



ASSESSMENT OF CIVIL SOCIETY AND COMMUNITY ORGANIZATIONS WORKING ON TUBERCULOSIS IN CAMBODIA

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LIST OF ABBREVIATIONS

AHC	Angkor Hospital for Children
CARITAS	CARITAS Cambodia
CATA	Cambodian Anti-Tuberculosis Association
C-DOTS	Community-Direct Observation Treatment-Short course
CENAT	National Center for Tuberculosis and Leprosy Control
CFCS	Challenge Facility for Civil Society
CHC	Cambodian Health Committee
CIP	Commune Investment Plan
CRS	Catholic Relief Services
CSO	Civil Society Organization
DOTS	Direct Observation Treatment-Short
EMM	Eastern Mennonites Missions Cambodia
FHI360	FHI360
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
H&H	Human and Health
HC-DOTS	Health Center-Direct Observation Treatment-Short course
HEAD	Health and Development Alliance
HPA	Health Poverty Action
HSD	Center for Health and Social Development
INGO	International Non-Governmental Organization
IPHIA	Indigenous People Health Improvement Association
JATA	Japan Anti-Tuberculosis Association
JICA	Japan International Cooperation Agency
KAP	Key Affected Population
LNGO	Local Non-Governmental Organization
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant TB
MoH	Ministry of Health
MTI	Medical Teams International
NGO	Non-Governmental Organization
NTP	National Tuberculosis Control Programme
OP.ASHA	Operation ASHA
PHD	Provincial Health Department
Pro-TWGH	Provincial Technical Working Group on Health
RACHA	Reproductive and Child Health Alliance
RHAC	Reproductive Health Association of Cambodia
SHCH	Sihanouk Hospital Center of HOPE
TB	Tuberculosis
USAID	US Agency for International Development
US-CDC	USA-Center for Disease Control and Prevention
VHSG	Village Health Support Group
WHO	World Health Organization



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EXECUTIVE SUMMARY

Background

Cambodia remains one of the thirty countries with high burden of tuberculosis (TB) though it has made great strides in TB control. The incidence and prevalence rates of all forms of TB have significantly declined. The country has achieved the Millennium Development Goal (MDG) targets to halve TB deaths and prevalence by 2015. Under the National Tuberculosis Control Program (NTP), considerable achievements have been made. In the last 15 years, TB cases notified under NTP increased dramatically. The cure rate has been maintained over 90% for the last decade. The progress in TB responses has been largely thanks to the implementation of directly observed treatment, short-course (DOTS), particularly at community level.

TB responses have extended to other activities and avenues, including TB/HIV activities, TB-in-prison programs, and multidrug-resistant TB (MDR-TB) treatment sites. Infrastructure-wise, TB control is far-reaching, with TB services being provided at all referral hospitals (RHs) at provincial and operational district (OD) levels and at all health centers (HCs). Cambodia is also well-directed with policies, strategies and plans to end TB.

Nonetheless, the accomplishments in TB control could be jeopardized by the challenge of shrinking funding. To eliminate TB by 2030, it is pivotal to maintain the momentum of current activities and expand services, especially to vulnerable groups. However, there are huge financial gaps in the present and future funding apparatuses. In the face of dwindling budget, experience elsewhere depicts that community

resource mobilization could offer an alternative for sustaining community-level activities to fight TB. Moreover, building and sustaining networks of civil society organizations (CSOs) that raise vital TB-related issues at national level, represent, support, and are accountable to communities is a stepping stone for successful engagement with stakeholders at various levels.

This study addressed the following objectives:

- ❖ To map the existing civil society and community organizations working on TB in Cambodia, including geographic regions, service areas, and vulnerable population coverage.
- ❖ To identify in the existing networks geographic gaps, service area gaps, and vulnerable population coverage gaps.
- ❖ To describe possible barriers to the effective collaboration of the existing networks in engaging in the national TB response.

Methods

This study employed semi-structured interviews with one national institution, one donor agency, one TB patient representative, 15 TB-active NGOs including eight international NGOs (INGOs) and seven local NGOs (NGOs), and two TB-inactive local NGOs. The interviews were conducted in their offices in late May to late June 2016. The NGO participants were selected based on information provided by the National Center for Tuberculosis and Leprosy Control (CENAT). Interview responses were recorded and noted down, transcribed, read, and deducted into

categories. Thematic analysis was conducted to identify emerging themes, which were reviewed to examine common patterns across the responses. The preliminary findings were presented and verified at a consultative meeting with the interviewees.

Results

Currently, there are 15 NGOs (eight INGOs and seven LNGOs) working on TB in Cambodia. There are many NGOs that have no funding to continue their TB programs. The major funding sources for the National TB Program (NTP) managed directly and indirectly by CENAT comprise the government, Global Fund (GF), and USAID. CENAT was the principal recipient of GF and five NGOs were sub-recipients of this fund. Moreover, two NGOs received funding from USAID under Challenge TB Project. US-CDC provided financial support and equipment as well as lab technical support to CENAT and referral hospitals (RHs).

There exist coordination mechanisms at various levels. At the national level, the coordination mechanism for actors working on TB encompasses a TB Annual Conference and Sub-Technical Working Group for TB Control (Sub-TWG). Under this Sub-TWG, there were specialty working groups such as on MRD, Diabetes and TB in prisons. At subnational and local levels, there were monthly meetings on general health issues at provincial health department (PHD) (Pro-TWGH) and OD levels. Nonetheless, there were no regularly-scheduled meetings specifically on TB at PHD and OD levels. There were bi-monthly meetings on TB at HC level as well.

This assessment identified some geographic, service area, and vulnerable population gaps. Geographic gaps included big HC and OD coverage that could not be reached by inadequate numbers of NGO and HC staff responsible for TB work, long distance from screening places in the villages and HCs to RHs, and limited coverage in

highland or north-east areas.

Concerning service area gaps, inadequacy of community screenings and active case findings was salient. Moreover, lack of consultation and treatment support at some HCs and RHs was pointed out. Another gap was limited data collection on the number of 0-5 year-old children, who may be at risk in terms of infection from adults. Further, lack of TB programs in commune councils' development plans was highlighted as a challenge for expanding coverage to rural areas and initiating ownership of and commitment to TB programs by local authorities. Some NGO informants revealed that they experienced late budget approval by donors, which made them achieve outcomes below the targets. Also, they encountered budget holding by donors, which disrupted their implementation plan and retarded their target achievement. Some other NGOs faced decline in external funding, which reduced their activities. Finally, absence of evaluation of TB projects by implementing NGOs was raised as a bottleneck for systematic learning and improvement regarding TB services provided at community level.

A number of barriers that limited vulnerable population coverage were identified by the informants. First, some patients, especially indigenous peoples, did not trust public health facilities and still used traditional medicines to treat their disease at home. Second, although currently TB programs are widely implemented in prisons, there was a need for better participation from health professionals to improve the quality of services. Third, only one LNGO worked with garment factory workers to prevent and treat TB at 14 factories. Fourth, the treatment approach made some patients receive late treatment, and lost some others due to their migration to other areas. Migrants were also hard to be reached by NGO programs since they were quite mobile. Some patients were poor and too busy working

to earn a living to go for treatment. Finally, in many villages, elderly persons rarely came to receive consultation and treatment services if they had the disease.

The study pinpointed that collaboration and coordination among institutions working on TB should be strengthened in various facets. First, the non-existence of a TB network or coordination institution for NGOs and community-based organizations (CBOs) barred the implementers and policy makers from sharing their work plans and synergistically tackling hindrances. Second, there were no regularly-scheduled meetings specifically on TB at PHD and OD levels. Bi-monthly or quarterly meetings on TB at HC level were irregular due to unpredictable funding and availability of members. Third, there was poor communication between RH and NGO staff and village health support group (VHSG), which did not smooth medicament and contact with patients.

This loophole was compounded by lack of a patient database system, which could track patients for medicament monitoring and adherence enforcement. Moreover, migration of VHSG (and patients) to other areas contributed to the difficulty in maintaining the existing work relationships between these community workers and health personnel. Fourth, high HC staff and VHSG turnover was also a key barrier to effective collaboration.

Further, new HC staff and VHSG were not recruited and trained on time, which at times blocked ongoing activities. Notably, commitment and capacity of HCs was pointed out as a major hindrance to community mobilization and outreach. Fifth, limited participation and contribution by commune authorities hampered intuitional collaboration and area coverage at the grassroots level.

Better participation from village, commune and district authorities was required and needed to be institutionalized. Finally, lack of equipment (such

as X-pert and X-ray machines) and maintenance capacity at some ODs and RHs slowed down consultation, examination and treatment processes, which demotivated key stakeholders (specifically VHSG and patients) to dodge the processes.

Conclusions and Recommendations

This assessment concedes that despite making great strides in fighting TB, concerned institutions need a more concerted synergy to stop the disease as planned. Cambodia's strengths to end TB lie in the firm political will and precise policies, strategies and guidelines supportive for better institutional collaboration. Moreover, the existing institutions have strong fundamental infrastructure, capability and experience. Since NGOs are active in many rural areas, integrating a TB component into programs of those non-active in TB would expand the coverage and bolster early diagnosis, treatment and prevention. Potential also manifests in decentralizing TB programs in mainstream institutions at local level, such as "Fast Track" mechanism at HCs and inclusion of TB programs in Commune Investment Plans (CIPs).

Nonetheless, challenges exist at various levels. First, there is a clear need to have an institutional network or mechanism that can pool TB stakeholders together on a regular basis to discuss shared difficulties and endorse joint solutions. Second, work flow and communication among subnational and local players need to be refined. Third, there is a need for a centralized patient database system to enhance adherence and monitoring of patients and the connection between patients and health care providers given the frequent turnover and migration of local health staff and patients. Fourth, strengthening health staff's morale and professionalism through proper incentive and capacity development will address the turnover issue, boost the quality of services and expand the coverage areas. Finally, improving the availability of equipment and maintenance capacity

of staff will expedite consultation, diagnosis and treatment services, and subsequently better attract and retain patients.

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Keywords: Tuberculosis (TB), National response, Civil society organizations, Communities, Gaps, Barriers, Networks, Cambodia



Interview with CHC staff



Interview TB patient who received treatment at home

1. INTRODUCTION¹

Cambodia is one of the thirty countries with high-burden tuberculosis (TB) though it has made great strides in TB control (WHO, 2016a). In 2014, the incidence and prevalence rates of all forms of TB were 390/100,000 (about 60,000 cases per year) and 668/100,000 (a decline from 1670/100,000 in 1990), respectively. The country has achieved the Millennium Development Goal (MDG) targets to halve TB deaths and prevalence by 2015. The death rate was 58/100,000 in 2014, decreasing from 157/100,000 in 1990. However, TB in children increased from 1,600 cases in 2007 to 6,857 cases in 2015 (Tieng, 2016). HIV seroprevalence among TB patients soared from 2.5% in 1995 to 11.8% in 2003, but declined to 6.3% in 2009, yet constituting a significant TB/HIV co-epidemic.

Under the National Tuberculosis Control Program (NTP), considerable achievements have been made (Tieng, 2016). In the last 15 years, TB cases notified under NTP were 531,361 for all forms and 251,543 for smear positive. Cases notified have been stable, with 39,055 for all forms and 14,082 for smear positive in 2013 and 35,638 for all forms and 10,280 for smear positive in 2015. The cure rate has been maintained over 90% for the last decade. The progress in TB responses has been largely thanks to the implementation of directly observed treatment, short-course (DOTS), particularly at community level. DOTS started in 1994, but until 1998 DOTS services were available only at hospital level. DOTS at health centers (HC-DOTS) commenced in 1999, but massive HC-DOTS expansion started in late 2001 and by the end of 2004 all HCs had DOTS services. Cases notified have increased drastically since the start of HC-DOTS expansion.

Community DOTS (C-DOTS) began in 2002; and 861 HCs practiced C-DOTS in 2015, an increase from 503 HCs in 2008.

TB responses have extended to other activities and avenues. TB/HIV activities started in 2003; and currently all 92 operational districts (ODs) have TB/HIV services, rising from 74 ODs in 2008. The percentage of referral cases from both TB and HIV have increased from 40% in 2007 to over 80% in 2015. TB-in-prison programs, which commenced in 2005, are presently active in 26 prisons. There are 11 treatment sites for multidrug-resistant TB (MDR-TB), which started in 2006. MDR-TB cases shored up from 56 in 2011 to 75 in 2015; but, the number declined significantly during this period. In 2013 and 2014, the cases were 121 and 110, respectively.

Infrastructure-wise, TB control is far-reaching. At the national level, under the National Center for Tuberculosis and Leprosy Control (CENAT), the NTP has a Technical Bureau armed with 30 staff, a Referral TB/Chest Hospital with 130 beds, and a National TB Reference Laboratory. At the provincial level, all Provincial Referral Hospitals have TB services. At the OD level, all Referral Hospitals (RHs) and HCs provide TB services, 215 HCs are equipped with TB microscopes, and 861 HCs serve C-DOTS.

Cambodia is also well-directed with policies, strategies and plans to end TB. The goal of the NTP is to “contribute to improving the health of the Cambodian people in order to contribute to socio-economic development and poverty reduction in Cambodia by reducing the morbidity and the mortality due to TB” (Ministry of Health (MoH), 2010, p.7). This goal is corroborated by concrete

¹ This section is mainly from WHO (2016a) and Tieng (2016).

objectives “to ensure equity and universal access to quality TB services, maintain a high cure rate..., and reduce the prevalence of TB and death due to tuberculosis...” The National Health Policies and Strategies for TB Control 2011-2015 (MoH, 2010) and the National Health Strategic Plan for Tuberculosis Control 2011-2015 (MoH, 2011) are fine-tuned, mutually articulated, and technically aligned with the National Health Strategic Plan 2008-2015 and the Stop TB Global Strategies and Plan 2006-2015. The National Health Policies and Strategies for TB Control 2011-2015 provide precise and interactive guideposts with seven policy statements and about 50 strategic directions.

Nonetheless, the accomplishments in TB control could be jeopardized by the challenge of shrinking funding (Tieng, 2016). To eliminate TB by 2030, it is pivotal to maintain the momentum of current activities and expand services, especially to vulnerable groups. Put another way, this requires resources to maintain and increase the TB control infrastructure, including lab equipment and capacity, anti-TB drugs, diagnostic supplies, and professionals’ capacity upgrading. However, there are huge financial gaps in the present and future funding apparatuses. To exemplify, the budget for core/basic NTP activities needed for 2014-2020 is about USD 30 million per year. But, the current funding in 2016 is at around USD 11 million, including budgets from the government and development partners. Specifically, in 2015 the NTP required USD 31 million for its activities, but only 59% of the budget was funded (WHO, 2016b). Out of this funding, 47% was international and only 12% was domestic (from the government). The major donor is Global Fund to Fight AIDS, TB and Malaria (GFATM), which has committed to USD 15.66 million for 2015-2017 programs.

In the face of dwindling budget, experience elsewhere depicts that community resource

mobilization could offer an alternative for sustaining community-level activities to fight TB (WHO, 2007; CORE Group TB Working Group, 2013). Moreover, building and sustaining networks of civil society organizations (CSOs) that raise vital TB-related issues at national level, represent, support, and are accountable to communities is a stepping stone for successful engagement with stakeholders at various levels (WHO, 2016c). This is consistent with the “ABCs” (advocacy, baseline preparedness, and coordination and collaboration) of the “End TB Strategy” (WHO, 2016d).

This study mapped out civil society stakeholders working on TB in Cambodia and examined interactions of their activities with one another. The focus was on identifying their geographic, service, and vulnerable population coverage gaps, and on exploring ways for better coordination and collaboration to address these gaps. The findings of this study will be used to devise an engagement plan to establish a network of civil society and community organizations that will make a more effectual contribution to ending TB in Cambodia by 2030. This assessment is part of Stop TB Partnership’s Challenge Facility for Civil Society (CFCS), which supports meaningful engagement of CSOs in activities aimed at TB elimination.

Concretely, the objectives of this study were:

- ❖ To map the existing civil society and community organizations working on TB in Cambodia, including geographic regions, service areas, and vulnerable population coverage.
- ❖ To identify in the existing networks geographic gaps, service area gaps, and vulnerable population coverage gaps.
- ❖ To describe possible barriers to the effective collaboration of the existing networks in engaging in the national TB response.

2. METHODS

2.1. Sampling

This study employed semi-structured interviews with one national institution, one donor agency, one TB patient representative, 15 TB-active NGOs including eight international NGOs (INGOs) and seven local NGOs (LNGOs), and two TB-inactive LNGOs. The NGO participants were selected based on information provided by CENAT. According to CENAT, there were 15 NGOs (eight INGOs and seven LNGOs) currently implementing TB programs in Cambodia. Thus, these 15 TB-active NGOs were chosen to partake in the study. There were many NGOs that had no funding to continue their TB programs. Therefore, two TB-inactive LNGOs were selected for interviews to find out their past activities. The selected NGOs had their programs in Phnom Penh, Siem Reap, Stung Treng, Ratanakiri, Mondulakiri, Prey Veng, and Kampong Speu provinces.

2.2. Data Collection Tools

Research tools were developed by CFCS. The research team adapted the tools and devised prompt questions in response to the objectives of each part of the tools in order to garner comprehensive and context-specific responses. The tools and questions were translated into Khmer by the research team. A pre-test of the tools was conducted with two LNGOs.

2.3. Data Collection Procedure

The interviews were conducted in late May to late June 2016. The data collection procedure

comprised four steps. First, the researchers contacted the selected organizations to identify the responsible staff for the interviews. Second, the researchers introduced the assessment goal and objectives to the interviewees and made interview appointments with them. Third, the researchers conducted the interviews at the interviewees' offices. The interviews were recorded and noted down by the researchers. Finally, the researchers emailed or called the interviewees to clarify incomplete data or request additional information after the interviews.

2.4. Data Analyses

Interview responses were transcribed, read, and deducted into categories. Thematic analysis was conducted to identify emerging themes, which were reviewed to examine common patterns across the responses. The preliminary findings were presented and verified at a consultative meeting with the interviewees.

2.5. Ethical Considerations

Interviews were conducted in private venues (i.e. the interviewees' offices). The researchers explained the assessment goal and objectives to the interviewees and sought their agreement to participate in the study. Verbal informed consent was obtained from the interviewees before the interviews commenced. Individual identities of the interviewees and their organizations were not revealed in the analyses of the study.

3. RESULTS

3.1. Key actors working on TB

The major funding sources for the NTP comprise the government, Global Fund (GF), USAID (including TBCARE and Challenge TB), US-CDC, WHO, JICA/JATA, and others (including TBREACH and NGOs) (Tieng, 2016). Based on our interviews, CENAT was the principal recipient of GF and five NGOs (RHAC, OP.ASHA, HPA, CHC, and CRS) were sub-recipients of this fund (see Figure 1). Two NGOs (FHI360 and RACHA) were recipients of USAID funding under Challenge TB Project. Through CENAT, NGOs submitted their proposals to the Country Coordination Mechanism (CCM) that assessed and approved

funding for these proposals in consultation with CENAT. CCM is composed of representatives each from CENAT, LNGOs, INGOs, donors, and TB patients.

Some NGOs (including CRS, CARITAS, MTI, OP.ASHA, and EMM) had some complementary TB fund from their headquarters. Diabetes Foundation funded an LNGO (HSD). An INGO (FHI360) funded CATA. US-CDC provided financial support (operational cost) and equipment (such as X-pert and X-ray machines) as well as lab technical support to CENAT and RHs.

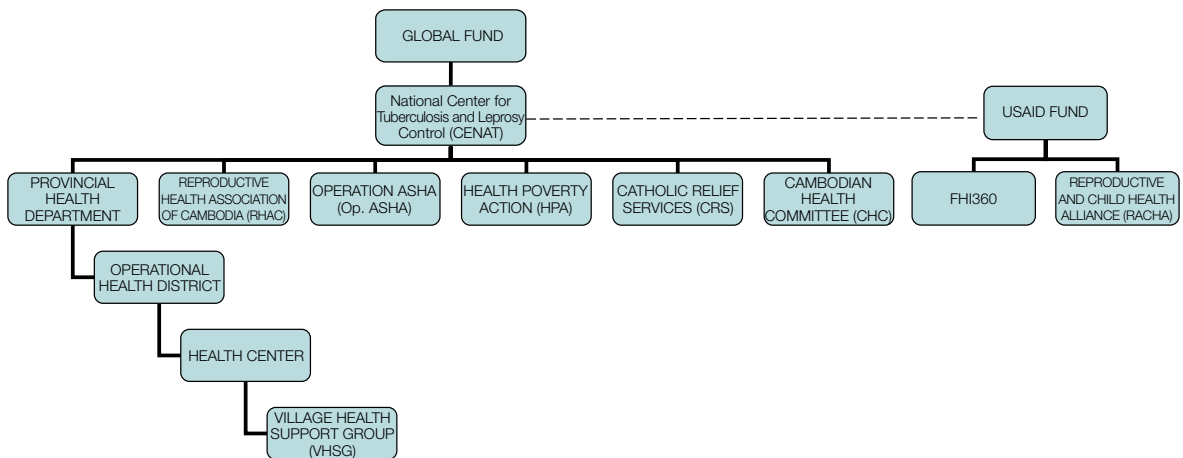


Figure 1: TB Funding Flow at National Level

Note: All NGOs working on TB worked with PHDs, ODs, HCs, and VHSG

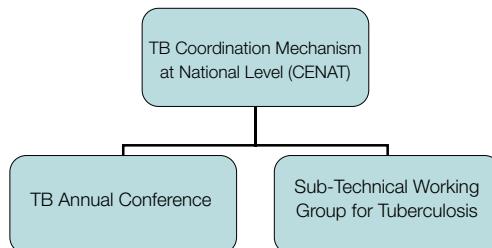


Figure 2: TB Coordination Mechanism at National Level

At the national level, the coordination mechanism for actors (government institutions, NGOs and donors) working on TB encompasses a TB Annual Conference and Sub-Technical Working Group for TB Control (Sub-TWG). At the TB Annual Conference, country-wide progress, experiences, challenges, and solutions are shared, discussed, and assessed. The Sub-TWG meets quarterly to update activities, discuss issues, and propose actions among members. Under this Sub-TWG, there were specialty working groups such as on MRD, Diabetes and TB in prisons, which also convenes monthly or quarterly.

At subnational and local levels, there were monthly meetings on general health issues at provincial health departments (PHD) (Pro-TWG) and OD levels. Health-related NGOs could partake in Pro-TWG meetings to share and discuss their activities. But, if NGOs wanted to attend OD-level meetings, they needed to request it to the OD director. Nonetheless, there were no regularly-scheduled meetings specifically on TB at PHD and OD levels. There were bi-monthly or quarterly meetings on TB at HC level, where NGOs working in the HC area could join. However, these HC-level meetings were irregular due to unpredictable funding and availability of members.

3.2. Geographic gaps

The key geographic gaps mentioned by the interviewees included large area coverage by HCs and ODs, long distance from screening places to referral hospitals, and limited coverage in highland or north-east areas. Many ODs cover many HCs, which are mandated to serve many villages. Only one NGO staff is responsible for one OD, which over-stretches their capacity to monitor the work. There were only two personnel at each HC responsible for TB. The shortage of staff working on TB were also common at ODs (only one staff), PHDs (only two staff, one responsible for laboratories and the other responsible for programs), and in villages (only two VHSG, one male and one female, in a village).

“ NGO staff cannot sufficiently reach their target areas. For instance, in Oddor Meanchey province there are over 30 HCs and there is only one responsible staff. It means it takes two months to visit these HCs...Based on good practices, a staff should be responsible for only 4-5 HCs. One staff responsible for one OD is too difficult. One OD covers 2-3 administrative districts and in some cases a whole province.” - INGO informant

The lack of NGO and HC staff left some coverage areas inadequately followed up and implemented. Moreover, long distance from screening places in the villages and HCs to RHs discouraged VHSG to bring potential patients' sputum for examination at the RHs. The long distance also demotivated VHSG to regularly go to take medicines from HCs for patients. Finally, some informants pinpointed that due to remoteness many villages in highland or north-eastern provinces could not be reached by NGO and HC staff, leaving patients there un-monitored or un-treated. National strategies, such as 2016-2020 Health Strategic Plan, could not apply common blueprints to the north-eastern areas since they are characterized differently in terms of geography and people, which require tailor-made and context-specific approaches. There was a call for adjusting the strategy of TB national response to focus on these hard-to-reach areas and small NGOs working there.

“ I think there should be a refined national policy to aid north-eastern areas to catch up with the others in terms of financial and human resources (for fighting TB)...We small NGOs are difficult to seek fund to work on TB... But we have 4-10 years of work expertise and local knowledge...” - LNKO informant

Some NGO informants indicated that NGOs were active in many rural areas, but many of them did not work on TB. So, it was hard to collaborate with them to reach target areas with difficult access. They said incorporating TB activities into programs of NGOs not working on TB would enhance resource mobilization to increase the coverage in rural areas.

3.3. Service area gaps

Concerning service area gaps, inadequacy of community screenings and active case findings was salient. NGO informants emphasized a need to increase screenings and case findings at community level, particularly by VHSG. For instance, according to an LNGO informant in Rattanakiri province based on estimated TB incidence in comparison to population, there should be 380 cases found per year in the province. But, only 115 cases have been identified in the province annually. This may be due to VHSG's limited capacity and high workload as will be discussed later. Nevertheless, a barrier to symptom diagnosis concerned lack of a fluid system that linked the national program to the sub-national and community entities in some areas. For example, the linkage between community DOTS (C-DOTS), and laboratories was not sufficiently responsive, meaning laboratories could not test all cases submitted by VHSG.

“In communities, we encouraged VHSG to find 20-30 (sputum) cases per village. But when we sent them to laboratories, they examined only ten cases, and at some laboratories they could not admit the cases.”
- LNGO informant

This inadequate examination particularly occurred at RHs where there was only one X-pert machine per RH (or province). This machine examined only sputum from key affected population or high-risk people (such as TB/HIV patients, TB/diabetes

patients, family members and close contact of a TB patient, and 55+ year-old people), and could examine only 12 cases per day. At times, lab staff used this machine to examine other cases such as MDR, TB/HIV, and TB/diabetes, which took time away from examining TB sputum cases. In some provinces, the X-pert machines were broken, and lab staff lacked capacity to maintain the machines. Limited storage facility for sputum at RHs also hindered the optimal examination of cases. At HCs, staff used microscopes to examine sputum cases; but, the process was slow, and staff also used the microscopes for other purposes. Moreover, only quality sputum was examined, meaning not all cases were examined by RH and HC staff. Sometimes, VHSG submitted low-quality sputum that was rejected by RH or HC staff. However, according to some NGO informants, during the Global Fund Round 7 (which ended in 2014) RH and HC lab staff had been given 1 USD per examined case by partner NGOs, and more cases had been examined by the staff.

Moreover, lack of consultation and treatment support at some HCs and RHs was pointed out. Some NGO informants mentioned that patients experienced insufficient consultation service at HCs, especially difficulty in meeting with health staff. Treatment service at RHs was indicated as lacking in symptom examination (e.g. not all sputum samples were checked and if checked, not examined in a timely manner) and follow-up with patients (e.g. irregular monitoring due to absence of patient database). “Fast Track” sputum diagnosis for at-risk population at HCs was suggested as a more efficacious way to diagnose and treat patients.

Another gap was limited data collection on the number of 0-5 year-old children, who may be at risk in terms of infection from adults. National data covered 0-4 year-old children, but NGOs collected data for 0-5 year-old children for their programs. Thus, this gap presented a challenge for NGOs in collecting the required data.

Further, lack of TB programs in commune councils' development plans was highlighted as a challenge for expanding coverage to rural areas and initiating ownership of and commitment to TB programs by local authorities. Some NGO informants revealed that they experienced late budget approval by donors, which made them achieve outcomes below the targets. Also, they encountered budget holding by donors, such as in times of checking irregular travel allowances and approving travel plans late, which disrupted their implementation plan and retarded their target achievement. Some other NGOs faced decline in external funding, which reduced their activities, such as from conducting active case findings annually to every three years. Finally, absence of evaluation of TB projects by implementing NGOs was raised as a bottleneck for systematic learning and improvement regarding TB services provided at community level.

3.4. Vulnerable population coverage gaps

A number of barriers that limited vulnerable population coverage were identified by the informants. First, some patients, especially indigenous peoples, did not trust public health facilities and still used traditional medicines to treat their disease at home. Thus, this cohort was left out of the national response system.

“Another issue is that they (people) do not trust public health services. Till after we have explained to them several times, and they have learnt that TB patients have come to receive services, they trust. For them, they do not trust public health services since they think that state hospitals are slow and provide little medicines that cannot cure their disease... They prefer private services since they are smiled at and given lots of medicines that can treat their sickness rapidly...”
- LNGO informant

Second, before 2005, inmates were not serviced since there were no TB programs implemented in prisons. However, currently TB programs are widely implemented in prisons, involving PHD, OD, RH and HC staff. However, there was a need for better participation and commitment from these professionals to improve the quality of services. According to an LNGO, health post officers and prison directors were willing to cooperate with health professionals since they regularly attended NGOs' annual TB meetings. Third, only one LNGO worked with garment factory workers to prevent and treat TB at 14 factories. The work with garment factory workers encountered some difficulties, such as un-cooperation from them during busy production periods and disruption of cooperation in times of change in line managers. Hence, this population was under-reached given their sheer size in the industry and their working conditions that are conducive to TB exposure and endemic. Fourth, the treatment approach made some patients receive late treatment, and lost some others due to their migration to other areas. Some NGOs had different teams to monitor case findings and to ensure that cases were admitted and treated at HCs or RHs. When the latter team was late to follow up, the cases got lost or treated so late. Migrants were also hard to be reached by NGO programs since they were quite mobile. At times, it took half to one month to make an appointment with patients for follow-up. Some patients were poor and too busy working to earn a living to go for treatment. They did not perceive TB as a severe illness since it did not immediately affect their health from the outset. Thus, they prioritized earning income over seeking treatment.

“...In grassroots communities, people think their job is more important than their illness. They stand for their disease and do not seek treatment if it is not serious. They think if they cannot earn money this week, they will die next week. With TB, they are slightly ill every day, not like malaria, which does not frighten them...”
- INGO informant

Finally, in many villages, only elderly persons (especially grandmas taking care of grandchildren) remained since adult family members had migrated to work. These elderly rarely came to receive consultation and treatment services if they had the disease.

3.5. Barriers to effective collaboration

The respondents by and large agreed that collaboration and coordination among institutions working on TB should be strengthened in various facets. First, the non-existence of a TB network or coordination institution for NGOs and CBOs barred the implementers and policy makers from sharing their work plans and synergistically tackling hindrances. Many NGOs did not know activities of other NGOs working in the same community areas, particularly on non-TB projects. This shortage of knowledge made them unable to collaborate with those that provided health-related services in case they wanted to refer TB patients to them. Second, there were monthly meetings on general health issues at PHD (Pro-TWG) and OD levels. Health-related NGOs could partake in Pro-TWG meetings to share and discuss their activities. But, if NGOs wanted to attend OD-level meetings, they needed to request it to the OD director. Nonetheless, there were no regularly-scheduled meetings specifically on TB at PHD and OD levels. There were bi-monthly or quarterly meetings on TB at HC level, where NGOs working

in the HC area could join. Notwithstanding, these HC-level meetings were irregular due to unpredictable funding and availability of members. The NGO respondents also unveiled that they did not hold adequate meetings with their peers, HCs and commune authorities to discuss and update their TB activities.

Third, on the ground, some respondents stated that there was poor communication between RH and NGO staff and VHSG, which did not smooth medicament and contact with patients. For instance, VHSG could submit sputum cases of key affected populations directly to RHs although it seldom occurred (about once a month). However, they were not confident enough to contact RH staff despite HC staff facilitated their communication. Moreover, when VHSG did not come to get medicines for patients from a HC or RH, it was difficult to follow up with patients. Only two LNGOs provided a mobile phone and free credit, the main contact means between VHSG and NGO staff, to VHSG for communicating their work. However, due to over-loaded work on the part of VHSG, they often encountered disconnection. Inadequate budget support for communication, transport and meetings was cited as the prime reason for this fragmentation.

This loophole was compounded by lack of a patient database system, which could track patients for medicament monitoring and adherence enforcement. Moreover, migration of VHSG (and patients) to other areas contributed to the difficulty in maintaining the existing work relationships between these community workers and health personnel. Fourth, high HC staff and VHSG turnover was also a key barrier to effective collaboration. According to one LNGO, annually about 10% to 20% of HC staff and 50% of VHSG were turned over. This was exacerbated by limited and overloaded capacity of HC staff and VHSG coupled with their low incentive for work. Many VHSG also worked as a focal point for non-health (such as education, environment and human

rights) projects in their villages. Some of them served as DOTS watchers as well. Moreover, due to difficulty in recruiting VHSG, some village heads and deputy heads performed as VHSG.

“VHSG do not have cash incentive (from the government), so they do not fully commit to their work. But since they are in the health system, they have to work. They receive incentive (travel allowance) at different rates from various NGOs and they have lots of tasks to do, so they partake only with NGOs that offer much incentive...”
- LNGO informant

Further, new HC staff and VHSG were not recruited and trained on time, which at times blocked ongoing activities. The processes for recruiting and training new VHSG were lengthy, involving village meetings and approval by CENAT. Moreover, many VHSG were elderly people with low education level, who took time to learn new stuff. Thus far, the NTP has never provided TB training to NGO staff, and NGOs alone are ineligible to conduct TB training to VHSG at community level. Only HCs, with guidance from CENAT, can offer TB training with NGO staff as co-trainers to VHSG based on the TB national guideline.

Notably, commitment and capacity of HCs was pointed out as a major hindrance to community mobilization and outreach. Some HCs could not mobilize enough villagers for meetings to raise awareness and discuss progress of activities. For example, a HC had 29 villages in its coverage; but, only representatives from 19 villages attended meetings. HC staffs were inadequately committed due to lack of monetary incentive.

“We need better commitment and participation from HC staff. Thus far, our personnel have done almost everything. We need their participation because we are merely their aid; we want them to lead us, not vice versa...”
- LNGO informant

Fifth, limited participation and contribution by commune authorities hampered intuitional collaboration and area coverage at the grassroots level. As afore-mentioned, TB programs were not incorporated into commune councils' development plans, an indication of lack of institutional buy-in. The NGO informants mentioned that commune authorities seldom attended their meetings. If TB programs were included in commune councils' development plans and executed by the Commune Health Committee, such costs as related to travel allowances for patients and VHSG, patient referrals and associated meetings, could be covered in commune investment plans (CIPs). In this way, commune councils would own and account for TB programs, and the programs themselves would be sustainable in the absence of such external agencies as NGOs and development partners.

Better participation from village, commune and district authorities was required and needed to be institutionalized. There was a suggestion to establish a “TB Committee” that would encompass these local authorities and relevant stakeholders so that regular meetings could be held to discuss challenges and explore collective remedies regarding TB programs. Moreover, the existing health coordination mechanisms of diabetes, HIV and AIDS and maternal and child health needed to be better cemented among themselves and with the would-be “TB Committee” since these mechanisms are intertwined disease- and population-wise.

Finally, lack of equipment (such as X-pert and X-ray machines) and maintenance capacity at some ODs and RHs slowed down consultation, examination and treatment processes, which demotivated key stakeholders (specifically VHSG and patients) to dodge the processes. To exemplify, as mentioned above, not all sputum samples were checked and/or diagnosed in a timely fashion, which according to some NGO informants discouraged VHSG to collect sputum from potential patients.

Limitations of the Study

This study captured the views of only one national institution, one donor agency, one TB patient representative, and a number of NGOs suggested by CENAT. There are other donor agencies and NGOs working on TB that were not consulted. Moreover, such other stakeholders as PHDs, ODs, RHs, HCs, VHSG, and village and

commune authorities were excluded from the study. Thus, the findings should be interpreted in light of these limitations. However, we believe that these organizational participants were the chief players working closely with the NTP, therefore rendering insights from their standpoints as CSOs working actively and directly with local communities to eliminate TB in Cambodia.



Discussion on the results of field assessment



Sharing of field assessment results

4. CONCLUSION AND RECOMMENDATIONS

This assessment concedes that despite making great strides in fighting TB, concerned institutions need a more concerted synergy to stop the disease as planned. There are both opportunities and challenges for improving joint efforts to tackle TB in a more effectual manner. Cambodia's strengths to end TB lie in the firm political will and precise policies, strategies and guidelines supportive for better institutional collaboration. Moreover, the existing institutions (both state and non-state actors) have strong fundamental infrastructure, capability and experience, which can be scaled up collectively. There are already health-related institutional coordination mechanisms that can be learnt from in order to forge an institutional synergy for TB stakeholders. Since NGOs are active in many rural areas, integrating a TB component into programs of those non-active in TB would expand the coverage and bolster early diagnosis, treatment and prevention. Potential also manifests in decentralizing TB programs in mainstream institutions at local level, such as "Fast Track" mechanism at HCs and inclusion of TB programs in CIPs.

Nonetheless, challenges exist at various levels. First, there is a clear need to have an institutional

network or mechanism that can pool TB stakeholders together on a regular basis to discuss shared difficulties and endorse joint solutions. This network can be capitalized on other health-related alliance mechanisms that perform well. Second, work flow and communication among subnational and local players (RHs, ODs, HCs, VHSG and NGOs) need to be refined. It is hoped that with a TB coordination entity such relations will be improved. Third, there is a need for a centralized patient database system to enhance adherence and monitoring of patients and the connection between patients and health care providers given the frequent turnover and migration of local health staff and patients. A database system for poor patients under Health Equity Fund could be a good model. Fourth, strengthening health staff's morale and professionalism (particularly HC staff and VHSG in remote service areas) through proper incentive and capacity development will address the turnover issue, boost the quality of services and expand the coverage areas. Finally, improving the availability of equipment and maintenance capacity of staff (especially at RHs and ODs) will expedite consultation, diagnosis and treatment services, and subsequently better attract and retain patients.

5. REFERENCES

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6. ANNEXES

Annex 1: Interview Guide

ឈ្មោះអង្គការ៖ Name of Organization:
ទីតាំងរបស់អង្គការ៖ Location of the organization:
បុគ្គលិកទំនាក់ទំនង៖ Contact person at the organization:
អាស័យដ្ឋានលំអិត៖ Organization contact details:
កាលបរិច្ឆេទ៖ Appointment date:
ពិពណ៌នាអំពីការងាររបស់អង្គការ (សួរផ្ដោតលើព័ត៌មានទៅតាមផ្នែកខាងក្រោម) Description of organization's work (specifically ask the org to provide information in the following areas)

ផ្នែកសេវា

Services

1) សកម្មភាពជុំវិញការស្វែងរកការគាំទ្រ និងការត្រួតពិនិត្យគរសម្លេង (ឧ. បញ្ចុះបញ្ជូលរដ្ឋាភិបាល)
 Enabling environment and advocacy (i.e. lobbying the government)

➤ តើអង្គការអ្នកបានធ្វើសកម្មភាពអ្វីខ្លះដើម្បីស្វែងរកការគាំទ្រនៅលើកម្មវិធីរបស់អង្គការ?
 Have you ever done any advocacy activities in your TB program?

i. ផ្នែកអ្នកផ្តល់សេវា (ចម្លើយរំពឹងទុក)
 Supply site: (Expected answers)

- សិក្ខាសាលាតម្រង់ទិស
 Project orientation workshop
- កិច្ចប្រជុំប្រចាំខែជាមួយបុគ្គលិកមណ្ឌលសុខភាព ការិយាល័យស្រុកប្រតិបត្តិ អំពីការផ្តល់សេវា ការគ្រប់គ្រងឱសថ និងបញ្ហាពាក់ព័ន្ធផ្សេងទៀត
 Monthly meeting with HC and OD staff on service delivery, drug management, or any relevant other issues.
- ចែករំលែកនូវរបាយការណ៍ប្រចាំត្រីមាស ប្រចាំឆ្នាំ និងឯកសារពាក់ព័ន្ធដទៃទៀត (របាយការណ៍វាយតម្លៃគម្រោង របកគំហើញថ្មីៗតាមរយៈការស្រាវជ្រាវ.....។ល។
 Sharing quarterly and annual report and other related documents (evaluation reports, other research findings,...etc.)
- កិច្ចប្រជុំប្រចាំត្រីមាសជាមួយបុគ្គលិកមណ្ឌលសុខភាព ការិយាល័យស្រុកប្រតិបត្តិ អំពីការផ្តល់សេវា ការគ្រប់គ្រងឱសថ និងបញ្ហាពាក់ព័ន្ធផ្សេងទៀត
 Quarterly meeting with HC and OD staff on service delivery, drug management, or any relevant other issues.

5. ព្រឹត្តិការណ៍ ឬយុទ្ធនាការផ្សេងៗដែលចូលរួមរៀបចំដោយបុគ្គលិកមណ្ឌល ការិយាល័យស្រុកប្រតិបត្តិ និងមន្ត្រីមន្ទីរសុខាភិបាល និងអ្នកពាក់ព័ន្ធផ្សេងទៀត.....។ល។
Events or campaigns involving HC, OD, and PHD staff; relevant stakeholders.....etc.
6. កិច្ចប្រជុំជាមួយបុគ្គលិកមណ្ឌល ការិយាល័យស្រុកប្រតិបត្តិ និងមន្ត្រីមន្ទីរសុខាភិបាល ដើម្បីដាក់បញ្ចូលសកម្មភាពរបស់គម្រោងទៅក្នុងផែនការរបស់ពួកគេ និងស្នើសុំពួកគេចូលរួមអនុវត្ត
Meeting with HC, OD and PHD staff on integrating plan and suggesting them to be involved in the activity
7. ចូលរួមកិច្ចប្រជុំក្រុមការងារបច្ចេកទេសថ្នាក់ខេត្តដើម្បីចែករំលែកនូវឧបសគ្គ/កត្តាប្រឈម និង ភាពចន្លោះប្រហោងក្នុងការអនុវត្តកម្មវិធី
Joining Pro-TWG meetings at provincial level for sharing barriers/challenges and gaps of program implementation.
8. ចូលរួមសន្និបាតរបេងប្រចាំឆ្នាំដើម្បីចែករំលែកនូវឧបសគ្គ/កត្តាប្រឈម និងភាពចន្លោះប្រហោង ក្នុងការអនុវត្តកម្មវិធី
Joining annual TB conference for sharing barriers/challenges and gaps of program implementation.

ii. **ផ្នែកអ្នកទទួលសេវា (ចម្លើយរំពឹងទុក)**

Demand site: (Expected answers)

1. សិក្ខាសាលាតម្រង់ទិស
Project orientation workshops
2. ចូលរួមកិច្ចប្រជុំប្រចាំឆ្នាំជាមួយក្រុមប្រឹក្សាឃុំដើម្បីដាក់បញ្ចូលសកម្មភាពរបេងខ្លះទៅក្នុង ផែនការវិនិយោគឃុំ/សង្កាត់
Joining annual meeting with commune council for integrating some TB activity into commune investment plan.
3. ចូលរួមកិច្ចប្រជុំប្រចាំត្រីមាសជាមួយក្រុមប្រឹក្សាឃុំដើម្បីចែករំលែកនូវឧបសគ្គ/កត្តាប្រឈម និងបញ្ហាពាក់ព័ន្ធផ្សេងៗ
Joining monthly or quarterly meetings with commune council in the purpose of sharing barriers/challenges and other related issues
4. លើកកម្ពស់ចំណេះដឹងអំពីសិទ្ធិក្នុងការទទួលសេវាព្យាបាលរបេង និងកត្តាពាក់ព័ន្ធផ្សេងៗ ជាមួយអង្គការជនដី ព្រះសង្ឃ ចាស់ព្រឹទ្ធាចារ្យ អ្នកដឹកនាំសហគមន៍ និងអ្នកពាក់ព័ន្ធផ្សេងទៀត។
Raising awareness on TB rights and other related issues amongst local authority, monks, elder people, community leaders, other relevant stakeholders.....etc.
5. ចែករំលែកនូវរបាយការណ៍អំពីឧបសគ្គ/កត្តាប្រឈមនៃការអនុវត្តកម្មវិធីជាមួយអង្គការជនដី និងអ្នកពាក់ព័ន្ធ
Sharing report on barriers/challenges of program implementation with local authority, relevant stakeholders.....etc.
6. លើកកម្ពស់ចំណេះដឹងអំពីសិទ្ធិក្នុងការទទួលសេវាព្យាបាលរបេង និងកត្តាពាក់ព័ន្ធផ្សេងទៀត ជាមួយអ្នកជម្ងឺ សមាជិកគ្រួសារអ្នកជម្ងឺ អ្នកភូមិ...។ល។
Raising awareness on TB rights and other related issues with TB patients, patient's family members, villagers.....etc.

2) បណ្តាញសហគមន៍ ទំនាក់ទំនងផ្សេងៗ ភាពជាដៃគូ(ឧ.បណ្តាញអ្នកជម្ងឺរបេង.....)

Community networks, linkages, and partnerships (i.e. patient networks)

➤ តើមានបណ្តាញអ្នកជម្ងឺរបេងនៅក្នុងសហគមន៍របស់ដែរឬទេ ?

- បាទ/ចាទ ទេ

ប្រសិនបើមាន សូមរៀបរាប់

- ✓ ក្រុមសន្សំ
- ✓ ក្រុមជួយខ្លួនឯង
- ✓ ផ្សេងៗ(សូមបញ្ជាក់).....

Are there any TB patient network in community?

- Yes No

If yes, please describe

- ✓ Saving group
- ✓ Self-help group
- ✓ Others.....

3) ធនធានផ្សេងៗ និងការបង្កើនសមត្ថភាព (ឧ. វគ្គបណ្តុះបណ្តាល សិក្ខាសាលា.....)

Resources and capacity building (i.e. training workshop)

➤ តើវគ្គបណ្តុះបណ្តាល/សិក្ខាសាលាអ្វីខ្លះដែលអង្គការរបស់អ្នកបានទទួល និងផ្តល់ទៅអោយសហគមន៍ ?
What kind of training/workshop has your organization received and provided to community?

i. ផ្នែកអ្នកទទួលសេវា៖

Demand site:

1. សិក្ខាសាលាគម្រោងទិស
Project orientation workshop
2. វគ្គបណ្តុះបណ្តាលអំពីការស្វែងរកអ្នកជម្ងឺមេរោគ/ជម្ងឺរបេង រោគសញ្ញា...។ល។
TB screening, TB symptom training
3. វគ្គបណ្តុះបណ្តាល ? ? ?
TB ToT training
4. ផ្សេងៗ.....
Others.....

ii. ផ្នែកអ្នកផ្តល់សេវា៖

Supply side:

1. សិក្ខាសាលាគម្រោងទិស
Project orientation workshop
2. វគ្គបណ្តុះបណ្តាលអំពីការស្វែងរកអ្នកជម្ងឺមេរោគ/ជម្ងឺរបេង
Screening, case detection and.....etc training/workshop
3. ផ្សេងៗ.....
Others.....

4) សកម្មភាពសហគមន៍ និងការផ្តល់សេវា (ឧ. កម្មវិធីអ្នកផ្តល់សេវាសុខភាពសហគមន៍)

Community activities and service delivery (i.e. community health worker program)

➢ តើសកម្មភាពអ្វីខ្លះដែលអង្គការរបស់អ្នកគាំទ្រអោយមានដំណើរការដោយអ្នកផ្តល់សេវាសុខភាពសហគមន៍ (ក្រុមគាំទ្រសុខភាពភូមិ និងបុគ្គលិកមណ្ឌលសុខភាព) ?

What type of activity does your organization provide to community health worker (VHSG and HC staff)?

i. **ការស្វែងរកអ្នកផ្ទុកមេរោគរបេងក្នុងសហគមន៍**

Community based screening and detection

ii. **លើកកម្ពស់ចំណេះដឹងតាមរយៈមួយទល់មួយ រៀបចំព្រឹត្តិការណ៍/យុទ្ធនាការផ្សេងៗ ការផ្សព្វផ្សាយតាមរយៈការប្រគំតន្ត្រីនៅក្នុងសហគមន៍។ល។**

Raising awareness by face to face education, organizing event/campaigns, village concerts....etc.

iii. **វគ្គបណ្តុះបណ្តាលសម្រាប់អ្នកអង្កេតដូតស៍**

DOT-watchers training

iv. **ការអង្កេតរកអ្នកជម្ងឺរបេងជាមួយសមាជិកគ្រួសារ និងអ្នកនៅជុំវិញ**

Contact investigation

v. **ការចុះអភិបាល**

Supervision

vi. **ផ្សេងៗ**.....

Others.....

5) ភាពជាអ្នកដឹកនាំ និងការពង្រឹងសមត្ថភាព (ឧ. ការកំណត់ និងភ្ជាប់ទំនាក់ទំនងអ្នកដឹកនាំសហគមន៍)

Organization leadership and strengthening (i.e. identifying and engaging community leaders)

➢ តើអង្គការអ្នកមានសកម្មភាពដើម្បីផ្សារភ្ជាប់ទំនាក់ទំនងអ្នកដឹកនាំសហគមន៍អោយជួយគាំទ្រសកម្មភាពរបេងសហគមន៍របស់អ្នកដែរឬទេ ?

បាទ/ចាទ ទេ

ប្រសិនបើមានសូមរៀបរាប់

- ✓ សិក្ខាសាលាតម្រង់ទិស
- ✓ កិច្ចប្រជុំគណៈកម្មាធិការគ្រប់គ្រងមណ្ឌលសុខភាព
- ✓ កិច្ចប្រជុំផែនការវិនិយោគឃុំ/សង្កាត់
- ✓ កិច្ចប្រជុំក្រុមប្រឹក្សាឃុំ/សង្កាត់
- ✓ កិច្ចប្រជុំជាមួយអ្នកស្ម័គ្រសុខភាពភូមិ
- ✓ យុទ្ធនាការប្រយុទ្ធនឹងជម្ងឺរបេង
- ✓ ផ្សេងៗ.....

Does your organization engage community leaders to support your TB community program?

No Yes (If yes, please describe)

- i. Project orientation workshops
- ii. Health center management committee (HCMC) meetings
- iii. Commune investment plan meetings
- iv. Commune council meetings
- v. VHSG meetings
- vi. TB campaigns
- vii. Others.....

6) **តាមដាន និងវាយតម្លៃ (ឧ.ផ្តល់ព័ត៌មានត្រឡប់ទៅម្ចាស់ជំនួយលើគុណភាពសេវា ធ្វើឱ្យដឹងពីចំនួនអតិថិជនដែលបានផ្តល់ប្រឹក្សា)**

Monitoring and evaluation (i.e. providing feedbacks to donors on service quality, tracking the number of clients who have been counseled)

➤ How often do you conduct monitoring and evaluation on your program?

- i. **ការស្រាវជ្រាវមុនចាប់ផ្តើមគម្រោង**
Baseline survey
- ii. **តាមដាន និងការចុះអភិបាល**
Monitoring and Supervision
- iii. **ការស្រាវជ្រាវបញ្ចប់គម្រោង**
End-line survey
- iv. **ការវាយតម្លៃពីផលប៉ះពាល់**
Impact valuation

7) **ផ្នែកផ្សេងៗ ឬសេវាដែលបានរកឃើញដោយអ្នកអនុវត្តការស្រាវជ្រាវ**

Other categories or service identified by the grantee

➤ មានសេវាណាខ្លះទៀតដែលកំពុងដំណើរការនៅក្នុងសហគមន៍របស់អ្នក? តើអ្នកណាខ្លះដែលពាក់ព័ន្ធនៅក្នុងសេវាទាំងនោះ?

បាទ/ចាស ទេ

ប្រសិនបើមាន ចូររៀបរាប់អ្នកដែលពាក់ព័ន្ធ

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Are there any services existing in your community? Who are involves in those services?

Yes No If yes, please list down

ផ្នែករដ្ឋបាល

Administration

1. តើសកម្មភាពទាំងអស់ដែលបានអនុវត្តស្របតាមកម្មវិធីជាតិ?

- ស្របតាមកម្មវិធីជាតិ
- មិនស្របតាមកម្មវិធីជាតិ

Do these activities fall within a formal / national program or outside?

- Formal/National program
- Outside

ក្រុមគោលដៅ និងតំបន់គ្របដណ្តប់

Population & Geographic Coverage

1) តើក្រុមគោលដៅរបស់អ្នកជាអ្នកណា?

- អ្នកទោស
- ជនជាតិភាគតិច
- កម្មកររោងចក្រ
- ក្រុមចំណាកស្រុក
- ក្រុមពិការ
- របេង/អេដស៍
- របេង/ទឹកនោមផ្អែម
- របេងកុមារ
- ប្រជាជនទូទៅ
- មនុស្សចាស់អាយុលើស ៥៥

What are the target populations?

- Prisoner
- Minorities
- Factory worker
- Migrant
- Disable
- TB/HIV
- TB/diabetic
- Childhood TB
- General population
- Elderly 55+

2) សូមពណ៌នាអំពីទីតាំងភូមិសាស្ត្រដែលអង្គការរបស់អ្នកបានផ្តល់សេវា

Describe the geographic areas of the country where the organization provides services.

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3) ពណ៌នាថាតើក្រុមគោលដៅណាដែលងាយរងគ្រោះជាងគេក្នុងចំណោមក្រុមគោលដៅរបស់អ្នកទាំងអស់

Describe the vulnerable populations² with which your group works.

➤ ក្រុមគោលដៅដែលងាយរងគ្រោះ:.....

Vulnerable population:.....

2 The Stop TB Global Plan to End TB defines “key populations” as people who are vulnerable, underserved or at risk of TB infection and illness. Key populations vary by country and include people with increased exposure to TB due to where they live or work, people with limited access to quality TB services and people at greater risk due to biological or behavioural factors. E.g. people living with HIV, people living in urban slums, rural poor, prisoners, miners etc.

ឧបសគ្គ និងខ្វះចន្លោះ

Barriers & Gaps

1) តើឧបសគ្គអ្វីខ្លះដែលអ្នកបានជួបក្នុងកំឡុងពេលអនុវត្តការងាររបស់អ្នក?

What are the barriers you have encountered in your work?

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2) តើអ្វីខ្លះដែលអ្នកមើលឃើញថាមានភាពខ្វះចន្លោះនៅក្នុងការអនុវត្តការងាររបងដែលស្ថិតនៅតំបន់ដែលគ្មានអ្នកផ្តល់សេវា ឬមានអ្នកផ្តល់សេវាតិចតួច?

What are some of the gaps you see in the field of TB where there are few or no service providers?

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ព័ត៌មានបន្ថែម

Additional information

1) តើមានអ្វីផ្សេងទៀតទេដែលអ្នកចង់ប្រាប់ខ្ញុំអំពីអង្គការរបស់អ្នក ?

Is there anything else you would like to tell me about your organization?

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2) តើអ្នកមានស្គាល់ឈ្មោះនិងមានព័ត៌មានរបស់អង្គការផ្សេងទៀតដែលកំពុងអនុវត្តការងាររបេង (ឬ ការងារសុខភាពដែលទាក់ទងជម្ងឺរបេង) ដែរឬទេ ?

Do you have the names and contact information of any other organizations working on TB (or health related issues)

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Annex 2: List of Organizational Interviewees

No	Full Name	Abbreviation	Position Programme
1	Angkor Hospital for Children	AHC	
2	Cambodian Anti-Tuberculosis Association	CATA	
3	Cambodian Health Committee	CHC	
4	Caritas Cambodia	CARITAS	
5	Catholic Relief Services	CRS	
6	Center for Health and Social Development	HSD	
7	Eastern Mennonite Missions Cambodia	EMM	
8	FHI360	FHI360	
9	Health and Development Alliance	HEAD	
10	Health Poverty Action	HPA	
11	Human and Health	H&H	
12	Indigenous People Health Improvement Association	IPHIA	
13	Medical Teams International	MTI	
14	National Center for Tuberculosis and Leprosy Control	CENAT	
15	Operation ASHA	OP.ASHA	
16	Reproductive and Child Health Alliance	RACHA	
17	Reproductive Health Association Of Cambodia	RHAC	
18	Sihanouk Hospital Center of HOPE	SHCH	
19	USA-Center for Disease Control and Prevention	US-CDC	

Photo credit:

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Khana is a linking organisation of the global partnership
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