



# **Linking HIV and TB – Underlying issues to consider when scaling up integration of HIV and TB services in Cambodia**

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## **Preface and Acknowledgements**

This study was commissioned by the International HIV/AIDS Alliance as part of their ongoing support to the Khmer HIV/AIDS NGO Alliance (KHANA) in Cambodia. The purpose of the study was to identify the underlying issues related to linking HIV and TB services that affect scale up of Prevention, and Care & Support Programmes in Cambodia. The author wishes to express his gratitude to the following sources of information:- Phnom Penh Home Care Network Group, Director and Deputy Director of the Municipal Health Department, staff from selected Health Centres in Phnom Penh, staff and advisors from the National TB Centre (CENAT), Home-care staff, Volunteers, Programme Managers and Policy Makers, and to the TB and HIV/AIDS patients & their families who were interviewed in the course of the study. The author also wishes to express his appreciation for the help and support provided by KHANA and the International HIV/AIDS Alliance throughout the study.

## **Executive Summary**

Cambodia has the fastest growing HIV/AIDS epidemic in Asia. Cambodia is also one of the 23 high burden countries for tuberculosis in the world and there are high and increasing levels of HIV/TB co-infection. Current estimates reveal that 8% of all TB patients are HIV positive, and that more than 20% of PLHA have active TB. The number of new TB cases seen at public health facilities has trebled over the last decade, and around 100,000 people are suffering from active tuberculosis. This number is expected to double in the next 1-2 years. It is estimated that the HIV epidemic will cause an additional 2000 positive pulmonary TB cases in Cambodia every year during the next 5 years.

Patient delay in accessing the health services is often more than 6 months, and a critical mass of contagious cases prevents a decline in transmission rates. There is an urgent need, especially in the context of the HIV epidemic, to reduce the delay between the first symptoms of TB and free access to DOTS.

A recent study in Cambodia revealed that there are presently major barriers to effective collaboration and linking of TB and HIV/AIDS interventions. Parallel programmes are failing to address the needs of patients and are inhibiting early TB detection and treatment. HIV/AIDS prevention and care efforts do not specifically target TB patients, and there is currently only limited co-ordination between DOTS and HIV/AIDS home-based care activities.

People at community level face major barriers in accessing public health services in general, and especially in accessing free TB services. Stigmatization of TB patients, which derives partly from the confusion between HIV and TB, is a major barrier to screening and treatment, and is hampering both active & passive case detection.

Private sector providers/traditional healers, who are the first points of contact for over 70% of the population when they are ill, present major barriers to case detection and treatment of TB. Furthermore private practitioners are not merely failing to address issues related to HIV prevention but are posing a real danger to PLHA and people with active TB.

Developing an integrated approach to providing HIV and TB services may ultimately involve changes in the way these two vertical programmes are structured. However, significant gains can be achieved within existing structures by addressing missed opportunities.

Opportunities are being missed to inform and counsel TB patients and contact cases on HIV prevention and to inform and counsel PLHA and caretakers on prevention, detection and treatment of TB.

There is a need to build capacity of HIV workers, including home care teams, to understand and implement systems for early detection and treatment of TB. This should be complemented by building capacity of TB DOTS teams to include HIV/AIDS education and counseling as part of their routine programmatic work.

The Home Care network Group (HCNG), with support from KHANA, must work towards improving referral and follow-up mechanisms between DOTS teams, Home Care Teams, Health Centres, CENAT and National Hospitals.

A critical step in scaling up the integration of HIV/TB services will be to link the expansion of home care provision in the provinces to the expansion of DOTS at health centers.

There is an urgent need to inform and educate private providers about issues related to TB and HIV, and to advocate for improved legislation and regulation from MoH to address concerns related to these providers.

There is a need for a greater focus on improving early TB detection and treatment among high-risk groups, including the military, prisoners, and people living in squatter and resettlement areas.

There is a need to advocate for greater awareness among the donor community to support integrated HIV/TB interventions, and to use money ring-fenced for HIV/AIDS to leverage funding for improved TB services.

Finally, there is an identified need to make HIV and TB services more client-focused, and to help “market” free TB services to the community.

## **1. Background**

### **1.1 HIV/AIDS in Cambodia**

Cambodia has the fastest growing HIV/AIDS epidemic in Asia. Results from the Surveillance Surveys<sup>1</sup> indicate that approximately 169,000 Cambodians are now infected with HIV, giving an adult prevalence rate of around 3%. It also indicates that the HIV epidemic is moving from urban areas and those with high-risk behaviors, and is establishing itself within the general population.

This is in a country recovering from 3 decades of conflict, with an already high dependency rate (50% of the population are under 18 years), where 40% of people live below the poverty line, and where the majority of the population (87%) lives in rural areas without essential services. Cambodia has fewer than 8000 hospital beds in total throughout the country, and even without HIV, poor families spend 25% of their income on health care.

There are currently only six approved centers for HIV counseling and testing in Cambodia, all located in urban areas and therefore difficult for rural access. In addition to this, the testing regimen used is laboratory-based and requires people to return several days later for the result. The restricted access to good quality voluntary counseling and testing (VCT) for HIV, is a significant barrier to providing effective community-based HIV/AIDS prevention and care to vulnerable groups.

The economic and social impact of HIV/AIDS-related sickness and death on poor families and communities is already high. Prevention projects linked to home based care and other support services, particularly those targeting groups vulnerable to HIV infection, need to be rapidly scaled up so that the impact on development in Cambodia can be mitigated.

### **1.2 TB in Cambodia**

Cambodia is one of the 23 high burden countries for tuberculosis in the world. It is estimated that 64% of the population (or more than 7 million people) are infected with TB in Cambodia. The number of new TB cases seen at public health facilities has trebled over the last decade, and around 100,000 people are suffering from active tuberculosis. Half of them are contagious pulmonary positive, and the other half - including a considerable number of children - suffer from less contagious forms like pulmonary negative or extra pulmonary tuberculosis. The present level of mortality due to tuberculosis is 90/100,000,

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<sup>1</sup> Report on Sentinel Surveillance in Cambodia, NCHADS/MoH, 1999

which means that an estimated 10,000 people die of TB in Cambodia every year, most of them adults in the productive age groups.

According to the Global TB Control Report 1999, the key to tackling the TB problem lies in expanding case detection. The two objectives of Cambodia's National TB Programme (NTP) remain in line with the WHO Global TB Control policy

- To maintain the high cure rate of at least 85% between now and 2004
- To detect 70% of the new sputum positive cases by the year 2004.

Cambodia has achieved remarkable results since 1994 and has one of the highest detection rates in the region for contagious cases (53%) and also one of the highest cure rates (89% consistently since 1995), which surpasses the WHO recommended target of 85%.

Despite the success of NTP, the real burden of TB is still unknown. The number of notified cases has increasing by an average 5% per year since 1995, but the case finding rate is stagnant.

Patient delay in accessing the health services is often more than 4 or 6 months, and a critical mass of contagious cases prevent a decline in the transmission rates. There is an urgent need, especially in the context of the HIV epidemic, to reduce the delay between the first symptoms of TB and free access to DOTS (Directly Observed Treatment, Short-course).

Home-based DOTS has been piloted for 2 years in Phnom Penh, while health facility-based DOTS is reported to be available in all provinces. The government strategy is to expand DOTS in health centers from the present 17% to 100% by 2005. In the meantime, DOTS is generally only available at referral hospitals, and therefore effectively out of reach for many patients, and especially the rural poor.

A pilot project in 9 health centers to identify implementation issues revealed that treatment at HC level is both feasible and likely to strengthen community confidence in HCs. However, significant technical assistance will be needed to expand TB services at HCs nationwide, as the introduction of DOTS involves complex logistical, managerial and technical mechanisms.

The advent of HIV/AIDS and the corresponding increase in TB cases (expected to double within 1-2 years) makes it imperative to escalate the introduction of TB detection and treatment to community level.

### **1.3 HIV and TB in Cambodia**

HIV-related immune system depression speeds up the onset of disease in people newly infected with TB, and causes the reactivation of previously infected people. It is also recognized that tuberculosis worsens the evolution of the AIDS disease

There are high, and increasing, levels of HIV/TB co-infection in Cambodia. Current estimates for HIV/TB co-infection in Cambodia reveal that 8% of all TB patients are HIV positive, and that more than 20% of PLHA have active TB. It is estimated that the HIV epidemic will cause an additional 2000 positive pulmonary TB cases in Cambodia every year during the next 5 years.

There is also a high mortality rates associated with HIV/TB co-infection, with TB being the main cause of death in people who are HIV-positive.

Despite the inter-relationships between HIV and TB, HIV/AIDS prevention and care efforts do not specifically target TB patients, and there is currently only limited co-ordination between DOTS and HIV/AIDS home-based care activities.

## **2. Objectives of the study**

In order to help strengthen programmatic linkages and reduce barriers to accessing services, the International HIV/AIDS Alliance commissioned a study in Cambodia. The objective was to identify the underlying issues related to linking HIV and TB services that affect scale up of Prevention, and Care & Support Programmes in Cambodia.

The research was undertaken by an Alliance Associate Consultant, over the period May – July 2001. The consultant conducted interviews with TB patients, HIV/AIDS patients & their families, members of the Phnom Penh Home Care Network Group, the Director and Deputy Director of the Municipal Health Department, staff from Health Centres in Phnom Penh, staff and advisors from the National TB Centre (CENAT), Home-care staff, Volunteers, Programme Managers and Policy Makers. The consultant observed a number of provider/client interactions in health centers and at CENAT. Finally the consultant conducted a review of recent Cambodia-focused research.

### **3. Research findings**

#### **3.1 Overview**

The study revealed that while there are presently major barriers to effective collaboration and linking of TB and HIV/AIDS interventions, there are significant opportunities to enhance collaboration and to improve services.

One of the main barriers affecting linkages between HIV and TB programmes is the disparity of funding allocated to the two programmes. Cambodia currently receives significant donor support for government and non-governmental organizations implementing HIV/AIDS programmes, while the National TB Programme (NTP) remains seriously under-funded. This has a number of implications, the most serious of which is the inability of the NTP to fully implement its policy of providing free TB services to the public.

In theory, TB screening and treatment should be provided free of charge to everyone. However, charging unofficial fees for both screening and treatment has become commonplace. The major reason is that TB workers receive little incentive to provide free services. Few NGOs are involved in supporting TB provision, while government TB workers generally have no access to user-fee income and receive no donor-supported salary incentives. To help address this situation, JICA has recently introduced a policy of paying salary supplements to TB staff at CENAT, in an attempt to improve staff motivation and eliminate unofficial fees.

#### **3.2 Barriers to accessing public services**

In addition to the difficulties experienced in accessing free TB services, people face major barriers in accessing public health services in general. These barriers may be categorized as financial, physical, socio-cultural, cognitive and organizational.

Financial barriers include high opportunity costs, unpredictable informal charges, no system for phased or deferred payments, and a general failure of the exemption system to protect the poor.

Physical barriers include distance/time to reach the nearest health facility, lack of transport, poor road conditions and restricted times of opening of health facilities.

Organizational barriers include real and perceived poor quality of care, unprofessional staff attitudes, unethical treatment of patients, ineffective referral mechanisms, and services that are not customer-oriented.



The health coverage plan, health financing charter and the provision of MPA and CPA are beginning to address some of the physical, financial and organizational barriers. However, socio-cultural and cognitive barriers remain largely unaddressed.

Socio-cultural barriers include a cultural preference for home-based health care and a general reluctance to travel far from the home, partly as a result of low levels of social integration beyond the nuclear family. Seasonal variation in opportunity costs, and in the ability and willingness to attend and to pay for health care also present barriers to access.

Cognitive barriers include lack of information on what services are available and at what times, lack of information on user fees & exemption schemes, little understanding of consumer rights, lack of confidence in public health facilities, low understanding of how modern allopathic health care works, and low understanding of the importance of preventive health care.

Research in Cambodia has shown that health-seeking behaviour is often inappropriate. Consumers use numerous practitioners, over-rely on self-prescribed medications and intravenous infusions, and self-refer late to tertiary facilities. These practices result in high health care expenditure, continuing ill health, debt and increased poverty.

In addition to these barriers, which are faced by all people accessing health care, there are additional barriers faced by people accessing TB screening services and those requiring TB treatment. These are outlined below.

### **3.3 Barriers to TB Screening and Treatment**

As noted earlier in the report, TB screening and treatment services are limited, particularly in the provinces. Furthermore, there is limited awareness among the general public of what services are available, and at what times. For those who are able to access services, they face further barriers because of the policy of some health centers and hospitals to require patients attending for TB screening to stay for a period of two days in the facility, in order to provide sputum samples. This policy is imposing significant opportunity costs to patients.

Despite efforts to improve quality, concerns remain about the effectiveness of TB screening at health centers. TB screening services in Phnom Penh have recently been expanded from four to fifteen health centers. However, some health centers providing screening services are still unable to provide treatment to patients who are found to have active TB.

The expansion of DOTS in Phnom Penh and in the provinces is helping to increase compliance. However, patients who cannot provide an address (e.g.

some squatters and recent fire victims in Phnom Penh), or who have more than one address (e.g. some displaced families) are currently ineligible to receive services from the DOTS home care team.

Stigmatization of TB patients, which derives partly from the confusion between HIV and TB, is a major barrier to screening and treatment, and is hampering both active & passive case detection.

### 3.4 Private practitioners

One of the major barriers to improved case detection is the detrimental role played by private practitioners with regard to TB (and HIV). A Study<sup>2</sup>, recently conducted among private practitioners in Phnom Penh, revealed alarming findings with regard to TB detection and treatment. The Mystery Client Study used trained researchers who posed as real clients and visited a representative sample of private practitioners in Phnom Penh. In one scenario used in the study, a researcher posed as a young man presenting with chronic productive cough and weight loss. Of the 25 private practitioners who were consulted:-

- none referred him for sputum test
- none discussed HIV/AIDS
- one referred him for X-ray
- one gave inappropriate corticosteroids
- 19 gave antibiotics, of which 13 gave inappropriate courses and 2 gave multiple antibiotics
- one referred for inappropriate surgery
- none informed of possible diagnosis

In summary, 24 of the 25 consultations were potentially hazardous. If this pattern is typical (and there is no reason to suppose that it isn't) then over 90% of private practitioners present major barriers to case detection and treatment of TB. Furthermore, since none of the private practitioners discussed HIV/AIDS with the client, significant opportunities are being missed to address issues related to HIV prevention.

Studies in Cambodia reveal that private sector providers/traditional healers (largely drug sellers) are the first points of contact for over 70% of the population when they are ill<sup>3</sup>. Even those who initially access public sector services are likely

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<sup>2</sup> Vickery C, et al. 2001, "Private Practitioners in Phnom Penh: A Mystery Client Study", Draft Report, Phnom Penh Urban Health Project, Options

<sup>3</sup> National Institute of Public Health, 1998, *The Demand for Health Care in Cambodia*. This report includes drug sellers, traditional healers and private physicians in its definition of the private sector. The report disaggregates first action health-seeking behaviour into 57.3% self-medication, 4.5% traditional healer, 8.4% private practitioner (total 70.2%). Van de Put (1995) in *Empty Hospitals, Thriving Business* (Phnom Penh, MSF) argues that many private practitioners are an extension of self-medication as people engage them to administer purchased drugs and infusions.

to turn to traditional healers and private practitioners for subsequent (or supplementary) treatments of the same illness. The implications for early detection and treatment of TB, and for addressing issues related to co-infection of TB and HIV, are alarming.

### **3.5 Missed Opportunities**

Developing an integrated approach to providing HIV and TB services may ultimately involve changes in the way these two vertical programmes are structured. However, significant gains can be achieved within existing structures by addressing missed opportunities.

Opportunities are being missed to inform and counsel TB patients and contact cases on HIV prevention. TB staff generally have little capacity or incentive to counsel on HIV/AIDS, and there is a need to provide training and supervision to address capacity gaps. Financial incentives now being provided by JICA should help to address the incentive issue, provided that they are incentive based.

Opportunities are also being missed to inform and counsel PLHA and caretakers on prevention, detection and treatment of TB. People who attend for VCT are not made aware of specific tests and treatment for TB.

Government health providers and NGOs are missing opportunities to make TB and VCT services more client-focused. Using a 'one-stop-shop' approach to providing integrated services, where the focus is on addressing client needs, rather than on provider convenience, will help improve access, demand and quality.

## **4. Entry points for interventions**

### **4.1 Care & Support (C&S) Teams**

For organisations working in care and support (including home care teams) there are a number of entry points to scale up and help provide a more integrated approach to HIV and TB interventions.

Providing education and information on TB transmission and treatment to people at community level, and providing information about the availability of free TB detection and treatment can help increase active and passive case detection. Education is also needed to address issues of stigma, discrimination and marginalisation of people with TB and/or HIV.

C&S Teams should also provide information about the availability of free TB detection and treatment to PLHA self-help groups, individuals and families. It is

particularly important to ensure that these individuals and groups can recognize TB symptoms and understand that TB can be cured. There is a need to raise awareness at community level about the Afternoon Clinic at CENAT, which is held specifically for patients at high risk (including those with HIV/AIDS). There is a further need to refer all PLHA to the Afternoon Clinic, and to provide follow-up and support to these patients.

## **4.2 Programmatic interventions**

In addition to specific service interventions outlined above, there are a number of broader programmatic interventions which can help to address missed opportunities and mitigate against the failure of parallel programmes to meet the needs of patients. There is a need to build capacity of HIV workers, including home care teams, to understand and implement systems for early detection and treatment of TB. This should be complemented by building capacity of TB DOTS teams to include HIV/AIDS education and counseling as part of their routine programmatic work.

KHANA should regularly update LINGO partners about evolving intervention strategies at TB and VCT centres (education, active case finding, and preventive therapy).

The HCNG, perhaps with support from KHANA, must work towards improving referral and follow-up mechanisms between DOTS teams, Home Care Teams, Health Centres, CENAT and National Hospitals.

A critical step in scaling up the integration of HIV/TB services will be to link the expansion of home care provision in the provinces to the expansion of DOTS at health centers. There will be a need to develop a shared culture and better systems for government and NGO staff, working in these two programmes, to adopt a more collaborative approach to providing integrated HIV/TB services.

## **4.3 Policy / advocacy interventions**

There should be a greater focus on high-risk groups, including the military, prisons, and people living in squatter and resettlement areas, to improve early TB detection and treatment.

Private practitioners are the first choice of provider for many people, including the poor. The Mystery Client Study in Phnom Penh revealed that private providers are not merely failing to address TB/HIV issues, but are posing a real danger to PLHA and people with active TB. There is an urgent need to inform and educate private providers about issues related to TB and HIV, although the difficulties involved in achieving this should not be underestimated. There is a clear need to

advocate for improved legislation and regulation from MoH to address these concerns.

There is a need to advocate for greater awareness among the donor community to support integrated HIV/TB interventions, and to use money ring-fenced for HIV/AIDS to leverage funding for improved TB services.

Following JICA's initiative in supporting incentives for TB staff at CENAT there is a need for further creative strategies to generate incentives for TB staff at provincial level. One approach is to reimburse health centres & referral hospitals for TB services they provide free of charge to community members.

Finally, there is an identified need to make HIV and TB services more client-focused, and to help "market" free TB services to the community.

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