CDC

Annex B: Participant List

Workshop on Scaling-up TB/HIV

Collaborative Activities

August 23-25, 2004

Venue: CENAT Conference Room

Participant List

N	Workplace	Name	Title	Telephone N
National staff				
1	NCHADS	Seng Sut Wantha	Deputy Director	012 819 055
2	NCHADS	Norng Kanara	Chief Of Aids Care	016 711 907
3	BTB (MR)	Ieng Kakvey		012 996 540
4	BTB (BTB RH)	Mak Sutthep	Chief Of TB Ward	012 827 269
5	BTB (PHD)	Tan Vutha	TB Manager	012 530 125
6	BTB (BTB RH)	Pec Vanna	OI Staff	012 928 525
7	BTB (MR)	Kem Arunrith	OD TB Supervisor	012 978 700
8	BTB (PHD)	Chou Seuth	Deputy Of Technical Bureau	012 947 440
9	BTB (PHD)	Lay Vithiea	PAO	012 823 067
10	BMC (SEREI SOPHON)	Pen Bunthorn	TB Staff	012 894 094
11	BMC	Theth Kantol	OD TB Supervisor (MBR)	012 620 166
12	BMC (MBR RH)	Heng Leang	TB Staff	012 636 254
13	BMC (POI PET)	Lim Ly	TB Staff	012 737 501
14	BMC (PHD)	Keo Samnang	TB Staff	012 939 635
15	BMC (PHD)	Kim Samoeurn	TB Supervisor	012 953 246
16	BMC (PHD)	Sin Eap	HIV/AIDS Coordinator	012 953 244
17	SHV (RH)	Chhay Narin	TB Staff	016 945 982
18	SHV (PHD)	Khem Saron	Deputy Director	012 870 084
19	SHV (HC)	Koek Sovann	HC Chief	012 681 988
20	SHV (HC)	Chiv Kunthea	TB Staff	016 890 197
21	SHV (PHD)	Koet Phannarith	Deputy Of PAO	012 870 355
22	SHV (PHD)	Long Ngeth	TB Supervisor	012 833 629
23	CENAT	Mao Tan Enag	Director Of CENAT	012 916 503
24	CENAT	Team Bak Khim	Deputy Director Of CENAT	012 981 808
25	CENAT	Chay Sokun	TB Officer	011 925 571
26	CENAT	Khun Kim Eam	Technical Bureau Staff	012 856 146
27	CENAT	Tieng Sivanna	Deputy Chief Of Technical Bureau	012 863 811
28	CENAT	In Sokhanya	Vice Chief Of TSR	012 454 521
29	CENAT	Keo Lay Heang	CENAT Staff	012 516 886
30	CENAT	Nuon Nory	CENAT Staff	011 722 968
31	CENAT	Long Pheavy	CENAT Staff	012 859 997

32	CENAT	Yuos Bun Heng	CENAT Staff	012 849 270
33	CENAT	Khloeung Phally	CENAT Staff	012 922 992
34	Municipal health department	Chhun Song	Assistant Coordinator	016 606 066
NGOs/IOs/Partners				
35	PHR*plus*	So Phat	TB/HIV Technical Manager	012 615 163
36	PHR*plus*	Seak Kunrath	TB/HIVTechnical Manager	012 958 347
37	PHR*plus*	Jayaseeli Bonnet	TB/HIV Program Coordinator	012 315 152
38	PHR*plus*	Caroline Quijada	Associate Technical Officer	
39	PHR*plus*	Vichet Than Kun	Admin Manager	012 805 012
40	URC	Kong Bun Navy	TB Manager	012 497 228
41	FHI	Chawalit N	Country Director	012 808 980
42	FHI	Eang Chanthol	FHI TB/HIV Coordinator	012 904 292
43	GORGAS	Phalkun Chheng	Program Administrator	012 418 835
44	JICA	Kosuke Okada	JICA Chief Advisor	016 880 361
45	JICA	Sim Ngim	Medical Project Assistant	012 969 426
46	WHO	Pratap Jayavanth	Medical Officer	012 443 993
47	CDC	Jack N. Spencer	Chief of US CDC Cambodia	012 902 644
48	CARE	Siang Chhorm Serey Rith	Care Staff	012 776 608
49	CARE	Kong Narom	Program Officer	016 899 337
50	Red Cross HC	Min Puthchethavann	Counselor	012 968 931
51	RHAC	Chou Dara	Counselor	012 756 877
52	STD clinic	Om Phanna	Counselor	016 900 020
53	USAID	Chak Chantha	Family Health Team Leader	012 810 213
54	French Red Cross	Som Dara	Coordinator Of Aids Care	012 845 223
55	USAID	David S. Hausner	Aids Team Leader	012 905 351

Annex C. Presentations on Current Practices in Implementing TB/HIV Collaborative Activities

Workshop on Scale Up TB/HIV Collaborative Activities

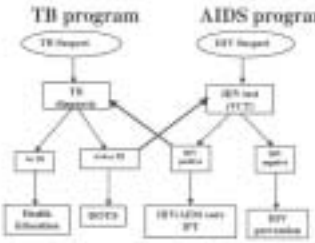
Phnom Penh Activities

JICA-CENAT

Lesson learnt and recommendation

23-24-25 August 2004

Concept of TB/HIV Country Framework, Cambodia, 2002



Collaboration between TB and HIV/AIDS program activities

-Partners: TB, HCNG, HBC, VCT (NGOs)

-Meeting: Monthly, Bimonthly and Quarterly meeting

-Role of partners

*TB side: detection and treatment, Refer TB to VCT

*AIDS side: Refer PLWHA to TB screening, DOT watcher, Defaulter tracing ……

-Technical working group: provide technical support for TB diagnosis and management as national level.

Constraints

- The partners are not actively collaborated: no clear job description and lack of responsibility.
- Bimonthly meeting is not regular: over workload
- There is no good collaboration from some of HBC teams.

Recommendations

- Should have clear job description and responsibility in work plan.
- Should follow the instruction
- Meeting should be regular
- Should form Technical Working Group in order to support clinical and management issues

Referral mechanism

- TB to VCT:
  - Counsel TB patient about HIV
  - Referral slip
  - Self referred patients (no transportation fee support, no accompany)
- HBC to TB:
  - Counsel PLWHA about TB
  - Referral slip
  - Referred patients with transportation fee support and accompany
- VCT to TB:
  - Counsel PLWHA about TB
  - Referral slip
  - Self referred patients (no transportation fee support, no accompany)

Constraints

- TB to VCT:
  - quality of counseling skill?
  - awareness of HIV testing importance
  - lack of IEC materials
  - Lack of transportation fee and accompany
- HBC to TB:
  - if the transportation fee is not provided, PLWHA cannot reach TB screening. Due to poverty, low awareness about Health Care
- VCT to TB:
  - quality of counseling skill?
  - awareness of TB
  - lack of IEC materials
  - Lack of transportation fee and accompany

Recommendations

- TB to VCT:
  - Strengthen quality of counseling
  - Provide transportation fee with good management of spending
  - Is Mobile VCT an alternative solution?
  - Can VCT be created attached to TB ward?
- HBC to TB:
  - Transportation fee support should be continued
- VCT to TB:
  - Strengthen quality of counseling
  - IEC material should be available
  - Provide transportation fee with good management of spending

Case detection and management

- TB side:
  - TB diagnosis for PLWHA: Physical examination, Chest X-ray, Sputum microscopy, Culture, Ultra sound, etc…
  - Treatment: hospitalized, ambulatory and home delivery DOT.
  - Diagnosed TB patient referred to HC for treatment
  - Follow-up of PLWHA: 6 month interval, and follow up before appointment date.
  - Follow-up of TB/HIV patients: sputum/chest X-ray follow up, physical examination.
  - TB/HIV patient file for follow up.

- AIDS side:
  - HIV counseling for TB patients
  - DOT watcher under supervision of HC staff.
  - Feed back support of TB/HIV patients
- IPT

*TB side:
- Exclusion and inclusion criteria for IPT
- INH: 9 month treatment regimen
- Monthly follow up at CENAT
- 9 month INH supply to HBC

*AIDS side:
- Weekly supply INH, weekly supervision of drug adherence, side effect and possibility of TB development.
- Accompany IPT clients to CENAT for monthly follow up.
- Feed back of client defaulter

- CPT and ART: under discussion

Constraints

- Primary defaulter:
  - Diagnosed TB patients from VCT
  - TB patients from VCT referred to HC.
- Over workload of CENAT staff for regular follow up of PLWHA.

Recommendations

- CENAT staff should convince VCT clients to joint HBC team.
- Financial support for communication
- Strengthening TB diagnostic capacity for HIV positive clients
- Financial support for defaulter tracing

Human resource development

- TB side
  - Training on TB/HIV
  - HIV Counseling training (CENAT)
  - Clinical management in Thailand
  - Diagnosis training on TB/HIV
  - Symposium on TB/HIV]
  - AIDS International Conference (TB/HIV)
- AIDS side
  - TB training for HBC team

Constraints

- HBC staff are mostly not medical background so it is difficult to train them.

Recommendations

- Refresher training
- Study visit to other pilot sides in order to improve knowledge, know-how and sharing information
- Financial support for international TB/HIV conference

Information Sharing

- Regularity of monthly report
- Sharing information and report based on request.
- Quarterly meeting

Constraints

- Inaccurate feed back information (HBC team)
- No join educational message on TB/HIV
- Feed back result of referred TB/HIV clients to HC/RH is not obtaining timely

Recommendations

- Ensure formal information sharing system
- VCT and TB side need to share monthly report/information of referred clients so as to know how many clients are missing

Workshop on Scale up TB/HIV Collaborative Activities

23-24-25 August 2004

TB/HIV Activities in Banteay Meanchey

Started: October 2003

Purposes

- Collaborative Activities
- Referral Mechanism
- Information Sharing
- Human Resource Development
- Case Detection and Management

1. Collaboration

TB/HIV Working Group

- Included in CoC committee (in Sereisophon HC) CoC activities in Mongkul Borey have not started yet
- MMM Groups (Mondul Mith Chuoy Mith: Friends help friend Group) have been formed at Sereisophon and Poi Pet
- Activities carried out in collaboration with US-CDC, CARE and Dhammayietra

1. Collaboration (Cont.)

Meeting of TB/HIV Working Group

- Quarterly meeting at PHD office

. Review on TB/HIV activities
. Collect information on TB/HIV
. Analyze information collected
. Provide feedback
. Solve problems/find solutions

Constraints

- Members of TB/HIV Working Group are very busy
- Members of TB/HIV Working Group do not understand TB/HIV activities very well
- Collaboration between TB and HIV/AIDS programs are limited
- Difference in incentive support for TB and HIV/AIDS staff
- Relation with NGO partners is limited

Recommendations

- Improve the collaboration between TB and HIV/AIDS staff and among partners at all levels
- Meeting between the two programs and partners should be conducted regularly
- National staff should go to the field regularly and provide technical assistance
- Provide incentive (financial support)

2. Referral Mechanism

- **From TB to VCCT**
  - . TB patients from all TB forms are referred to VCCT, except old patients and severe cases
  - . Referral is based on patient's consent (consent form) with referral slip
  - . Transportation support for the poor
  - . Most of TB patients were told by health staff and HBC staff about VCCT and they have to go by themselves

2. Referral Mechanism (Cont.)

- **From VCCT to TB screening**
  - . Counseling on importance of TB screening and Treatment
  - . Most of TB patients were told by health staff and volunteers (HBC and MMM Group) about TB screening place and go by themselves with referral slip

Constraints

- TB staff lack of knowledge on HIV counseling
- VCCT counselors lack of knowledge on TB counseling
- Some HIV+ clients find difficulty to decide immediately to go to TB screening just after HIV+ information
- Relation between the TB screening and VCCT is not good
- Long distance between the two services (TB service and VCCT)
- Referral slip is not standardized

Recommendations

- Guideline for referral of TB patients and HIV+ clients should be developed
- Refresher course of general counseling for referral of TB patients and HIV+ clients should be provided to staff who are implementing the TB/HIV activities
- Referral slip should be standardized

3. Information Sharing

- TB/HIV Working Group has regular quarterly meeting at PHD level
- Meeting of CoC committee is conducted and joined by staff from programs, communities and patients
- Monthly meeting of MMM Group participated by staff from programs, health providers and patients
- There are some meeting with national level, funding Agencies and NGOs concerned

Constraints

- Meeting is not conducted regularly since members of TB/HIV Working Group are very busy With their own activities
- There is no TB/HIV IEC materials to facilitate their consultation or counseling
- Information sharing between the two programs is not on time
- Lack of means for communication for TB/HIV staff at all level

Recommendations

- TB/HIV IEC materials should be developed for use
- Meeting should be conducted regularly
- Information and knowledge gained from meeting, workshop and training should be shared to colleagues for better understanding and improving activities

4. Human Resource Development

- Local training

  TB/HIV Basic training was provided by CENAT and NCHADS
- Overseas

  One study tour to Thailand to explore the experience

Constraints

. Training is always delayed

. Technical capacity is limited (X-ray reading...)

. Members of TB/HIV Working Group do not understand well about TB/HIV co-morbidity and importance of joint activities

Recommendations

- X-ray reading skills training should be provided
- X-ray facility should be equipped to other TB screening places
- CD4 machine should be provided

5. Case Detection and management

- TB screening for HIV+ clients is conducted in HC and RH through sputum examination and X-ray
- HIV screening among TB patients is conducted at VCCT (VCCT at Sereisorphorn, Mongkol Borei, and Poipet)
- Referral slip
- Monthly report: referral number, result

5. Case Detection and management (Cont.)

- Registration and code for patients
- Severe TB/HIV patients are admitted to general ward (Mongkol Borei and Poipet) and TB ward (in Sereisorphon)
- TB staff is responsible for providing TB drug
- CPT can be provided by HC and RH staff at weekly, biweekly or monthly basic.
- IPT is not started yet since the capacity to exclude active TB is limited.

Constraints

- HIV+ clients find it difficult to discharge sputum
- There is no X-ray interpretation (diagnosis) when referring HIV+ clients to HC for TB treatment
- HIV testing reagents always changed
- There is no clear instructions on reporting

Recommendations

- Diagnosis should include sputum examination, X-ray and physical examination
- Chest X-rays (TB/HIV) of clients taken should be documented by the X- Ray technicians as well as TB physicians before they make referrals to HC
- Reporting system should be improved

TB/HIV Collaborative Activity

supported by Family Health International

Battambang Province

Battambang OD and Moung Russey OD

August 23-25, 2004

Collaboration

TB/HIV partners

/FHI/GDRGAS (facilitation and technical support)

/CBO/HBC (refer, follow-up, information feedback)

-The meeting between PHD, OD, and RH, facilitate and direct activities.
-Organize meeting to prepare TB/HIV planning (both programs)
-The meeting to discuss and set up the TB/HIV technical working group in order to provide technical assistance to OD/RH
-TB/HIV facilitators are determined at OD/RH
-The technical working group discussed and set up the IPT checklist
-TB/HIV technical working group supervise IPT (integrated supervision)
-Set up the referral system between TB and VCCT (discuss between TB/HIV at the provincial level, OD and TB/RH-VCCT)
-Weekly meeting of these two programs

Challenges

Appointment between these two programs for meeting/discussion is difficult

Recommendations

-Any support from the national TB and HIV/AIDS programs
-Job description should be written to the staff
-Someone should be in charge of TB/HIV at the provincial level

Referral System

-VCCT to TB service
- *Referral slip is used (it was created by TB/HIV technical working group)
- * Transportation fee is paid to cases referred from outside the RH and the patients are accompanied by a staff member.
- *Counselors explain the benefit of TB screening and distribute the IEC material to the clients
- *Referrals are cross checked at both the services (number are referred and received in registers during the meeting)

-TB to VCCT:
- *TB patients undergoing treatment, are referred to VCCT
- *Referral slip is used for the referral (it is the same as referral from VCCT to TB service)
- * Referrals are cross checked at both the services (number are referred and received in registers during the meeting)

Challenges

-Referral cases from VCCT to TB service is happen at the end of cessions in morning or afternoon.
-Difficult to identify what condition of TB patients who should referred for HIV testing
-Some of TB patients do not show their HIV result to the physician at TB service.
-Lack of counseling skill is among the TB staff

Recommendations

-Transportation fee policy should be discussed
-IEC material should be developed for the benefit of TB/HIV screening (screening TB among PLHA and HIV among TB patients)
-Define clearly what types of TB patients should be referred for HIV screening
-The meeting should be conducted regularly TB service RH and VCCT.

Information Sharing

-CoC meeting (program, community, and patients)
-HBC network meeting
-MMM monthly meeting (health provider/program-patients)
-There are IEC materials to educate VCCT clients
-IPT monthly report (OD cc to TB and HIV programs at the provincial level)
-Integrate supervision and provide feedback information of the TB/
-HIV technical working group.

Challenges

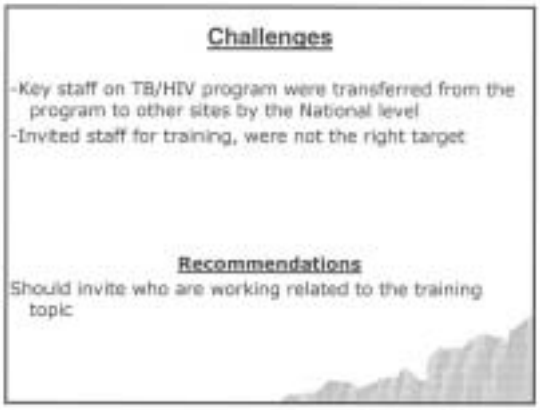
There is no IEC material to educate the TB patients for HIV testing

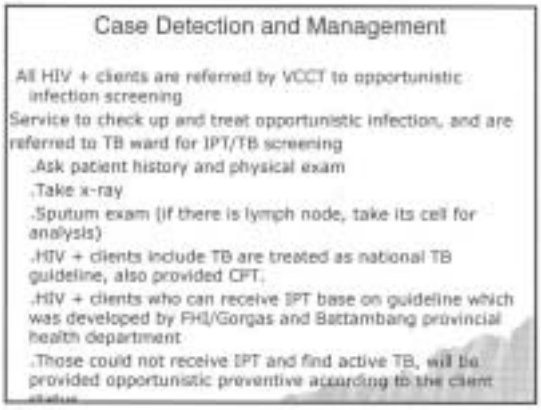
Recommendations

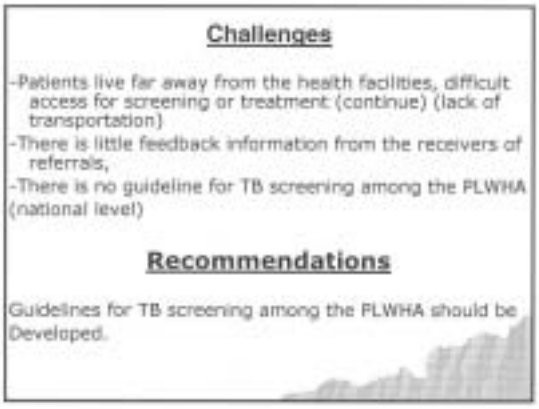
IEC material for HIV screening should be published

Human Resource Development

-TB/HIV technical working group discussed on the IPT guideline
-TB/HIV technical working group created the TB basic knowledge module for training
-Created the IPT checklist
-Published TB/HIV basic knowledge for village health support group
-Training:
- .Basic knowledge on TB/HIV
- .IPT
- .X-ray reading on TB/HIV and other opportunistic infection
- .Making smear on slide (health center staff)
- .Job aid
- .Opportunistic infection, universal precaution, and counseling
-Visit Thailand (IPT implementation)
-Visit Calmette hospital on how to take X-ray in appropriate way


Challenges
-Key staff on TB/HIV program were transferred from the program to other sites by the National level
-Invited staff for training, were not the right target
Recommendations
Should invite who are working related to the training topic


Case Detection and Management
All HIV + clients are referred by VCCT to opportunistic infection screening
Service to check up and treat opportunistic infection, and are referred to TB ward for IPT/TB screening
.Ask patient history and physical exam
.Take x-ray
.Sputum exam (if there is lymph node, take its cell for analysis)
.HIV + clients include TB are treated as national TB guideline, also provided CPT.
.HIV + clients who can receive IPT base on guideline which was developed by FHI/Gorgas and Battambang provincial health department
.Those could not receive IPT and find active TB, will be provided opportunistic preventive according to the client


Challenges
-Patients live far away from the health facilities, difficult access for screening or treatment (continue) (lack of transportation)
-There is little feedback information from the receivers of referrals,
-There is no guideline for TB screening among the PLWHA (national level)
Recommendations
Guidelines for TB screening among the PLWHA should be Developed.

Workshop on Scaling-up TB/HIV Collaborative Activities

Date: 23-24-25 August 2004
Venue: CENAT Conference Room

Sihanoukville Pilot

Lesson learnt and Recommendations

Collaboration between TB and HIV/AIDS Programs

Mechanism for collaboration

- Involvement of partners: PHD, RH, HC, TB, VCT, HBC, NGOs
- Coordinating Committee with TOR (HC, RH, HBC)
- Technical Working Group with TOR

Meeting

- Coordinating Committee: Quarterly meeting
- Technical Working Group: Monthly meeting

Roles of Committees

- Coordinating Committee: discuss general issues of TB/HIV
- Technical Working Group: Supports TB diagnosis and other case management issues

Recommendations

- Involvement all health partners in place is very important
- There is a need of support from NGO
- There is a need of cooperation of staff from VCT, RH, TB ward, HC and HBC

Referral System

- HBC to VCT
  - Find chronic disease clients, especially HIV/AIDS and send to VCT
  - Referral slip
  - Transportation (fee and accompanied)
- VCT to TB
  - Provide TB counseling
  - Referral slip
  - No need to provide transport fee since VCT is located next door to TB screening
- TB to VCT
  - HIV Counseling
  - Referral slip
  - No one accompanies TB patients to VCT (transportation fee is available)
- TB/HIV+ patients to HBC is well practised since HBC office is Located in HC where TB screening provided

Constraints

- Referral of TB patients to VCT
  - TB patients referred from remote HC cannot reach VCT because there is no mechanism to accompany them
  - TB patients are not interested in HIV status
  - TB patients always ask the importance of HIV status

Recommendations

- Referral of TB patients to VCT
  - Strengthen counseling of VCT importance
  - Machanism of spending should be set up in order to make patients reach VCT

Information Sharing

- TB/HIV IEC Strategy
  - Verbal health education is provided during counseling and consultation
  - Use IEC materials from vertical programs
  - TB/HIV IEC materials have not been developed yet
  - Outreach activities: Gather HIV+ clients and relatives at HC or patient's house and conduct health education about TB/HIV and other OI
- Information sharing

  Monthly report is prepared regularly and shared to national level.

Constraints

- There is no TB/HIV IEC materials for outreach activities and during counseling and consultation
- There is no clear instruction from national level of how to collect, compile, analyse and use data
- Financial support for IEC materials is the problem

Recommendations

- TB/HIV IEC materials should be developed
- Financial support for TB/HIV IEC material producing should be provided
- There is a need of clear instruction from national level about TB/HIV HIS

Case Detection and Management

- TB diagnosis:
  - TB and OI service are open 5 days/week
  - Most of clients (clinical sign) receive X-ray taking first
  - Sputum examination is requested when X-ray show abnormality
  - All HIV+ clients have patient file for follow up of TB screening and other OI
  - One month follow up for every client without TB
- TB Treatment for TB/HIV patients
  - Hospitalized DOT (RH), Ambulatory DOT (referred to HC)
  - TB/HIV patients received CPT at the meantime of TB Treatment
  - All TB/HIV patients receive HBC service if they want
  - HBC assist HC staff in providing DOT
  - HBC assist HC staff in tracing patients

Constraints

- Capacity in diagnosis TB S- is limited
- There is no TB/HIV clinical manual in Khmer for facilitating TB diagnosis for PHA
- IPT service is not established yet due to the capacity limitation

Recommendations

- There is a need to strengthen the capacity of TB diagnosis in TB S-, especially X-ray reading skill
- TB/HIV clinical manual in khmer should be developed and disseminated for practice
- There is need of technical support of IPT management

Human Resource Development

- Some trainings were provided:
  - Sensitizing Workshop on TB/HIV activities
  - Basic training of HIV/AIDS
  - Basic Training of TB
  - Supporting Counseling Training on TB/HIV
  - Nursing Care Training on TB/HIV

Constraints

- Training provided previously is not enough for implementation
- Training provided is just only basic
- Knowledge of staff are still limited

Recommendations

- The following trainings should be provided in Order to improve the activities:
  - X-ray reading skill training
  - CPT and IPT management training
  - Refresher course of counseling
  - Training should be more detail than basic

Annex D. Presentation of WHO and Country-specific Framework

Cambodia Country Framework and WHO Guidelines for Implementing TB/HIV Collaborative Activities

Workshop on Scaling-Up TB/HIV Collaborative Activities
Phnom Penh
23, 24, & 25 August 2004

Cambodia Country Framework

- Developed in 2002
- Based on WHO framework to address TB/HIV co-infection in the Western Pacific Region
- Result of joint collaboration between NTP and NAP
- Framework provides principles and directions for addressing the TB/HIV epidemic

Cambodia TB/HIV Diagnostic Framework

The framework requires:

- HIV+ patients should be referred to the TB control program for TB screening and to decide on the need for INH preventive therapy
- All patients diagnosed with active TB should be referred for VCCT

Cambodia's Epidemiologic Classifications and Interventions

Group	Epidemiologic Classification	Interventions
1	HIV- Active TB	DOTS IEC for HIV and TB
2	HIV-, but at risk Active TB	DOTS IEC for HIV and TB Screening and treatment for STI
3	HIV+ Active TB	DOTS HIV/AIDS Care CPT IEC for HIV and TB Screening and treatment for STI

Cambodia's Epidemiologic Classifications and Interventions (2)

Group	Epidemiologic Classification	Interventions
4	HIV+ TB infection	IPT HIV/AIDS care IEC for HIV and TB Screening and treatment for STI Monitoring for active TB
5	HIV+ No TB infection	IPT BCG (for small children, asymptomatic HIV) HIV/AIDS care IEC for HIV and TB Monitoring for active TB

Responsibilities and Collaboration between TB and HIV/AIDS programs

Epidemiologic Classification	NTP	Areas for Collaboration	NCHADS
HIV- Active TB	DOTS	IEC	
HIV-, but at risk Active TB	DOTS	IEC	Risk Reduction STI screening and treatment
HIV+ Active TB	DOTS	IEC Joint case holding	HIV/AIDS care Risk Reduction PCP prophylaxis STI screening and treatment

Responsibilities and Collaboration between TB and HIV/AIDS programs (2)

Epidemiologic Classification	NTP	Areas for Collaboration	NCH/AIDS
HIV+ TB infection	IEC	IEC Monitoring for active TB	HIV/AIDS care Risk Reduction STI screening and treatment IPT
HIV+ No TB infection	IEC Assess HIV status	IEC TB Prevention Monitoring for active TB	HIV/AIDS care Risk reduction STI screening and treatment IPT

WHO Guidelines for Implementing TB/HIV Collaborative Activities

- Developed in 2003
- Produced by the Stop TB Dept and Dept of HIV/AIDS at WHO Headquarters
- Guidelines provide an overview of the range of activities that could be undertaken in high burden TB/HIV countries

Steps for planning and establishing TB/HIV activities

- National Level
  - NTP and NAP collaboration
    - Define responsibilities
    - Develop a national TB/HIV strategic plan
    - Define opportunities for collaboration
    - Develop tools to support district implementation
    - Build district capacity
    - Support districts to plan and implement collaborative TB/HIV activities
    - Monitor and evaluate implementation

Steps for planning and establishing TB/HIV activities (2)

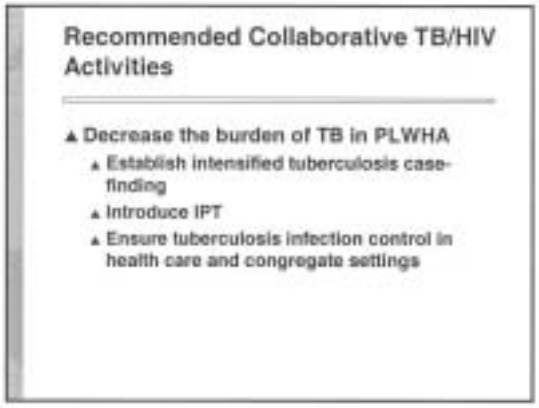
- District level
  - Establish TB/HIV coordinating committee
    - Plan TB/HIV collaborative activities
    - Coordinate district-level TB/HIV activities
  - Establish referral system
  - Develop supervisory systems
  - Develop staff support systems
  - Monitor and evaluate implementation
  - Document the process

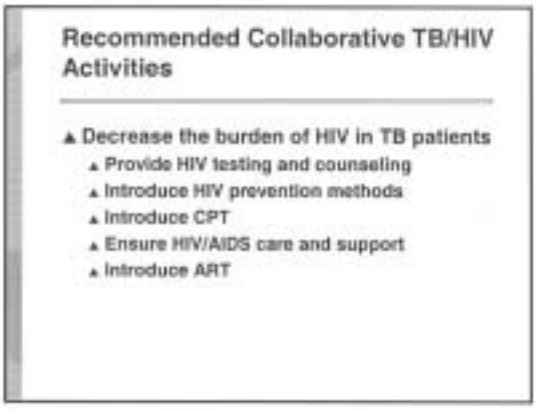
Recommended Collaborative TB/HIV Activities

- Establish mechanisms for collaboration
  - Set up a coordinating body for TB/HIV activities effective at all levels
  - Conduct surveillance of HIV prevalence among tuberculosis patients

Recommended Collaborative TB/HIV Activities

- Establish mechanisms for collaboration
  - Carry out joint TB/HIV planning
    - Resource mobilization
    - TB/HIV capacity building, incl. training
    - TB/HIV communication
    - Enhance community involvement
  - Conduct monitoring and evaluation


Recommended Collaborative TB/HIV Activities
▲ Decrease the burden of TB in PLWHA
▲ Establish intensified tuberculosis case-finding
▲ Introduce IPT
▲ Ensure tuberculosis infection control in health care and congregate settings


Recommended Collaborative TB/HIV Activities
▲ Decrease the burden of HIV in TB patients
▲ Provide HIV testing and counseling
▲ Introduce HIV prevention methods
▲ Introduce CPT
▲ Ensure HIV/AIDS care and support
▲ Introduce ART


Thank You

Annex E: Participants, per Working Group

No.	Name	Remarks
Group 1		
1	Theth Kantol	BMC
2	Heng Leang	BMC
3	Tan Vutha	BTB
4	Ieng Kakvey	BTB
5	Chhay Narin	SHV
6	Chiv Kunthea	SHV
7	Nuon Nory	PP
8	Mak Sutthep	BTB
9	Chou Dara	RHAC
10	Sim Ngim	JICA
11	Chhun Song	MHD
12	Eang Chanthol	FHI
Group 2		
1	Sin Eap	BMC
2	Long Ngeth	SHV
3	Pel Vanna	BTB
4	Lay Vithiea	BTB
5	Koet Phannarith	SHV
6	Keo Lay Heang	PP
7	Long Pheavy	PP
8	Keo Samnang	BMC
9	Som Dara	FRC
10	Kong Narom	CARE
11	Pen Bun Thorn	BMC
Group 3		
1	Kem Arunrith	BTB
2	Chou Seuth	BTB
3	Kim Samoeurn	BMC
4	Khem Saron	SHV
5	Yuos Bun Heng	PP
6	Lim Ly	BMC
7	Koek Sovann	SHV
8	Om Phanna	STD
9	Phalkun Chheng	GORGAS
10	Serey Rith	CARE
11	Min Puthchethavann	Red Cross HC

Annex F. Group Work Facilitation Guides

Collaboration

1. What types of collaborative bodies should be formed for joint TB/HIV activities?
2. Should collaborative bodies be formed at all levels? National level? PHD level and OD level?
3. Who should participate in the collaborative bodies? What types of decisions should be made?
4. Does anyone have TOR to share?
5. Should there be a joint work plan of TB/HIV activities prepared by TB and HIV/AIDS programs? Who should be involved in preparation?
6. What kinds of joint meetings/workshops (monthly/quarterly) of TB/HIV activities should be conducted?
7. How often should joint supervision activities be conducted at each level?
8. What should checklists contain? Same at each level?
9. How to integrate/combine supervision visits?
10. Ways to provide supervision: Phone? Visits? Regular communication?
11. What types of communication should exist between programs outside of collaborative bodies
12. Are there any other resources needed?
13. What are the recommendations for scale-up?

Referral Mechanisms

VCCT/HBC to TB

1. What are the barriers to referring HIV+ clients from VCCT to TB service?
2. What kinds of effective mechanisms for referral should be used? referral slip use, self-referred, providing transportation, or accompanying clients?
3. If financial support for transportation fee is available, what are good practices to ensure that the clients reach TB screening service?

4. If financial support for transportation fee is not available, how could we ensure that the clients reach TB screening service?

5. What is the best system to track referrals?

6. What are the barriers/issues to referring all HIV+ clients to TB screening (currently most only refer TB suspects)? How can they be improved? What recommendations do you have for scale-up?

TB to VCCT

1. When should TB patients be referred to VCCT – once registered, after TB treatment, a few weeks after starting treatment, or during continuation phase of TB treatment ?

2. Should TB suspects (at TB consultation service) be referred to VCCT?

3. What appropriate referral mechanisms could be used – referral slip, self-referred, providing transportation, accompanying clients?

4. If financial support for transportation fee is available, what are good practices to ensure that the clients reach VCCT service?

5. If financial support for transportation fee is not available, what are ways to ensure that the clients reach VCCT service?

6. What is the best system to track referrals?

7. What are issues surrounding referrals? How can they be improved? What recommendations do you have for scale-up?

Information Sharing

1. What additional IEC materials are necessary? Should specific IEC materials dealing with TB/HIV be developed?

2. What messages should be included?

3. What additional information campaigns should be conducted? Radio? Health promotion days? Billboards?

4. What are the best ways to share information with the community?

5. What types of community groups are currently engaged in TB/HIV collaborative activities? Are these groups an effective method for getting clients screened, treated and follow up?

6. How can on-going communication be facilitated between the TB and HIV programs (beyond formal mechanisms such as TB/HIV coordinating committees)?

7. What information should be shared between the two programs on a regular basis?

8. What recommendations do you have for scale-up?

Human Resources

Links between TB and HIV

1. What training modules currently exist that can be shared?
2. What topics/modules of trainings are needed in carrying out TB/HIV interaction interventions?
    - △ Basic knowledge about the clinical interaction between TB and HIV (either formal or informal)?
    - △ TB/HIV co-morbidity counseling skills?
    - △ TB/HIV CoC and follow-up?
    - △ TB/HIV diagnostic skills training?
    - △ TB/HIV treatment and follow-up skills? preventive therapies (CPT, IPT, ART, palliative care, etc.)?
    - △ Information management (how to collect, compile, analyze and use data)?
3. Who should be trained?
4. What additional knowledge do you need in terms of laboratory skills?
5. When are on-the-job/refresher training appropriate? During supervision visits?
6. How to ensure that staff adhere to treatment protocols? Are operational procedures necessary?
7. What are the challenges currently faced in regard to human resources (challenges faced to carry out tasks appropriately)?
8. What would be the recommendations for scale-up?

Case Detection and Management

I. Case detection:

What should the procedure be to:

1. Screen/diagnose for TB among PLWHA?
2. Screen for HIV among TB patients?

II. Case management:

1. Where could you keep the TB/HIV patients?
2. If TB/HIV patients are kept at TB ward, who should manage HIV/AIDS care? How to deal with discrimination?

3. What information is needed for case management in patient file for IPT, CPT, and ART?

4. How can we prevent TB transmission among PLWHA (TB/HIV patients in AIDS wards, PLWHA/TB patients in TB ward)?

5. Are national protocols and standards are available for preventive therapies?

6. Are national protocols and standards available for laboratories?

7. Are there challenges faced in implementing the protocols appropriately?

8. Based on your experience, are there recommendations for improvement for these protocols?

9. What lessons can be learned from clinical services offering preventive therapies (e.g. IPT and CPT) to PHA (long term compliance, follow-up and disclosure issues?

A. CPT

1. What should you counsel TB/HIV patients or HIV + clients about CPT?

2. Who should provide Cotrimoxazole? at what levels should it be provided?

3. Where will TB patients access CPT after completion of TB treatment? (Currently TB patients get CPT at the facility)

4. Where should PLWHA best access CPT?

5. What should the clinical checklist contain?

6. What would be the recommendations for scale-up?

7. Should we have a clinical supervision checklist?

B. IPT

1. Who should provide IPT to the HIV + clients at the facilities?

2. How do you follow up during IPT implementation?

3. What are the best methods:

    - △ -To screen for IPT?
    - △ -To support clients on IPT? (Mechanism how to give IPT)
    - △ -To manage clients developing active TB while taking IPT?
    - △ -To supervise and monitor facilities prescribing IPT?

4. What would be the recommendations for scale-up?

Annex G. Report on Information Subgroup Methodology and Progress

Methodology in developing TB/HIV Co-morbidity Information Management Systems

Step 1: Collect all the data collection tools (at all levels) currently used by the 4 pilots

Step 2: Analyze the tools based on their source and the information that was collected

Step 3: Analyze all the tools to identify their purpose and information that was collected

Step 4: Establish the TB/HIV information subgroup (consisting of NCHADS, CENAT and PHR*plus* staff) to facilitate the drafting of standardized tools

Step 5: Identifiy information needs at different levels

Step 6: Identifiy and determined basic TB/HIV co-morbidity surveillance, monitoring and evaluation indicators

Step 7: Determine the data collection tools (forms, registers, report formats, etc.) to be standardized

Step 8: Prepare draft tools

Step 9: Conduct a workshop to identify information needs regarding case management and follow-up

Step 9: Share draft forms with the TB/HIV TWG for feedback

Step 10: Incorporate feedback from TWG members

Step 11: Prepare job aids, guides and training material for field testing of the tools

Step 12: Field test the tools, job aid & guides, training material

Step 13: Incorporate findings and changes from field

Step 14: Finalize drafts, training material, and job aid guides

Step 15: Obtain approval from the Ministry of Health for implementation