



GENDER ASSESSMENT IN THE NATIONAL TUBERCULOSIS RESPONSE IN CAMBODIA

2017



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LIST OF ACRONYMS

| | |
|----------------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Treatment |
| CDHS | Cambodia Demographic and Health Survey |
| CENAT | National Center for Tuberculosis and Leprosy Control |
| C-DOT | Community-DOT |
| FGD | Focus Group Discussion |
| GDP | General Department of Prison |
| GBV | Gender Based Violence |
| HCV | Hepatitis C |
| HEF | Health Equity Fund |
| HIV | Human Immunodeficiency Virus |
| IDI | In Depth Interview |
| IEC/BCC | Information, Education and Communication/Behavioral Change Communication |
| KHANA | KHANA |
| KII | Key Informant Interview |
| KP | Key Populations |
| MDG | Millennium Development Goals |
| MoWA | Ministry of Women's Affair |
| NAA | National AIDS Authority |
| NACD | National Authority for Combating Drugs |
| NCHADS | National Center for HIV/AIDS, Dermatology and STDs |
| NGO | Non-Governmental Organization |
| NIS | National Institute of Statistic |
| NSP | National Strategic Plan |
| NTP | National Tuberculosis Program |
| NMCH | National Maternal and Child Health |
| PLHIV | People Living with HIV |
| PSC | Project Steering Committee |
| PWID | People who injecting drugs |
| PWUD | People who use drugs |
| SDG | Sustainable Development Goal |
| STWG | Sub-Technical Working Group |
| SoP | Standard Operating Procedure |
| SRHR | Sexual and Reproductive Health and Rights |
| TB | Tuberculosis |
| TOR | Term of Reference |
| UN | United Nations |
| USAID | United States Agency for International Development |
| VHSG | Village Health Support Group |
| WHO | World Health Organization |
| OD | Operational District |
| PHD | Provincial Health Department |

EXECUTIVE SUMMARY

Cambodia remains one of the 30 countries in the world with high-burden TB despite the great strides the country has made in TB control and the achievement of the MDG target to halve TB deaths and prevalence by 2015. To overcome the remaining challenges, the National Strategic Plan (NSP) for Control of Tuberculosis (2014-2020) has introduced a package of activities for both active and passive case finding strategies among key and vulnerable populations.

In Cambodia, women accounted for 51% of the total population in the country, and 45% of TB newly cases detection occurred in women in 2016. To address gender-related concerns, the NSP for Control of Tuberculosis (2014-2020) has increased the focus in addressing specific needs and barriers related to gender, social support, and human rights.

UNAIDS and Stop TB Partnership established a partnership to develop the Gender Assessment Tool for National HIV and TB Responses. The Tool is intended to assist countries to assess their HIV and TB epidemic context and responses from a gender perspective, helping them to make their intervention programs gender sensitive. Cambodia is one of the countries in which gender-sensitive interventions need to be assessed. The assessments are critically important to explore potential strategies that could be used to address the gender-related issues and integrate them into the national TB response programs.

This report aims to assess the gender consideration in the national TB response in Cambodia with the intention to provide recommendations to move towards gender-transformative national TB response in Cambodia. The main objectives of the assessment are:

1. To review gender-specific policies, guidelines, and standard operating procedures (SoPs) in the context of the national TB response;
2. To identify evidence-based information and gaps on gender-specific issues in TB response to inform the national TB intervention programs; and
3. To recommend the way forward toward gender-specific interventions for TB control to the national TB programs.

This gender assessment is exploratory, and the production of the study is stakeholder-participatory in nature and was guided by the Gender Assessment Tool for National HIV and TB Responses. Using a mixed method approach, the following process was utilized to collect the necessary data and information: (1) establishment of the Project Steering Committee (PSC) and Sub-Technical Working Group (STWG); (2) an initial stakeholder workshop; (3) desk review; (4) collection of additional information and data; and (5) a validation workshop. This assessment process is captured in details in the introductory chapter.

A majority of the quantitative data were mined from the national TB surveillance system of the Center for Tuberculosis and Leprosy Control of the Ministry of Health via the completion of a data template developed by the assessment team and its affiliated Provincial Health Departments (PHD) and Operational Districts (OD) via the completion of a short survey sent out via email correspondence as well as collection via the field work directly from the selected PHD and OD. Some quantitative data were collected via email and/or phone correspondence with other government agencies, as acknowledged throughout in the report.

Besides the discussion during the PSC and STWG meetings and the two consultative workshops, which yielded considerable data and information and data clarification, the qualitative data were collected via focus group discussions with the selected TB key populations across five provinces and in Phnom Penh and key informant interviews with sub-national health staff at all levels in the five provinces. To collect extra data from people who use and inject drugs, four key informant interviews were conducted with informants from this key population group too.

This assessment report is structured as follows. The introductory chapter provides a snapshot of the current TB situation in Cambodia and outlines the key goal and objectives of the study and the assessment process and methodology. The second chapter covers the TB epidemics and contexts in Cambodia and discusses the TB prevalence, incidence and behavioral information; social, cultural and economic factors, and legal and political factors that may contribute to, amongst others, TB contact and transmission and that may influence access to and use of the TB services. The third chapter aims to understand the national TB response in Cambodia,

with a specific focus on gender equality in TB policies and programs; a comprehensive TB response, and gender considerations per community. All the data were disaggregated by gender and location, where appropriate and possible. The last chapter concludes the assessment and provides key recommendations for policy considerations and directions. In light of the findings and in close consultation with the stakeholders, the assessment report highlights the following recommendations:

First and most important of all, there is an urgent need to improve the current national and sub-national routine TB reporting system and database management system. These systems are supposed to capture all the key data that are essential for understanding of the disease epidemiology, program interventions, program monitoring and evaluation, and policy directions and with data for key indicators identified and broken down, among others, into gender, age and location (province and district), where appropriate. Relatedly, effort should be made to strengthen and update the TB management information system and the capacity to manage the data and database to ensure that: (1) the data are properly and safely stored; (2) the data are effectively used to inform program intervention and policy formulation; and (3) the quality of the data is closely monitored and maintained to ensure that it reflects the reality.

Second and as planned in the NSP, the regular conduct of the national TB prevalence survey planned for 2019 and other important surveys enlisted in the plan is important to understand and update the TB situation in Cambodia. These surveys should be prioritized and conducted regularly, according to the schedules proposed. Ad hoc and regular surveys on other key issues such as nation-wide KP estimation and behavior of service consumption among the KPs as well as the general population and the quality of TB service provisions should also be considered. Efforts should also be made to better understand the TB epidemiology and the situation of people living with TB nation-wide and/or among selected KPs to better understand the constraints and challenges and to identify the opportunities and service gaps so as to improve program intervention and long-term planning through conduct of relevant research, including into gender and TB, to inform policies and practices.

Third, while the NTP should be applauded for the inclusion of gender consideration into its national TB response to some extent, more effort can be made to integrate or permeate gender consideration

into the circle of its operation, including budgeting and activity planning, budget allocation, program implementation, and program monitoring and evaluation.

Fourth, there has been linkage of and collaboration between TB services to other key health services mainly HIV and AIDS, diabetes, NMCH, and TB in prisons, and these initiatives and effort should be applauded. However, there is a general view that the collaboration needs to be better enforced, strengthened and funded. It is also recommended that effort shall be made to integrate and/or link TB services to other key services such as drug rehabilitation, SRHR services, and campaign to end GBV and other forms of violence or discrimination.

Fifth, as can be seen above, misperception among the general population (and even the KPs themselves) about TB still exists, and reportedly there is some degree of stigma and community discrimination (which is sometimes related to the misperception) as well. Besides, while there are some sources of financial support to cover the TB treatment-related costs for some target groups such as the poor and the elderly (although TB treatment itself is free of charge) such as the social equity fund and other social fund run by NGOs, the sources are widely known to the potential users and are thus under-utilized by potential health service seekers (CENAT, 2014). There is also a need to improve TB prevention services and practices among the general population, and especially the KPs, in order to relieve the treatment burden. Therefore, effort should be made to conduct wide dissemination about TB and TB services to the general population and especially the KPs through conduct of public campaign or community forums; traditional and new media such as radio talk show and spot, TV talk show and spot and social media campaign; integration of TB knowledge and understanding through comedy shows; and wider use of VHSG for dissemination and awareness raising. Effort also needs to be made to strengthen the inclusion of basic TB knowledge into the general education curriculum, especially the second-level primary education or junior secondary education.

Sixth, big strides should be made to raise the awareness of gender and TB among the health providers, including VHSG. This awareness is even more important in light of the integration and linkage of TB services to/with other health or health-related services. Activities and initiatives to better integrate and permeate the gender and TB may include, but are not limited to, preparation of necessary

gender-related guidelines within the context of TB response and provision of the related training, and integration of key aspects of gender and TB into the pre-service curriculum for health workers and IEC/BCC guidelines. In this regard, there is a need to mobilize financial, technical and, if necessary, political support from the stakeholders to integrate gender into TB services and for the conduct of related training.

Seventh, whereas the involvement of other sectoral stakeholders, including from MoWA, in the preparation of TB plans and policies and sometimes their implementation should be applauded, there is a need to better use national plans and policies adopted by other relevant sectors, including gender and the elderly to inform and/or guide TB program planning, program implementation, and policy formulation.

Eighth, over the decades, the national program has implemented numerous intervention programs, and there are many good programs and practices. These good (pilot) programs and practices such as the childhood TB program should be better documented and expanded or adapted to cover other KPs to increase wider treatment coverage and improve cost efficiency in program execution.

Finally, all the key stakeholders, including CENAT, should be applauded for working together and collaborate on many fronts to fight TB. The current platforms for inter-agency cooperation and collaboration should be continued to be utilized for further program cooperation and collaboration, sharing good practices and lessons learned from program intervention, and discussion of other pertinent issues. However, effort shall be made to re-enforce and strengthen the effectiveness of many of the current collaborative platforms, where necessary. The platforms may also be used to integrate and permeate gender into TB program intervention and policy formulation through, for instance, the invitation of government institutions and NGOs working on gender to be their members or attend the meetings, where necessary. A few mechanisms for community involvement in the TB response such as C-DOTS have been known to be effective and efficient to fight TB. These mechanisms for civil society organizations and the KPs to get involved in the provision of TB services need to be strengthened, enforced, and funded in the fight to end TB by 2035 in Cambodia.

I. INTRODUCTION

Globally, the incidence and mortality of tuberculosis (TB) have been significantly reduced in the last 15-year period (2000 to 2015) of the Millennium Development Goals (MDG) of the United Nations (WHO, 2015; WHO, 2016). As a result, in the Sustainable Development Goals (SDG), it has been agreed that TB should be eliminated within 15 years between 2016 and 2030 (UN-SDG, 2015). However, it is estimated that it will take decades from now to eliminate this largely curable disease if the current global annual reduction of 1.5% continues (WHO, 2016). In addition to inadequate programmatic and service delivery issues that impact the effectiveness of TB response, a large proportion of people with active TB across the world have not been reached by the existing intervention programs (WHO, 2016). These people are likely to be disproportionately concentrated among TB key populations who are at higher risks of TB (WHO, 2016). Moreover, the SDG of TB elimination by 2030 could be threatened by the global rise of TB drug resistance and the complexity of TB epidemic in key populations including socially marginalized populations (WHO, 2016). Therefore, tailor-made response strategies must be in place to overcome the emerging challenges.

In addition to the above-mentioned challenges in TB implementation programs among key populations, gender inequalities and imbalanced gender norms and practices continue to contribute to TB and HIV related vulnerability (UNAIDS, 2014; WHO, 2015). Most TB cases and deaths occur among men (over 60% of TB incidences occur in men in 2014), but TB remains among the top three causes of death among women worldwide (UNAIDS, 2014; WHO, 2015). There were an estimated 480,000 TB deaths among women in 2014, more than one-third of whom were HIV-positive women (WHO, 2015). The incidence of TB is higher in men, despite higher HIV prevalence among women (UNAIDS, 2014). TB risks are also gender specific. Men are more likely to work in high-risk settings, have more social contacts, smoke, possible higher alcohol consumption, and limited health seeking behavior, while female-specific risks include higher stigma, delayed diagnosis, and less access to treatment services (UNAIDS, 2014). TB screening and diagnosis are also more difficult in women due to higher rates of extra-pulmonary TB among them than that among men. To capture these different needs, gender-specific TB intervention programs are needed.

Across different settings, TB enrolment, treatment and cure rates are not uniform in terms of gender dynamics. In some countries, enrollment rates and treatment outcomes are better in women than those in men, while the opposite trends have been observed in other countries. In most low and middle-income countries, about two-thirds of reported TB cases are men, and it is not well known whether this is due to a higher risk of developing TB among men or under-notification of TB among women with the evidence that women are less likely to be diagnosed with TB and successfully treated (WHO, 2015).

Karim and colleagues (2007) conducted a study to assess gender variations in delay from symptom onset to help seeking, diagnosis, and treatment of TB in Bangladesh. They found that, compared with men, women experienced longer delays at various stages of the clinical process of care and treatment seeking for TB which warrants appropriate measures to improve the situation. These findings suggest that TB care and treatment behavior among men and women requires a systematic assessment from a gender perspective to inform national planning and budgeting for gender-specific and -transformative responses.

Cambodia has made great strides in TB control and achieved the MDG target to halve TB deaths and prevalence by 2015 (WHO, 2016). In 2016, the incidence rate of all forms of TB was 345/100,000, a significant reduction from 580/100,000 in 1990 (CENAT, 2017; WHO, 2016). In 2016, newly detected TB cases of all forms were 32,010, of whom 14,676 were women (CENAT, 2016). The death rate was 20/100,000 in 2016, decreasing from 157/100,000 in 1990 (WHO, 2016). However, TB in children increased from 1,600 cases in 2007 to 6,857 cases in 2015 (Tieng, 2016). HIV sero-prevalence among TB patients also soared from 2.5% in 1995 to a peak of 12.0% in 2003 and dropped to 6.3% in 2009, constituting a significant TB/HIV co-epidemic (Tieng, 2016). And the country remains one of the 30 countries in the world with high-burden TB (WHO, 2016). To overcome the remaining challenges, the National Strategic Plan for Control of Tuberculosis (2014-2020) has introduced a package of activities for both active and passive case finding strategies among key populations that include people living with HIV, TB contacts, people aged 55 and older, diabetics, migrant workers, and prisoners

(CENAT, 2014). The priority and definitions of these populations need to be reviewed in light of the changes in the epidemic and global directions.

In Cambodia, women accounted for 51% of the total population in the country (National Institute Statistics, 2016), and 45% of TB newly cases detection occurred in women in 2016 (CENAT, 2016). To address gender-related concerns, the National Strategic Plan of TB Control (2014-2020) has increased the focus in addressing specific needs and barriers related to gender, social support, and human rights (CENAT, 2014). Moreover, the National Strategic Plan on HIV 2015-2020 also devotes a particular attention to gender issues (NCHADS, 2014).

In HIV programs, the UNAIDS developed the HIV Gender Assessment Tool in 2010 in response to the need for more systematic data collection on gender equality and HIV (UNAIDS, 2010). The tool has been used in several assessments in different countries including Cambodia (UNAIDS, 2014). The tool aims to support countries with the assessment of their HIV epidemic, context, and response from a gender perspective, and to inform the development of gender-sensitive national strategic plans and country investment cases.

Rationales

Recognizing the need for a similar tool in TB responses, the UNAIDS and Stop TB Partnership established a partnership to develop the Action Framework for Tuberculosis Key Populations (Stop TB Partnership & UNAIDS, 2017a) and Gender Assessment Tool for National HIV and TB Responses (Stop TB Partnership & UNAIDS, 2017b), building on the UNAIDS HIV Gender Assessment Tool. The Tools are intended to assist countries to assess their HIV and TB epidemic context and responses from a gender perspective, helping them to make their intervention programs gender sensitive and reduce the dual burden of HIV and TB infection. A few

countries have used the Gender Assessment Tool to assess the national responses to TB epidemic in the gender perspective and provide recommendations for gender-sensitive interventions (Nashandi et al., 2017; Niger Country Coordinating Mechanism, 2017). The assessment helps to identify gender related barriers to services as well as specific needs of men, women, transgender people, and key populations in the process to reinforce political commitment and build civil society capacity to better respond to these barriers and needs. Cambodia is one of the other countries in which key population and gender-sensitive interventions need to be assessed. The assessments are critically important to explore potential strategies that could be used to address the key population- and gender-related issues and integrate them into the national intervention programs.

GOAL AND OBJECTIVES

The goal of the gender assessment is to explore the extent to which gender issues have been taken into account in the national TB response and recommend gender-sensitive intervention programs to relevant stakeholders, policy makers, and donor agencies. The main objectives of the assessment are:

1. To review gender-specific policies, guidelines, and standard operating procedures (SoPs) in the context of the national TB response (including TB/HIV co-infection) in Cambodia;
2. To identify evidence-based information and gaps on gender-specific issues in TB response to inform the national TB intervention programs; and
3. To recommend the way forward toward gender-specific interventions for TB control to the national TB programs.

II. METHODOLOGY

Process of assessment

This assessment was conducted in Cambodia between October to December, 2017. To process the assessment, five core activities were carried out including:

1. Establishment of national multi-stakeholder working groups for gender assessment that included a Project Steering Committee and a Sub-Technical Working Group;
2. A consultative stakeholder workshop to identify and prioritize key populations and explore availability of potential sources of information and data to be used for the assessment;
3. A desk review to map intervention programs in the national TB response related to key populations in the country;
4. Collection of additional information and data necessary to address the research questions proposed for the assessment; and
5. A validation workshop aiming to seek for agreement and additional inputs from stakeholders from government bodies, development partners, non-governmental organizations (NGOs) as well as community representatives.

Establishment of Project Steering Committee (PSC)

The key population assessment was conducted under the direction of the Director of the National Center for Tuberculosis and Leprosy Control (CENAT) and technically lead by KHANA Center for Population Health Research. To ensure the technical leadership and involvement from relevant stakeholders and beneficiaries, the assessment was conducted through a close collaboration between several relevant stakeholders, communities, and beneficiaries. A Project Steering Committee were formed (Annex 1) to oversee and guide the preparation and implementation of the assessment. Members of the committee included representatives from:

- CENAT/National Tuberculosis Program (NTP) (Chair of the Committee)
- National Center for HIV/AIDS, Dermatology and STD (NCHADS)

- Ministry of Women Affairs (MoWA)
- NGOs working on TB (Cambodia Anti-Tuberculosis Association, Cambodian Health Committee, Catholic Relief Services, FHI 360, Health Poverty Action, KHANA, Operation ASHA, Reproductive and Child Health Alliance, Reproductive Health Association of Cambodia)
- United Nations and donor agencies (WHO and USAID)
- TB communities and key populations

Establishment of Sub-Technical Working Group (STWG)

A sub-technical working group (STWG) was also established for assisting the preparation, implementation, and reporting, together with supports from national and international technical assistants (Annex 1). Members of the STWG were invited to regular meetings at least once in every two weeks and as needed to get informed about the progress of and discuss emerging issues related to the assessment. In order to implement the assessments effectively, two international and two local consultants were employed. The consultant was responsible for supporting the development of key population definitions and size estimation protocol and tools, desk reviews, reviews of the preliminary data, and validation of the results.

Project Steering Committee and Sub-Technical Working Group Meeting

To get an agreement from the stakeholders and endorsement from the national TB program, findings from the stakeholder consultative workshop were presented and discussed at the meetings of the Project Steering Committee and Sub-Technical Working Group. The list of prioritized TB key populations identified through the stakeholder consultative workshop was presented to the Project Steering Committee and Sub-Technical Working Group separately for a review and endorsement.

Consultative Stakeholder Workshop

To gather the information required for the assessment, a consultative stakeholder workshop was conducted. Core activities in the stakeholder workshop included a review and prioritization of TB key populations in Cambodia, a review of the Key Population Assessment Tool introduced by

Stop TB Partnership, and identification of TB risks and barriers in access to TB services among key populations in the country.

Participants of the workshop included approximately 70 representatives from the national TB programs at different levels, development partners, national and international NGOs working on TB programs, community people, and beneficiaries from across the country. To identify and prioritize key populations in Cambodia, the participants were divided into small groups to discuss each KP listed in the National Strategic Plan for Control of Tuberculosis 2014-2020 (CENAT, 2014). The template for discussion was adapted from the KP Assessment Framework introduced by Stop TB Partnership (Annex 2).

Methods of Data Collection

Desk Review

We comprehensively reviewed several existing documents and data from national programs at different levels (CENAT, provincial health departments, operational districts, health centers, clinics, etc.) to obtain necessary information on key-population-related policies and intervention programs in the national TB response in Cambodia and relevant NGOs working on TB programs. Key sources of the information for desk review included:

1. National Strategic Development Plan 2014-2018
2. Health Strategic Plan 2008-2015 and 2016-2020
3. National Strategic Plan for Comprehensive and Multi-Sectoral Response to HIV and AIDS III 2011-2015 and 2016-2020
4. Cambodia Inter-censal Population Survey, 2013
5. Population Projection of Cambodia 2013-2023
6. National Strategic Plan for Control of Tuberculosis 2014-2020
7. Strategic Plan For HIV/AIDS and STI Prevention and Control in the Health Sector in Cambodia 2015-2020
8. Cambodia Demographic and Health Survey 2014
9. Action Framework for Tuberculosis Key Population
10. Gender Assessment Tool for National HIV and TB response
11. Reports from NGOs, provincial health departments, operational districts, health centers, clinics, etc.
12. Database of CENAT, provincial health

departments, operational districts, health centers, clinics, relevant NGOs working on TB and HIV, etc.

13. Progress report of NCHADS and CENAT 2016

Key Informant Interview (KII)

In addition to the desk review and stakeholder consultative workshop, additional information and data were also collected through key informant interviews (KIIs) with representatives of:

1. National Center for Tuberculosis and Leprosy Control (CENAT)
2. National Center for HIV/AIDS, Dermatology and STD (NCHADS)
3. NGOs working on TB programs
4. United Nations and donor agencies (WHO and USAID)
5. TB affected communities and key populations

Focus Group Discussions (FGDs)

Data were also collected through focus group discussions (FGDs) with representatives of TB-affected communities and key populations in six municipality and provinces including Phnom Penh, Banteay Meanchey, Kampong Chhnang, Prey Veng, Siem Reap, and Takeo. In each province, a FGD was conducted for each key population with six to eight members in each group. The key populations included people living with HIV, adult TB contacts, diabetics, prisoners, and elderly people aged 55 and older and people who use drugs and people who inject drugs.

In-Depth Interviews (IDI)

Data were also collected through in-depth interview (IDI) with people who use drugs and people who injecting drugs. The individual interview was conducted to dig out and explore the details of the information and perception in regards to their live experience.

Data Collection Team

Data collection was performed by well-trained and experienced enumerators and supervisors with a consideration of gender balance. The enumerators and supervisors worked under the direction of the lead investigators. One of the lead investigators was also performed as a field coordinator. Data collection was facilitated thorough collaboration with relevant authorities at different levels under coordination roles of CENAT.

Data Collection Training

The lead investigators conducted a two-day training for the data collection enumerators and supervisors at KHANA Center for Population Health Research. The training focused on the survey protocol, data collection procedures, research ethics including sensitivity and confidentiality of the study, and how to conduct FGDs, IDIs, and KIs. Data collection tools were pretested at a TB clinic of CENAT and the Phnom Penh Municipal Health Department. Individuals participating in the pre-test were excluded from the main study. A consultative meeting was also held with Project Steering Committee and Sub-Technical Working Group to validate the tools before developing the final version of the tools for use in the field data collection.

Data Management & Analyses

The information and data analysis plan was developed in consultation with the Project Steering Committee and the Sub-Technical Working Group. The analysis plan aimed to respond to the main objectives of the assessments:

- The assessment team with technical support from National and International Consultants reviewed the existing list of key populations in the National Strategic Plan for Control of TB 2014 -2020 (CENAT, 2014).
- In order to answer additional questions that emerged during the design of the assessments or the stakeholder workshops, existing program data available from the intervention programs were analyzed using excel spreadsheet, SPSS, or Stata statistical software as appropriate.
- Content analyses were performed using Nvivo to categorize themes by pulling out the core available service packages, accessibility to TB services among each key population, TB risks and exposure, TB risk drivers, and existing TB intervention programs for each key population. A five-category scale were used (very low, low, medium, high, and very high) to estimate the burden of TB, and a no (0) and yes (1) category were used to score TB risks and TB risk drivers among each key population. A simple sum was then calculated for the results of prioritization and discussion through the consultative stakeholder workshops, FGDs, IDIs, and KIs.

Validation Workshop of Research Findings

A two-day validation workshop was organized in Phnom Penh with representatives from:

1. National Center for Tuberculosis and Leprosy Control (CENAT)
2. National Center for HIV/AIDS, Dermatology and STD (NCHADS)
3. National AIDS Authority (NAA)
4. Ministry of Women Affairs (MoWA)
5. Provincial Health Departments
6. NGOs working on TB (Cambodia Anti-Tuberculosis Association, Cambodian Health Committee, Catholic Relief Services, FHI 360, Health Poverty Action, KHANA, Operation ASHA, Reproductive and Child Health Alliance, Reproductive Health Association of Cambodia)
7. United Nations and development partners (WHO and USAID)
8. TB affected communities and key populations

Approximately 63 people participated in the workshop. The research team presented key findings from the desk review, consultative meetings, and field data collection (FGDs, IDIs, and KIs) and opened to the floor for questions, comments, and inputs. The participants were then divided into six groups to discuss findings for each key population with about 10 participants per group.

Key discussion points for individual group included:

1. Definition of the key population
2. TB risks, and barriers in access to quality TB services among the key population
3. Estimation of national population size of the key population
4. Recommendations to the national programs for filling the identified gaps in TB services among the key populations based on the findings from the assessments.

A representative from each discussion group presented findings from discussion within their group and opened to the floor for questions and comments.

Report Writing

Under the leadership of Project Steering Committee, KHANA Center for Population Health Research as Technical Lead, in consultation with the taskforce developed the report outlines. Consultative meetings with stakeholders including TB affected communities and key populations, relevant NGOs working on TB programs, as well as United Nations and donor agencies (WHO and USAID) were consecutively

held from the assessment process development to the final report. Final report was reviewed and validated through consultations with the Project Steering Committee and the Sub-Technical Working Group. Based on comments from Committee and Group, the report was revised and finalized with the endorsement of the CENAT.

Application, Dissemination, and Transposition of Findings

We have planned to share findings from this study to relevant stakeholders, development partners, communities at local, regional, and international levels through different means. We will collaborate with national institutions, such as the CENAT and NCHADS in Cambodia, who have been aware of and involved in this project, to disseminate the findings from this study locally. We would invite stakeholders from all provincial health departments to a disseminating workshop in order to share our results. We have also planned to share the findings to regional and international audiences particularly to researchers, policy makers, and development partners working on TB programs in other developing countries with high burden of TB through regional and international meetings and conferences as well as through peer-reviewed journal article publications.

Ethical Considerations

The study protocol and tools were approved by the National Ethics Committee for Health Research (Ref 226 NECHR.) of the Ministry of Health in Cambodia. Permission and supports were also obtained from relevant authorities and institutions. Each participant in FGDs, IDIs, and KIs provided a verbal informed consent prior to the data collection. To protect the privacy of the respondents, we conducted the interviews in private places, and confidentiality of the information and data were strictly protected by removing all personal identifiers from the questionnaires and field notes.

Potential Risks and Benefits

Human Subjects

This study will involve human subjects and the protection of human subjects is in accordance with the guideline of the NECHR within the Ministry of Health in Cambodia. The NECHR review research protocols involving human subjects with a view to safeguard the dignity, rights, safety and well-being of all actual or potential research participants. They state that the goals of research, however important, should never be permitted to override the health and well-being of the research subjects. No research or

recruitment of subjects was performed without the approval of the NECHR.

Risks to Human Subjects

Human Subjects Involvement, Characteristics and Design

The focus of this study was to explore barriers and effective strategies to overcome the issues around TB key populations in order to increase the rates of TB case notification and access to key and vulnerable populations who are at-risk for TB. Because this study focused on TB key and vulnerable populations, all such populations defined by the national TB programs were eligible to be participants. All recruitment activities and study procedures involving study participants were implemented following the national guidelines.

Sources of Materials

As stated in the study protocol, research materials included program reports, national guidelines and policies, interview digital audio files and transcripts, focus group digital audio files and transcripts as well as field observation notes data. All data obtained through KIs and FGDs were de-identified and stored in password protected electronic files as well as in hard copy format in locked file cabinets at the office of KHANA Center for Population Health Research in Phnom Penh and made accessible only to the research coordinators, the principal investigators, and co-investigators.

Potential Risks

The risks to participation in this study were minimal. For those participating in focus groups, there may be an infringement on privacy if participants feel pressured or get caught up in the moment and disclose personal information to people they may know or see in their workplace or community. To address these risks, all study participants were informed about the voluntary nature of their participation and their right to end their study participation at any points during the study without any consequences.

Adequacy of Protection against Risks

Recruitment and Informed Consent

Before participation in any study activities, a verbal consent were obtained from individual participant. Data collectors signed the consent form to confirm that the study participants have been briefed about the study, assured of their confidentiality and have given their informed consent to participate in the

study. Study participants were also informed that they could refuse or withdraw from taking part in the assessment at any time.

Risk for Vulnerable Groups

We enrolled vulnerable populations and participants who may be former TB patients or receiving TB treatment during the study period. Being a TB patient on treatment does not exclude participants from the study. All activities with these groups met the procedural guidelines of NECHR. There were no known risks to the health of participants in this study. In addition, there may be benefits to them because trained TB service providers were made available to them throughout the study period.

Confidentiality

The records of this study were kept confidential. The research team included only the name list of participants without linking to particular personal identifiers or particular information or data provided through the assessment in our reports. The interview

and focus group recordings obtained from the participants were safely locked away in a digital recorder with a passcode. Electronic transcripts were stored on a password-protected laptop. Informed consent forms and demographic questionnaires with identifiable information were stored in a locked bag during transportation to and from the study sites. These forms were kept in a separate locked file away from digital recordings and transcripts. The research coordinator and principal investigators were the only persons who had access to these records.

Data Monitoring

Interview transcripts and audio recordings were kept in a secure environment. Every recorded interview was kept confidentially.

Costs of Participation

No cost of participation incurred.

III. KNOWING YOUR TB EPIDEMIC AND CONTEXT

TB PREVALENCE, INCIDENCE AND BEHAVIOURAL INFORMATION

TB prevalence rate, disaggregated by sex and age at national and provincial levels

Table 1 shows the available prevalence rates of tuberculosis at national level from 2011 to 2014. The

latest data on TB prevalence rate for all forms of TB is available for the years 2011 to 2014. The data indicate that the prevalence rates decreased quite significantly between 2011 (817 in 100,000 people) and 2014 (668 in 100,000 people). Data on the TB prevalence rates for later years were not available.

Table 1: Prevalence rate of tuberculosis at national level

| | 2011 | 2012 | 2013 | 2014 |
|---------------|-------|-------|-------|-------|
| Total | 817 | 764 | 715 | 668 |
| Male | (n/a) | (n/a) | (n/a) | (n/a) |
| Female | (n/a) | (n/a) | (n/a) | (n/a) |

Global TB Report 2015. Geneva: WHO, 2015.

NB: n/a throughout indicates that data is not available.

There is no data disaggregation for the latest TB prevalence by province, gender, and age. Such data broken down by gender, age and location (rural/urban) were available in the second national TB prevalence survey conducted in 2011 (for the data, see CENAT, 2012, pages 49-58). Overall, in this report when gender was disaggregated, they were disaggregated into bi-category of male and female, as the existing system does not record transgender people.

National TB incidence and notification rate (all new TB cases and all new smear-positive cases), disaggregated by sex, age at national level and by provinces

The national TB incidence and notification rates (i.e. for smear positive, smear negative, and other forms of TB, including mainly treatment re-lapse, treatment failure, loss to treatment follow-up and other cases, e.g. return to treatment after default) were estimates by CENAT based on the WHO's TB Global Reports and the data surveillance system of CENAT, respectively. As shown in Table 2, the data indicate steady decrease in the TB incidence in the past five years from some 393 cases per 100,000 people in 2012 to 345 cases per 100,000 people in 2016. The data show that there was quite a fluctuation in the notification rates in the past five years; however, in general there is a significant decrease of notification rate at an average of around 3.2% per year (per the recorded data).

Table 2: National incidence and notification rates of tuberculosis in 2012 – 2016

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|-----------------------------------|------|------|------|------|------|
| Total # of incidence | 393 | 380 | 368 | 356 | 345 |
| Notification rate | 271 | 258 | 285 | 228 | 211 |
| Notification rate (male) | n/a | n/a | n/a | n/a | n/a |
| Notification rate (female) | n/a | n/a | n/a | n/a | n/a |

Source: NTP estimation based on Global TB Report 2017. Geneva: WHO (2017); CENAT (2017).

There is no data disaggregation by gender, age and province for all forms recorded in the WHO's reports and the national surveillance system in this regard. However, data breakdown for new cases based

on gender is recorded in the national surveillance system and provincial data record, and this is illustrated in Table 3 and Figure 1.

Table 3: National TB notification of new cases

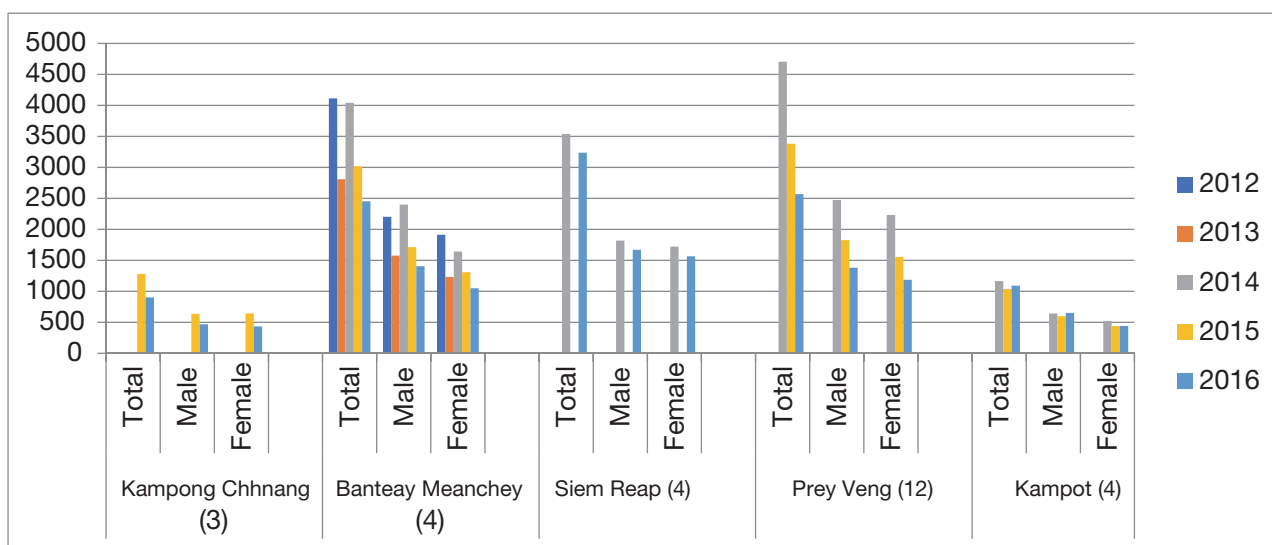
| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---------------|--------|--------|--------|--------|--------|
| Total | 38,652 | 37,300 | 41,522 | 33,702 | 32,010 |
| Male | 20,394 | 19,357 | 22,299 | 18,008 | 17,334 |
| Female | 18,258 | 17,943 | 19,223 | 15,694 | 14,676 |

Source: CENAT (2017).

While data disaggregated by gender for all cases (new and old) are not available, according to the data in Table 3 above, there is a general trend of more cases for males than females in the past five years for the new cases. Another observation is that

unlike the data for all cases which show a steady decline in all cases, especially in the past three years, there is quite a fluctuation of cases for the new cases, although there was a significant decline of cases in the past three years.

Figure 1: National TB Notification Rate in the study province (all forms)



The assessment attempts to collect the provincial level data from all the 25 PHDs throughout the country, by mean of email survey and field data collection directly from the PHDs during the fieldwork. However, the team merely managed to collect the valid and adequate data from 5 out of the 25 provinces and capital for selected years (see Figure 1 above), given the limited records available at the provincial level or inability to meet the right persons due to their out-province mission as well as the quality and adequacy of the returned survey results from the OD level to be collated into the provincial level data. There were three important

observations from the limited data collected. First, there has been a significant decrease in an average of around 3.0% annually in the TB notification in the five provinces in total number of cases and by gender in the past years. Second, the TB notification varies quite significantly from province to province, although it must be admitted that the number of ODs (as indicated in parenthesis nearby the name of each province) varies from province to province too – with, for example Kampong Chhnang having three ODs, Banteay Meanchey and Siem Reap, four ODs, and Prey Veng up to 12 ODs. Prey Veng, Banteay Meanchey, and Siem Reap recorded higher

incidence than two other provinces. Third, with the exception of Kampot, in all other provinces there was a slightly higher notification cases among males than females in all years. Data breakdown by age were not collected.

Mortality rate from TB disaggregated by sex, age at national level and by provinces

The annual TB mortality rate was retrieved from the

WHO's TB Global Report 2017 (Table 4). There was a remarkable steady trend of decrease in TB mortality rate in the past five years, from 24 cases in 2012 to 20 cases per 100,000 people in 2016. It is worth mentioning that the national surveillance system did not record the annual death cases, be it national or provincial levels. Data breakdown by gender, age and province were not available.

Table 4: TB mortality rates in Cambodia

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---------------|------|------|------|------|------|
| Total | 24 | 23 | 22 | 21 | 20 |
| Male | n/a | n/a | n/a | n/a | n/a |
| Female | n/a | n/a | n/a | n/a | n/a |

Sources of data: WHO. (2017). Tuberculosis Global Report 2016. Geneva: WHO, 2017.

TB-HIV co-infection

Table 5 shows TB/HIV co-infection (i.e. people with TB diagnosed for HIV) rates in Cambodia in 2012 – 2016. The data were derived from the number of cases recorded in the TB national surveillance system of CENAT, which can present some limitations in the quality and reliability of the data, yet this is the only

source where such data were recorded. There was a general trend of decreasing TB/HIV co-infection rates in the past five years – at least, among people with TB who came to receive treatment from the center and its associated referral hospitals, health centers, and health posts. There was no data disaggregation by gender, age, and province.

Table 5: TB/HIV co-infection rate in Cambodia in 2012 – 2016

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---------------|-------|-------|-------|-------|-------|
| Total | 3.50% | 3.20% | 2.20% | 2.10% | 2.30% |
| Male | n/a | n/a | n/a | n/a | n/a |
| Female | n/a | n/a | n/a | n/a | n/a |

Source: CENAT (2017).

Effort was made to request data on HIV/TB co-infection cases (i.e. people living with HIV diagnosed for TB) recorded by the NCHADS by the CENAT; however, at the time of the writing the assessment team has yet to receive the data from NCHADS.

Efforts were also made to retrieve data on TB/HIV co-infection (overall number of cases and data breakdown by gender) from the provincial health departments across the countries. However, none of the PHD returned the email survey, and the five PHD the assessment team visited did not record this co-infection data in their surveillance systems.

Ratio of case notification rate in men and women

The current data recording system did not record gender of 'old cases', and hence it was impossible to have the data of case notification rates for all forms. The system recorded the gender of 'new cases'. According to data presented in Table 6, there has been a consistent phenomenon of higher cases for men than women in the past five years. There average male-to-female ratio of new case notification in four provinces included in this assessment was 1.14:1 in the past five years.

Table 6: Ratio of new case notification rates in men and women

| 2012 | 2013 | 2014 | 2015 | 2016 |
|--------|--------|--------|--------|--------|
| 1.12:1 | 1.09:1 | 1.16:1 | 1.15:1 | 1.18:1 |

Source: CENAT (2017).

According to Table 7, in line with the national level data for new cases, there was a generally higher case notification of all forms of TB among males than females across the four provinces that supplied the data. The rate varies quite significantly from

province to province – with Banteay Meanchey recording the largest discrepancy (1.31:1 in 2015 and 1.34:1 in 2016) and Siem Reap recording the lowest discrepancy (1.06:1 in 2014).¹

Table 7: Ratio of new case notification rate in men and women in selected provinces

| | 2014 | 2015 | 2016 |
|-------------------------|---------|---------|---------|
| Kampong Chhnang | (n/a) | 0.99: 1 | 1.08: 1 |
| Banteay Meanchey | (n/a) | 1.31: 1 | 1.34: 1 |
| Siem Reap | 1.06: 1 | (n/a) | 1.07: 1 |
| Prey Veng | 1.11: 1 | 1.17: 1 | 1.16: 1 |

Sources: PHD in Kampong Chhnang, Banteay Meanchey, Siem Reap, and Prey Veng (2017)

While the provincial level data indicated higher case notification among men, an audit of the district level data indicated that there was a slight variation in data breakdown by gender in the past few years and across the districts that returned the survey – i.e. some ODs recorded higher notification among males and the other ODs higher notification among females.

Proportion of the population who correctly identify symptoms of TB and where to go for help disaggregated by sex, age and geographical location

According to the results from the FGDs with all the KPs identified in this study across all the provinces, there was an indication that the respondents (both males and females) and across the KPs covered

in the assessment had basic knowledge and understanding of TB symptoms, transmission, and prevention methods and where to go to get TB services. Nevertheless, Table 9 indicates that there were some misperceptions and misunderstanding regarding TB transmission and prevention methods. It should be acknowledged that some people did not respond to the questions and that there were fewer FGDs for people with diabetes (2), PWUD/PWID) (2), prisoners (1), and VHSGs (1).

Through the discussion, the KPs raised the following TB symptoms in the discussion, although the response was not disaggregated by gender. Overall, there was not much difference in the TB symptoms raised, although some KPs could recognize more symptoms than others (Table 8).

Table 8: TB symptoms raised by selected key populations during group discussion

| Key Population | TB Symptoms Raised in Discussion |
|------------------------------|---|
| People with diabetes | Two-week cough; rapid weight loss; loss of appetite; sweat and dry skin; tiredness; chest pain |
| Former people with TB | Cough for two weeks or more; weight loss; sweat at night; dry skin; joint pain; lump near the ear(s); haemoptysis; loss of appetite; sleeplessness; fever; tiredness |
| People with TB | Cough; tiredness; bubbly saliva; fever; chest pain; joint pain; sleeplessness; haemoptysis; weight loss; loss of appetite; sweat; skin rash; lump near the ear(s); sweating |

¹ In Kampong Chhnang, there was an incidence of slightly higher rate amongst women in 2015 – i.e. 0.99:1 in 2015.

| | |
|-------------------------------|---|
| People living with HIV | Cough for two/three weeks; weight loss; fever at night; sweat at night; loss of appetite; sleeplessness; breathing difficulty; tiredness; influenza; chest pain; haemoptysis |
| Elderly people | Cough for two weeks or more; weight loss; sticky bluish saliva; chest pain; haemoptysis; fever; joint pain; cramp; sore throat; influenza; sweat; skin rash; sleeplessness; loss of appetite; tiredness; lump near the ear(s) |
| TB contacts | Sticky bluish saliva; fever; cough; headache; haemoptysis; weight loss; influenza; chest pain; tiredness; sleeplessness |
| PWUD/PWID | Weight loss; one/two-week-long cough; sweat at night, skin rash; tiredness; bluish saliva; loss of appetite; haemoptysis; fever |
| Prisoners | Cough for one/two weeks or more; lump near the ear(s); sweat at night; fever; influenza; tiredness; weight loss |
| VHSG | Cough for more than two weeks; sweat at night; chest pain at night; fever at night |

Abbreviations: PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.
Source: Compiled by authors based on focus group discussion results.

Table 9 shows TB prevention methods raised by selected KPs through the FGDs. The KPs raised the following TB prevention methods (including some misunderstandings) to avoid contacting

and spreading TB (although the response is not disaggregated by gender). In the main, not much difference exists in the response, although some KPs raise more prevention methods than others.

Table 9: TB prevention methods raised by selected KPs during group discussion

| Key Population | TB Prevention Methods Raised in Discussion |
|-------------------------------|--|
| People with diabetes | Wearing face masks for people with TB and TB contacts; putting one's hand over the mouth when coughing for people with TB; use of common serving spoons; no smoking (above the wind); moving away from other people when coughing for people with TB |
| Former people with TB | TB vaccination, wearing masks when speaking to people with TB, using clean dishes, spoons and forks; keeping doors and windows widely open; putting one's hand over the mouth or moving away from other people when coughing (for people with TB); wearing masks or covering one's mouths with handkerchiefs for people with TB and talking to people with TB; screening for TB in case of suspicion; avoiding using eating and drinking utensils with people with TB; avoiding public spitting; avoiding speaking directly in front of people with TB; regular medication for people with TB (to avoid MDR-TB) |
| People with TB | Wearing masks or covering mouths with krama when talking to people with TB; speaking at a distance with people with TB; avoiding standing directly in front of other people for people with TB; avoiding smoking and drinking for people with TB (to avoid weakening immune systems); avoiding smoke, especially from cigarettes; walking away from other people when coughing for people with TB; minimizing contact with other people for people with TB; avoiding using eating and drinking utensils with people with TB; adequate protein; avoiding public spitting; regular medication for people with TB (to avoid MRD-TB) |
| People living with HIV | Wearing masks for people with TB and TB contacts; covering oneself with a hand when talking for people with TB; regular medication for people with TB (to avoid MDR-TB); cleaning bed and mosquito nets of people with TB; avoiding spoon feeding children by putting it in the mouth to make it cold; avoiding smoking and drinking; covering one's mouth when coughing for people with TB; avoiding public spitting; TB vaccination (for children); avoiding sharing eating and drinking utensils with people with TB |

| | |
|-----------------------|---|
| Elderly people | Wearing masks or krama for people with TB and TB contacts; living in a well-ventilated room/house; adequate protein; avoiding close contact with other people for people with TB; avoiding shared eating and drinking utensils with people with TB |
| TB contacts | Separate eating and drinking utensils for people with TB; abstinence; wearing masks (when talking to people with TB); separate meal for people with TB; covering oneself with a mask or krama when speaking for people with TB; avoiding close contact with people with TB; wearing a mask or covering one's mouth when coughing for people with TB |
| PWUD/PWID | Wearing masks for people with TB and TB contacts; avoiding using common eating and drinking utensils; avoiding close contact; avoiding public spitting for people with TB; abstinence |
| Prisoners | Using masks for people with TB and TB contacts; keeping a distance in talking with people with TB; hygienic eating and drinking utensils |
| VHSG | Wearing masks or covering mouths with handkerchiefs for people with TB |

Abbreviations: PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.
Source: Source: Compiled by authors based on focus group discussion results.

As shown in Table 10, the FGDs indicated that many of the respondents had good knowledge of health facilities where TB services were available, although there were some misperceptions among them regarding facilities where they can seek TB services when they needed them. Four groups, namely PWUD and PWID groups, one TB contact group, and one prisoner group raised 'big [public]

hospitals' in Phnom Penh and one group, people living with HIV raised private clinics as places where they can seek TB services. One group of people with diabetes raised that they can seek for such service information from former people with TB. In general, they referred to their local health centers, referral hospitals or provincial hospitals for TB treatment, care and support services.

Table 10: Understanding of TB service availability among selected KPs in focus group discussion

| Key Populations | TB Service Providers |
|-------------------------------|---|
| People with diabetes | Health center, provincial/ district referral hospital, asking information from former TB patients |
| Former people with TB | Health center, provincial/district referral hospital |
| People with TB | Health center, provincial/district referral hospital |
| People living with HIV | Health center, provincial/district referral hospital, private clinic |
| Elderly people | Health center, provincial/district referral hospital |
| TB contacts | Health center, provincial/district referral hospital; Russian Hospital (and other big hospitals) |
| PWUD/PWID | CENAT; Russian Hospital (and other public hospital); Hope Clinic; Preah Kossamak Hospital, municipal/district referral hospital, health center; Ketomealea Hospital |
| Prisoners | District referral hospital; national hospital (CENAT?) |
| VHSG | Health center; referral hospital |

Abbreviations: PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.
Source: Source: Compiled by authors based on focus group discussion results.

Percentage of the population that has an accurate understanding of the relationship between TB and HIV & access to TB services

Stigma and discrimination

In late November 2017, the assessment team ran a discussion session with representatives of NGOs working on TB under the framework of the STWG for this gender assessment, and the participants generally agreed that, in general, there has been no indication of discriminatory or coercive practices in health-care settings, irrespective of the gender of people with TB and TB KPs. Provision of treatment services is usually carried out straight away after the TB diagnosis. There has been, however, a sense of internal stigma among some people with TB themselves, and there have been a few cases whereby the patients refused to take medication on their own. There have been reportedly instances where some service providers may display some personally inappropriate behaviors.

Any indication of discriminatory or coercive practices in health-care settings that may impact access and utilization of TB services by women as well as by key and marginalized populations

The topic of stigma and discriminatory practices against people with TB from health service providers and law enforcement officers is extensively discussed with all the key stakeholders, including service providers from the national to provincial and district

There was no discussion of relationship between TB and HIV with people living with HIV, while the discussion as to where to access the TB and HIV services was presented in a section above.

levels, NGOs working on TB, and representatives of TB KPs. There was a general consensus among the stakeholders across all the sites covered in the assessment that there was no discrimination against or coercive practices on people with TB from the health service providers at all levels irrespective of the gender and towards all KPs covered. Stigmatization, especially among people with TB, reportedly exists, and there have been some instances in which some degree of discrimination within their communities, especially the immediate neighborhood, exist too. Service providers, NGOs working on TB and some target KPs indicated that personal stigmatization is sometimes the case in point, irrespective of gender.

Despite some instances of ‘inappropriate language use’, in general TB service users in Phnom Penh and all provinces covered in this gender and KP assessment had good praise towards the health (including TB) service providers they contacted given their support, including supportive language, psychological support, and even small financial support for their travel to and from the health centers. Table 11 below shows the results from the FGDs with the selected KPs and NGOs working on TB and from KIs with the service providers and provides selected remarks from the stakeholders on TB services.

Table 11: Perception as to whether discriminatory and coercive practices from health service providers exist towards women and KPs

| Stakeholder | Perception | Selected Remarks on TB Service Providers |
|-----------------------|------------|---|
| People with diabetes | No | <p>“At both TB health service providers, namely the health center and referral hospital, there is no discrimination. As for the elderly, there is extra care from the doctors. Doctors encourage patients to adhere to the medication prescription to get cured.” (Takeo)</p> <p>“At healthcare settings, there is no discrimination. Doctors are always ready to provide the services.” (Banteay Meanchey)</p> |
| Former people with TB | No | <p>“There are only cases where healthcare providers provide encouragement. There is no discrimination.” (Takeo)</p> <p>“TB treatment at health centers for women, girls, boys, men, and transgender is not discriminatory. There is no coercion – treatment is based on our consent.” (Banteay Meanchey)</p> <p>“There is no discrimination at healthcare settings these days. More than 90% of our people understand about TB, and there is no coercive practice.” (Siem Reap)</p> |

| | | |
|-------------------------------|-----------|---|
| People with TB | No | <p>“There is no coercive practice. There are only cases in which doctors force patients to take TB medication on the regular basis. There is no discrimination towards TB patients. When TB patients arrive at the hospitals, doctors are friendly.” (Takeo)</p> <p>“There is no coercive practice.... Women living with HIV are treated equally [like other patients] at health settings.” (Kampong Chhnang)</p> <p>“Doctors do not coerce patient; they take good care of patients and treat them equally. The elderly receive better treatment.” (Siem Reap)</p> <p>“There is no coercion or discrimination because the services are provided equally and [service recipients] receive treatment on the voluntary basis. If the villager support group volunteer suspects someone of TB, he/she advises, sends and/or accompanies [the person with TB] to hospital or health center.” (Banteay Meanchey)</p> |
| People living with HIV | No | <p>“Doctors don’t discriminate; they even advise [us] to protect ourselves. Our neighbours do.” (Kampong Chhnang)</p> <p>“The center (sic) does not discriminate and there is no coercive practice too. It even advises us to be good.” (Banteay Meanchey)</p> <p>“Previously (before 2005) when there were no NGOs [in our locality], there was discrimination. Nowadays, at the health settings there is no discrimination; they instead advise and encourage us.” (Prey Veng)</p> |
| Elderly people | No | <p>“There is no discrimination (against people living with HIV). Doctors follow the procedures; doctors in the district and province pay good attention to their work. As for (people with TB) there is no coercion.” (Takeo)</p> <p>“Doctors do not discriminate. They talk the patients to get treatment.” (Takeo)</p> <p>“As for women living with HIV and the elderly, there is no discrimination or coercion at the healthcare setting.” (Banteay Meanchey)</p> <p>“Health care settings (sic) do not discriminate (people with) TB. They advise the patients to take the medicine regularly, and NGOs help us get the ‘poverty card’ so that we are not charged when we sleep at the hospital for any treatment. As for TB treatment, there is no need for the poverty card; TB treatment is free of charge.” (Prey Veng)</p> |

| | | |
|-------------------------------------|---------------------|--|
| TB contacts | No | <p>“There is no coercion or discrimination. Whenever there are TB patients, doctors just cure all of them. They are not arrogant or evasive. There are attentive services and friendliness towards women living with HIV and the elderly who seek TB services.” (Kampong Chhnang)</p> <p>“There is no coercion or discrimination at health settings as TB patients receive the treatment voluntarily. Even for prisoners, they can still get treated in hospital.” (Banteay Meanchey)</p> <p>“In a majority of cases, there is no obstacle. When it is known that there is a TB case, the village volunteer comes straight to the residence. At the Takeo referral hospital there is no discrimination or coercion towards TB patients. I’ve never heard of it.” (Takeo)</p> <p>“At the health center, there is no discriminatory or coercive practice, including towards women living with HIV. As for the elderly, the doctors provide them the regimen that fits their strength and weight.” (Siem Reap)</p> <p>“There is no coercive practice at the center. Doctors just tell the patients to take their medication every month. Women with living HIV are treated like any other TB patients. As for the elderly, they are treated irrespective of their ages. The doctors treat the patients with care. Doctors provide treatment services to each and every one, whether they are transgender, elderly, young, female, male or having a criminal record. (Prey Veng)</p> |
| PWUD/PWID | Generally No | <p>“No, there is no discrimination. [They are] friendly, educate and encourage us. We are thankful that they advise and provide us with the services free of charge.” (Phnom Penh)</p> <p>“There is no coercion at the health settings towards women with HIV.... [However, according to one respondent] there is some discrimination towards PWID from service providers. It seems that they don’t whole-heartedly provide the services. This is not general – this applies to 20% of them only. The reason may be because of the perception that PWID do not correct themselves – they are gangsters.” (Phnom Penh)</p> |
| Prisoners | No | <p>“There is no discrimination. They only enforce the medication regimen. They don’t discriminate – they encourage. Previously, there was discrimination; now there is none because there are NGOs educating [about TB].” (Prey Veng)</p> |
| VHSG | No | <p>“There is no discrimination from the doctors – there are doctors that encourage – encourage patients to take after a good model of former patients who got cured.” (Kampong Chhnang)</p> |
| National Program | No | <p>“We have never heard of discrimination or coercive practices.”</p> |
| Provincial Health Department | No | <p>“There is no discrimination – people of any nationality can receive TB services equally.” (Banteay Meanchey)</p> <p>“There is no coercion in the provision of TB services, but we try to search for new cases. Sometimes we ask them to test for TB and if we find that they have TB, we may force them to get treated.” (Siem Reap)</p> <p>“(Some) health centers are not very active (in finding new cases) given that they are busy with other work” (Prey Veng)</p> |

| | | |
|------------------------------------|-----------|--|
| Health Operational District | No | <p>“There is no discrimination and no coercion. Nowadays, there is widespread TB service access given that it is free of charge.” (Takeo)</p> <p>“Maybe no.... Nowadays TB patients come to seek for services by themselves. They are very attentive; after they cough for some time, they come to meet the doctor to have the sputum tested.” (Banteay Meanchey)</p> <p>“When a patient comes in – whether he/she is female or male, old or young, we treat all of them.” (Siem Reap)</p> |
| Health Center | No | <p>“There is no (discrimination). In some cases, when they are too poor, I even give them each 5,000 riels when they come to pick up the medicine.” (Kampong Chhnang)</p> <p>“For every service, there is no discrimination. Even prisoners get treated – we doctors treat everyone. There are no coercive practices too.” (Takeo)</p> <p>“In a majority of cases, we treat the patients based on their volition – there is no coercion and the treatment is free.... There is no discrimination against anyone, irrespective of his/her race, financial status or age.” (Banteay Meanchey)</p> <p>“There is no discrimination. We treat everyone as far as they can come to take the medicine at the center, and the service is free of charge. In many cases, the problem is with the patients themselves. They can hardly commute to and fro the center; some live so far away from the center and some are fragile.” (Siem Reap)</p> |
| NGO | No | <p>“Instances of individual misbehavior amongst some service providers, in general, exist”.</p> |

Abbreviations: NGO, non-governmental organization; PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.

Source: Compiled by authors based on focus group discussion results.

Any indication of discriminatory practices by the judiciary or law enforcement personnel that may prevent women, girls or any other key or marginalized populations from accessing their rights

According to a representative of an NGO, there has recently been a good trend in which local authorities encourages local villagers and promotes the use of local public health services including HIV and TB in the target districts that the NGO works in. This is often discussed in the target communes, among the VHSGs and commune’s sub-committees on women and children. Nevertheless, there is an observation that there is an inclination among some villagers who prefer to seek for TB services outside their

communities of residence because of their own internal stigma.

The assessment team also attempted to examine whether there was any discriminatory or coercive practices from law enforcement officers, including local authorities, towards people with TB. From the respondents across the sites covered in this assessment there was a general indication that there were no discriminatory or coercive practices from them onto people with TB. NGOs working on TB and KPs interacted in general have a good praise for the local law enforcement officers, while it seems that TB service providers do not seem to have a good grasp of this issue. The table below illustrates selected remarks from the stakeholders across all the selected sites.

Table 12: Perception as to whether discriminatory and coercive practices from law enforcement officers exist towards women and girls and KPs

| Stakeholders | Perception | Selected Remarks on Law Enforcement Officers |
|------------------------|------------|---|
| People with diabetes | No | <p>“The authorities encourage the TB patients to seek for the treatment service speedily. They advise the patient to get the treatment quickly.” (Takeo)</p> <p>“The power holders [in my locality] do not discriminate these days. They are very helpful of the people.” (Banteay Meanchey)</p> |
| Former people with TB | No | <p>“Law enforcers don’t discriminate. Nowadays, citizens are even more powerful than the authorities.’ (Banteay Meanchey)</p> <p>“There is no discrimination from law enforcers towards TB patients. They encourage [them] to get recovered” (Siem Reap)</p> <p>“The authorities do not discriminate. They went around the locality to ask for saliva sputum, and if there are those who are seriously sick, they call me to look for an ambulance and they cover the cost. Pregnant women even get some financial support.” (Prey Veng)</p> |
| People with TB | No | <p>“Law enforcement officers and the court do not discriminate or ban TB patients from receiving the treatment. The village chief even encourages them to get treated – everyday it is announced via a megaphone three to four times to advise people to get treatment.” (Kampong Chhnang)</p> <p>“The authorities never discriminate or bar the patients to seek treatment; they even encourage and send them to look for the treatment at the referral hospital or nearest health center. If there is any suspicion, the village support group sends us to the health center and encourage the patients.” (Banteay Meanchey)</p> <p>“The government and police officials don’t discriminate or bar people from seeking the treatment services because everyone has equal rights.” (Siem Reap)</p> |
| People living with HIV | No | <p>“The powerful never discriminates against people with TB.” (Kampong Chhnang)</p> <p>“The power holders don’t discriminate against people with TB. They advised and even provided me with small money for travelling [to the center]. My wife and I got into regular arguments because of the illness and poverty and we went to the local government to file a divorce, but they advised us to suspend this and went to seek for treatment first. Now they jokingly asked me whether we still want to file a divorce.” (Siem Reap)</p> <p>“The law enforcement officers don’t discriminate against us. They encourage and advise us to go to hospital to seek for the services and take medicine regularly.” (Prey Veng)</p> |

| | | |
|-------------------------------------|---------------------|---|
| Elderly people | Generally No | <p>“Nowadays, it is convenient to receive TB services because the village support group walks around and encourages people to seek for the services. The authorities don’t discriminate or coerce. They encourage [people] to seek for the treatment service. The elderly are not discriminated against too – they are encouraged to receive the services.” (Banteay Meanchey)</p> <p>“There is no restriction from village and commune officials. There is only encouragement from them to the people to seek for the treatment service (for any illness) as soon as possible, but there is no financial support from the local government.” (Siem Reap)</p> |
| TB contacts | No | <p>“Court and police officers don’t discriminate against or bar people from getting the TB services. If they know any TB patients who forget to meet the doctor, they even remind them to go get medicine.” (Kampong Chhnang)</p> <p>“Village chiefs don’t discriminate against TB patients – they even inform the patients to get in touch with the TB service provider such as through the network to look for TB and guide them around to get the services.” (Banteay Meanchey)</p> |
| PWUD/PWID | | (Not explored) |
| Prisoners | No | “There is no discrimination – they advise us to be hygienic. They facilitate our travel to the health center.” (Prey Veng) |
| VHSG | No | “The (local) authorities and police officers don’t restrict (the rights of) the TB patients. When there is a meeting in the village, they allow [us] to disseminate TB services, and they are so happy when there is such dissemination as TB can get widespread easily.” (Kampong Chhnang) |
| National Program | No | “We have never heard of anything about this.” |
| Provincial Health Department | No | <p>“There is no discrimination.” (Siem Reap)</p> <p>“I cannot answer the question as it may affect other people.” (Banteay Meanchey)</p> |
| Health Operational District | No | <p>“There has seemingly been no reaction so far.” (Takeo)</p> <p>“There isn’t. I always visit every (health) center every month and I go to police stations as well (and they are generally supportive, even to people suspected of criminal acts).” (Siem Reap)</p> |
| Health Center | No | <p>“Talking about discrimination – now there is none – amongst doctors as well.” (Takeo)</p> <p>“There does not seem to have any discrimination.” (Banteay Meanchey)</p> |
| NGO | No | Instances of local authorities encouraging and promoting use of local health centers amongst local villagers exist. |

Abbreviations: NGO, non-governmental organization; PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.

Source: Compiled by authors based on focus group discussion results.

Monitoring and Evaluation (M&E) Systems

The national TB surveillance system administered by CENAT has recorded basic information about the patients, mainly the TB forms, their gender, ages, and

status of HIV. Other demographic information such as place of work, place of residence, occupation, pregnancy status, and incarceration have not been captured in the national database.

Regular monitoring and evaluation in the form of

survey had been periodically conducted. It is worth indicating that the NSP specifies that the following four key surveys shall be conducted between 2014 and 2020, i.e. National TB Prevalence Survey (once every five to ten years); National HIV Sero-prevalence Survey (once every two years or as required); National Drug Resistance Survey (once every three-five years), and knowledge, attitude and practice (KAP) Survey (once every three-five years).

SOCIAL, CULTURAL AND ECONOMIC FACTORS

KPs having higher risks of TB transmission

The twin report on KP Assessment discusses issues related to KPs in details; therefore, suffice here to say that besides the five high risk KPs raised in the NSP, the sub-national health staff and many of the participants in the STWG formed for the two assessments raised a few more groups who have potentially higher risks of TB and TB transmission. Some of the newly proposed groups were sub-groups of the KPs who have been much captured in the NSP. The sub-groups included children under five years of age, especially those in rural areas under custody of their grandparents, pregnant women,

wat frequenters (especially the elderly people and Buddhist monks), and migrant workers. PWUD, PWID, and female entertainment workers that were not included in the NSP were also proposed as potentially high-risk groups for TB in the assessment

Socio-cultural norms and practices that may contribute to increased risk of TB contact and TB transmission (by gender and among KPs and contributing factors for the continuation of the practices)

Through the interviews with key informants in Phnom Penh as well as the selected provinces and FGDs with the selected KPs, the assessment tried to gauge the socio-cultural norms and practices that may contribute to increased risks of TB and TB transmission among different genders (where possible) and among some KPs as well. The last three KPs in Table 13 did not raise any relevant points, although it must be admitted that there were fewer discussion groups for these three groups too. The following are some of the cultural norms and practices raised by the respondents:

Perceptions, including some misunderstanding, of the communities:

Table 13: Socio-cultural norms and practices that may contribute to increased risk of TB contact and TB transmission

| Stakeholder | Selected Remarks on Risks of TB Contact and TB Transmission |
|-----------------------|--|
| People with diabetes | <ul style="list-style-type: none"> • Chewing food for kids to make it warm • Smoking |
| Former people with TB | <ul style="list-style-type: none"> • Smoking and drinking, which weakens the immune systems • Having meal together (without a common serving spoon) at home and parties and other celebrations • Use of pesticide not adherent to the correct procedure, which weakens the immune systems • Drinking and (smoking) at KTV parlors • Chewing food for kids to make it warm |
| People with TB | <ul style="list-style-type: none"> • Gathering amongst, especially the elderly, in wats • Drinking with a common glass or cup |

| | |
|-------------------------------|---|
| People living with HIV | <ul style="list-style-type: none"> • Drinking outside the house, especially amongst men • Men as less attentive to their health (delay in seeking health services) • Women spending more of the time at home, decreasing the contact with other people • Drinking (water and alcohol) with a common cup or glass • Public spitting • Use of unclean eating and drinking utensils at the market • Having meal together (without a common serving spoon) at home and outside • Drug use • Smoking when children are around • Spending a lot of time at wats, especially for the elderly |
| Elderly people | <ul style="list-style-type: none"> • Smoking and drinking, especially in groups • Use of common cups or glasses • Public spitting |
| TB contacts | <ul style="list-style-type: none"> • Living in tight, close space • Gathering at wats |
| PWUD/PWID | <ul style="list-style-type: none"> • (no relevant points raised in discussion) |
| Prisoners | <ul style="list-style-type: none"> • (no relevant points raised in discussion) |
| VHSG | <ul style="list-style-type: none"> • (no relevant points raised in discussion) |

Abbreviations: NGO, non-governmental organization; PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.

Source: Compiled by authors based on focus group discussion results.

Perception of healthcare providers:

The following cultural norms and practices were reported to be generally more common among females:

- Chewing food for kids to make it warm
- Drinking at KTV parlors among female entertainment workers

The following cultural norms and practices were reported to be generally more common among males:

- Smoking and drinking
- Drinking and (smoking) at KTV parlors

Table 14: Socio-cultural norms and practices that may contribute to increased risk of TB contact and TB transmission

| Stakeholders | Selected Remarks on Risks of TB Contact and TB Transmission |
|---|---|
| Provincial TB Supervisor | <ul style="list-style-type: none"> • Gathering at wats amongst the elderly • Drinking in Karaoke parlors amongst male customers and female attendants • Chewing food for kids • Smoking and drinking • Living in poorly ventilated houses • Uncommon use of masks or handkerchiefs when coughing • Going to see doctors only when seriously/critically ill |
| Operational District TB Supervisor | <ul style="list-style-type: none"> • Smoking and drinking • Living in groups amongst garment factory workers • Living in poorly ventilated houses in rural areas • Gathering in wats |
| Health Center | <ul style="list-style-type: none"> • Living in tight, close space • Smoking and drinking • Gathering in wats |

Source: Compiled by authors based on focus group discussion results.

It is worth reiterating that some of the perceptions about cultural norms and practices that may increase the risk of TB contact and transmission raised by some of the KPs interviewed were rather misunderstanding, and even one health provider was even mistaken that ‘chewing food and then feeding it to children’ can transmit TB. Two key points from the NSP 2014-2020 (CENAT, 2014) are relevant here: (1) according to an evaluation report by FHI-360 in 2010 cited in the plan indicates that “knowledge of TB and TB symptoms in the community remain very low and (2) that funding for advocacy, communications and social mobilization have been very limited in recent years and only a small number of activities could be implemented.

Risk factors or social determinants—such as economic vulnerability, incarceration, malnutrition, smoking, indoor air pollution, silicosis, diabetes, drug and alcohol use, that contribute to increase vulnerability to TB

The discussion with the KPs and interviews with the health service providers delves into the risk factors or social determinants that contribute to increased vulnerability to TB, especially among the KPs under the assessment. This is covered extensively in the

other twin report on KP assessment and is thus not discussed herein.

LEGAL AND POLITICAL FACTORS

Legal frameworks or policy, basic health policies, and other general government policies that include any of the following: women and girls, men and boys, transgender people and key affected populations in relation to TB, HIV/TB, or DR-TB

The NSP 2014-2020, the principal guiding document for program interventions for the national TB response in Cambodia, states that the national TB programs aims to (1) ensure high quality basic services for all forms of TB for all population and (2) ensure that the most-at-risk groups and vulnerable populations (e.g., people living with HIV, pregnant women and children, contacts, diabetics, elderly, prisoners, internal and external migrants) have equitable access to basic TB services. These may be interpreted that the national TB programs has taken women, men, children, the elderly, and other selected KPs under a particular consideration. There was no indication of inclusion of other marginalized gender groups such as transgender people, men who have sex with men, etc.

The Technical Guidelines on the Fight against TB re-issued in 2016 by CENAT provides technical and procedural guidelines as to the handling of TB treatment of the high risk groups identified in the NSP

as well as other vulnerable groups, including people with MDR-TB, children, women during pregnancy and breastfeeding, and people with liver disorders.

IV. KNOWING YOUR TB RESPONSE

GENDER EQUALITY IN TB POLICIES AND PROGRAMS

Populations addressed in the TB national response

Legally and in actual practice, the Cambodian health system does not discriminate against any people who have TB. The NSP for Control of TB specifies that ‘everyone’ residing in Cambodia is entitled to access TB services free of charge. Nevertheless, considering the high risk groups, the NSP identifies at least five groups as TB KPs: people living with HIV, people with diabetes, prisoners, elderly people above 55 years of age, and TB contacts.

Through the workshops for this gender assessment, other potential KPs proposed by participants working in TB programs and other key stakeholders – to a varying degree of consensus – included PWUD, PWID, heavy smokers, karaoke frequenters, and attendants (or female entertainment workers, more broadly), and garment factory workers.

Inclusion of people with disabilities and older people, in particular older women, in the national TB response

The inclusion of the elderly people aged 55 and older in general (including women) in the TB national response has been a long practice within the healthcare system, and this is spelt out in the NSP, the national document that guides intervention programs and other initiatives. The NSP for Control of TB makes no mention of people with disabilities,

yet again as stated above everyone residing in Cambodia is entitled to TB services.

Whether the national TB response recognizes and addresses gender

The common narrative among TB service providers from the national to local levels, from both the government and NGO sector, is that there is no gender-based discrimination in the provision of TB services. The cliché is that ‘we provide the services to all TB service seekers equally irrespective of their gender’. While some may say that the response is gender insensitive, it can also be argued that the response is gender neutral. The NSP (CENAT, 2014) mentions the word ‘gender’ in one instance: “The new plan has increased focus in addressing specific needs and barriers related to gender, social support and human rights.” Yet, there were a few instances where the NSP specifically addresses interventions aimed towards either of the sexes (e.g. pregnant women and increase in the notification rate in the elderly people, especially among men). In general, it can be concluded that there is no gender-based discrimination in the response.

Extent to which the national TB response funded by domestic and external sources

Table 15: Funding sources for national TB response in actual amount and percentage

| (Amount in USD) | 2012 | 2013 | 2014 | 2015 | 2016 |
|--|-------------------|-------------------|-------------------|-------------------|-------------------|
| Total | 14,108,469 | 13,549,308 | 14,607,707 | 12,370,879 | 13,533,578 |
| Domestic | 1,531,870 | 1,718,114 | 1,886,609 | 2,327,395 | 2,448,770 |
| GFATM | 4,493,802 | 3,074,528 | 3,588,712 | 2,580,342 | 5,301,266 |
| USG (USAID and US-CDC) | 5,295,632 | 5,213,800 | 5,200,000 | 4,750,000 | 4,450,000 |
| Others Bi-&Multi-lateral Donors | 2,787,165 | 3,542,866 | 3,932,386 | 2,713,142 | 1,333,542 |
| (%) Total | 100% | 100% | 100% | 100% | 100% |
| Domestic | 11% | 13% | 13% | 19% | 18% |
| GFATM | 32% | 23% | 25% | 21% | 39% |
| USG (USAID and US-CDC) | 38% | 38% | 36% | 38% | 33% |
| Others Bi-&Multi-lateral Donors | 20% | 26% | 27% | 22% | 10% |

Source: CENAT (2017).

The funding for the TB national response has fluctuated quite slightly in the past five years. The average annual expenditure for TB response is around 13.6 million US dollars. There is a sign of a slight decrease in the past two years, with funding for 2015 and 2016 decreased to 12,370,879 and 13,533,578, respectively.

Although the funding from the government remained quite low (an annual average of 15%), there was a sign of gradual annual increase from 11% in 2012 to 19% in 2015 and 18% in 2016. The other two key funding sources were Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and US government (comprising of USAID and USCDC), which have provided an average annual funding of 28% and 37%, respectively. The funding from US government has been quite stable (i.e. 38% per annum), especially in the first four years (from 2012 to 2015), but there was a slight decrease in the last year (33%). Funding from other bilateral and multi-lateral development partners is quite significant too (albeit annual fluctuation exists) – with an annual average of 21%. However, the funding from these sources decreased to 10% in 2016. Funding to civil society organizations for the national TB response has been quite significant as well.

Whether there is an accessible system of information that documents expenditures (national and external) on gender and TB in the country?

There was no accessible system of information documenting expenditure (national and external) on gender and TB.

Whether the specific needs of women, girls, men, boys and transgender people considered in the budget allocation to the national TB response

There was consideration of expenditure allocation for such KPs as boys and girls, elderly people, and prisoners in budget planning and allocation. The planning and allocation of budget is not generally gender-based; however, there is specific mention of need to focus on pregnant women, children, and the elderly people in the NSP.

Whether the TB response disaggregate financial data collection and reporting by sex and age

The current TB response did not disaggregate financial data collection and reporting based on sex and age.

Whether pre-service curriculum of health-care workers include sensitivity training in gender, human rights, stigma and discrimination

According to the national and sub-national health staff interacted for the assessment, issues of gender, stigma, discrimination, and client rights and provider rights have been included in the updated pre-service curriculum of health-care workers to an extent, although the assessment did not conduct any assessment of the curriculum per se.

Whether standards of practice for health-care workers who deliver TB services include sensitivity training in gender, human rights, stigma and discrimination

In 2016, CENAT issued the revised Technical Guidelines for the Fight against Tuberculosis for healthcare workers who deliver TB services, which was first issued in 2003. The document mainly focuses on technical and procedural aspects of TB treatment and contains little stipulation on sensitivity training in gender, human rights, stigma and discrimination. However, the guidelines do specify the handling of treatment of TB in women during pregnancy and breastfeeding, children, and the five high risk KPs identified in the NSP.

According to some of the healthcare providers interviewed, there have been training on gender such as gender equality and provider rights and client rights to the healthcare providers, including health center staff and village support group volunteers. However, there has never been any training that focuses specifically on gender sensitivity, human rights (except for provider rights and client rights), stigma and discrimination, according to some of them, and the topic was under-explored in many interviews. The NSP spells out numerous capacity building training sessions that need to be offered to health providers; however, it seems that the training focuses more on the ‘technical aspects’.

Meaningful Participation

Overall, there were coordination mechanisms and platforms that enabled NGOs, civil society organizations (CSOs) and development partners, including WHO, to participate meaningfully in the design and implementation of the national TB response. One was the Sub-Technical Working Group on TB, which meets quarterly on the regular basis. Under the framework, the Interagency Coordinating Committee (ICC) for TB control

provided a venue for CENAT and NGOs and development partners working on TB to meet up more intensively and regularly for a few months during the preparation of TB funding proposals to submit to the funders, including the Global Fund. The platform also provided opportunities for the stakeholders to ‘update activities, discuss issues, and propose actions among members’ (Ngin et al., 2016).

The Annual TB Conference provides another venue for the beneficiary representatives, NGOs, development partners, and concerned ministries, including the Ministry of Women’s Affairs (MoWA), to discuss ‘country-wide progress, experiences, challenges, and solutions are shared, discussed, and assessed’ (Ngin et al., 2016). Another body, the TB Advisory Committee, comprising of CENAT, a representative of NGOs, a representative of UN agencies, a representative from USAID, a KP representative (currently a male former TB patient), provides another platform for stakeholder consultation and discussion. This committee and its meeting were ad hoc.

In its annual planning and on-going implementation of the national TB program, CENAT invited beneficiary representatives, relevant NGOs, development partners, and other concerned ministries, including MoWA, to its meetings and workshops for their opinions of its services and endorsement of the national program preparation and implementation. Likewise, NGOs also reported that they invited their respective beneficiary representatives to attend their annual operation plan formulation and review and annual conference to hear their opinions and feedback.

At the sub-national level, the provincial TWG, which met on the monthly basis, provided a venue for provincial health NGOs to discuss general health issues with PHD. At the OD level, participation of NGO in OD meetings can be done via a request to the OD director. Discussion specifically on TB at PHD and OD levels were not regularly scheduled. Bi-monthly or quarterly meetings on TB at HC level occurred occasionally, and NGOs working on TB could join, although such meetings ‘were irregular due to unpredictable funding and availability of members’ (Ngin et al, 2016).

At the community level, mechanisms for beneficiaries’ participation also existed. One of the platforms was the Health Center Management Committee, where a complaint mechanism existed for the service users to provide their feedback on the services. Another mechanism was the implementation of community score cards, which allowed beneficiaries to evaluate

the quality of health services (in general) provided by health service providers in their communities.

Any (legal, political and financial) provisions exist for capacity building and allocation of resources to support participation of KPs (specified) in TB response

According to the NSP (CENAT, 2014), former people with TB may participate in TB response via VHSG, which formed an integrated platform for the local people to participate in community-health activities. For TB, two VHSG members per village (one male and one female, Ngin et al, 2016) have been trained to refer TB suspects, collect and transport sputa, conduct community sensitization, support patients on treatment, and collect drugs from the health centers. Each have been provided with a travel enabler of one dollar for the travel to and from the health center to the community per trip. The regular meetings between the VHSG members and the health center workers have been used to provide refreshment training to them on basic knowledge and skills about TB screening, diagnosis, and treatment. This community participation in the TB response formed part of the community DOTS (C-DOTS) initiative, which was started in 2002 and which has expanded ever since. The program has so far expanded or contracted according to the availability of external funding (CENAT, 2014). There were 503 health centers practicing C-DOTS in 2008, and the figure increased to 861 in 2015 (Ngin, et al., 2016).

This was confirmed by the interviews with the sub-national health staff. According to the sub-national health staff, there were legal and financial provisions for capacity building and allocation of resources to support participation of KPs, especially former people with TB in national TB response. The provisions included administration of short training to KPs on dissemination of TB awareness and knowledge about TB to their communities. There were one or two TB village support group volunteers per village, and they were usually provided with small financial incentives for their participation in meetings, information dissemination, and for bringing in people with TB for treatment. A study by Ngin et al. (2016) discusses some constraints and limitations in the involvement of VHSG in the TB response. They included limited direct contact between VHSG members and RH staff, high turnover rate, and limited recruitment of new VHSG members.

Any KPs excluded—by laws, regulations or policies—from engaging in national TB response

There was a consensus among the health providers that there was no KP that has been excluded from engaging in the national TB response by any means, including legal stipulation, regulation enforcement and policy formulation and implementation.

Coordination of gender equality within the TB response

There was no formal coordination of gender equality within the TB response in the government agency, within the NGO communities working on TB, as well as between the government agency and NGOs at the central level (see also Ngin, et al., 2016). At the provincial level, the provincial sub-technical working group on TB provided a formal coordination platform between PHD and NGOs working on health issues to meet monthly to update their activities and discuss various issues (Ngin et al., 2016) including gender equality in TB response.

Any gender-related impediments to accessing, using and/or adhering to prevention services for women, girls, men, boys, transgender people and other KPs that should be considered and addressed

Through the FGDs, some of the KPs raised the following as gender-related impediments (response disaggregated by gender where possible) to accessing, using and/or adhering to prevention services amongst different gender and other KPs that should be considered and addressed in the policy response. It is noteworthy that the last four KPs did not see any gender-related impediments; however, it is worth noting that the last three groups constituted the least number of participants in the assessment. Among others, the following factors are raised as hindrance to accessing, using, and/or adhering to prevention services: attending to livelihoods and household chores, out-migration, ignorance, and patients' personal behaviors.

Table 16: Perceptions of selected KPs on gender-related impediments to accessing, using and/or adhering to prevention services

| Stakeholder | Selected Remarks on Gender-Related Impediments |
|--------------------------------|---|
| People with diabetes | <ul style="list-style-type: none"> - Lack of money for local transport to health centers (Takeo) - A need to make ends meet (Takeo) - Not wanting to expose one's weakness (illness) amongst male |
| Former people with TB | <ul style="list-style-type: none"> - Labor migration within and outside the country - Inability to tolerate the side effects from the medication - Busyness with making ends meet for the female poor - Drinking and not caring for one's health amongst men - Not wanting to reveal one's TB status for fear of social stigma, amongst the elderly - Going to take medicine only when one's not well |
| People with TB patients | <ul style="list-style-type: none"> - Living far away from the health center |
| People living with HIV | <ul style="list-style-type: none"> - Poverty and busyness with making ends meet - Busyness with household chore for female (and thus forgetting to take medication regularly) - Female is shier than male in seeking for the services - Going to seek for the services only when seriously/critically ill - Lack of money to commute to/from health centers |
| Elderly people | <ul style="list-style-type: none"> - Busyness with making ends meet - Side effects from the medication - Busyness with household chore (for female) - Lack of communication means to/from health centers |
| TB contacts | <ul style="list-style-type: none"> - (not an issue) |
| PWID/PWUD | <ul style="list-style-type: none"> - (not an issue) |
| Prisoners | <ul style="list-style-type: none"> - (not an issue) |
| VHSG | <ul style="list-style-type: none"> - (not an issue) |

Abbreviations: NGO, non-governmental organization; PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.

Source: Compiled by authors based on focus group discussion results.

Gender-related barriers for use and adherence to services to consider and address

Interviews were conducted with the provincial

and district health providers covered the issue of gender-related barriers for use and adherence to TB services among different gender and some KPs to consider and address in the policy response. The participants raised the following issues:

Table 17: Gender-related barriers for use and adherence to the TB services

| Stakeholders | Selected Remarks on (Gender-Related) Barriers for Use and Adherence to Services |
|-------------------------------------|---|
| Provincial Health Department | <ul style="list-style-type: none"> - Poverty - Under-utilization of public health services - Busyness in tending children and grand-children, especially for mothers and grand-mothers (in rural areas) - Lack of communication means to/from health centers, especially for the elderly - Migration - People living with HIV-TB wanting only one of the medication - Unbearable medication side effects |
| Health Operational District | <ul style="list-style-type: none"> - Difficulty in commuting to/from health providers for the elderly - Need to make ends meet - Living far away from health centers - Lengthy procedure in commuting prisoners to health providers - Busyness in tending children and grand-children for the elderly - Not daring to get treated for people with HIV for fear of discrimination - Poverty for diabetics - Parents not bring young kids to health centers - Fear of discrimination and social stigma |
| Health Center | <ul style="list-style-type: none"> - Busyness in looking after grand-children - Busyness in making ends meet - Lack of adherence to medication regimen - Living far away from service providers - Migration to neighboring countries - Lack of communication means to/from service providers - Poverty |

Abbreviations: HIV, immunodeficiency syndrome; TB, tuberculosis.

Source: Compiled by authors based on focus group discussion results.

A COMPREHENSIVE TB RESPONSE

TB Prevention

Basic TB prevention and supportive services have been provided at health facilities to service seekers at no cost. Such services included access to information about TB and HIV, INH prophylaxis for people living with HIV and people with latent TB infection, behavior change communication, and TB

contact tracing and treatment. The provision of BCG is the responsibility of the National Immunization Program (NIP) of the Ministry of Health. The services were mainly TB-related, with some integration of HIV services. However, many HIV-related services were not available at TB treatment services, and it was reported that such services were covered by NCHADS. There was no integration of other services for such KPs as drug users and diabetics.

Table 18: Availability of TB prevention and supportive services

| | |
|--|-----|
| Access to information about HIV and TB | Yes |
| BCG vaccination | Yes |
| INH prophylaxis for people living with HIV and people with latent TB infection | Yes |
| Behavior change communication | Yes |
| Peer education | Yes |
| TB contact tracing and treatment | Yes |
| Drug use harm reduction measures | No |

Abbreviations: BCG, Bacillus Calmette–Guérin vaccine; HIV, immunodeficiency syndrome; INH, Isoniazid; TB, tuberculosis.

Source: CENAT (2017).

Testing and Treatment

Table 19 shows percentage of people with TB who received an HIV test in each year and knew the results in 2012-2016. The percentage of people with TB who received the test each year and knew their

results have been quite constant in the past five years, although there has been a slight increase in the past two years at 83% and 85%, respectively. The annual average was some 82%. There was no breakdown of data by gender and by age recorded at the central level.

Table 19: Percentage of people with TB who received an HIV test in each year and knew the results

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---------------|------|------|------|------|------|
| Total | 80% | 82% | 81% | 83% | 85% |
| Male | n/a | n/a | n/a | n/a | n/a |
| Female | n/a | n/a | n/a | n/a | n/a |

Source: CENAT (2017).

The assessment attempted to collect the data breakdown by provinces from all the 25 PHD through an email survey and field data collection. However, it managed to collect data from only six PHD through the field data collection and email survey. As shown Table 20, the percentage of people with TB who received an HIV test in each year and knew the results varies quite significantly from province to

province – with Kampong Chhnang PHD recorded that all people with TB were tested for HIV in 2015 and 2016 and Prey Veng PHD ranked the lowest on this indicator. The other three provinces recorded that generally more than 90% of the people with TB were tested for HIV. Data breakdown by gender and age is hardly available.

Table 20: Percentage of people with TB who received an HIV test in each year and knew the results in selected provinces

| | Kampong Chhnang | | Banteay Meanchey | | Siem Reap | | Prey Veng | | | Kampot | | | Sihanoukville | | | | |
|---------------|-----------------|------|------------------|-------|-----------|-------|-----------|-------|-------|--------|------|------|---------------|-------|-------|-------|-------|
| | 2015 | 2016 | 2015 | 2016 | 2014 | 2016 | 2014 | 2015 | 2016 | 2014 | 2015 | 2016 | 2012 | 2013 | 2014 | 2015 | 2016 |
| Total | 100% | 100% | 98% | 98% | 87% | 93% | 66% | 64% | 78% | 91% | 95% | 92% | 95% | 93% | 99% | 97% | 95% |
| Male | 100% | 100% | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) | 90% | 97% | 89% | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) |
| Female | 100% | 100% | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) | 91% | 99% | 99% | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) |

Sources: Provincial Health Departments of Kampong Chhnang, Banteay Meanchey, Siem Reap, and Prey Veng (November, 2017).

The data on the number of people with TB who got diagnosed and treated in the past 12 months were not captured in the central database. However, according to the NTP senior officers, the gap is very small (less than 5%) and an absolute majority of the people who were diagnosed with TB were treated every year.

Table 21 shows that number of people diagnosed with MDR-TB and started treatment each year was relatively low – with an average of 83 cases per annum. There was a slight decrease in the notification of MDR-TB cases in the past two years from a peak of 121 in 2013 to 75 and 101 cases in 2015 and 2016, respectively. There was no data breakdown by gender, by age, and by province.

Table 21: Number of people diagnosed with MDR-TB and started treatment each year

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---------------|-------|-------|-------|-------|-------|
| Total | 110 | 121 | 110 | 75 | 101 |
| Male | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) |
| Female | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) |

Source: CENAT (2017).

TB treatment success rates in 2012-2016 are shown in Table 22. The rate (for smear positive) has been quite impressive – standing constantly at 93% per annum in the past five years. There was no data

breakdown by age, gender, and province available in the national surveillance system. The NSP correctly noted that the “treatment success rates are high by international standards” (CENAT, 2014).

Table 22: National TB treatment success rate in 2012 – 2016

| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---------------|-------|-------|-------|-------|-------|
| Total | 93% | 93% | 93% | 93% | 93% |
| Male | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) |
| Female | (n/a) | (n/a) | (n/a) | (n/a) | (n/a) |

Source: CENAT (2017).

Whether treatment services respect, promote and protect rights of women, girls, men, boys, transgender people and selected KPs

people with TB, regardless of their gender and other social and economic statuses. The response and remarks from the service recipients and providers are generally positive and are shown in Table 23.

The assessment tried to examine whether the treatment services respect, protect and promote the

Table 23: Whether treatment services respect, promote and protect rights of women, girls, men, boys, transgender people and selected KPs – perspectives of TB service recipients

| Stakeholders | Treatment services respect, promote & protect rights of women, girls, men, boys, transgender people and selected KPs | Selected Remarks on Services |
|------------------------|--|---|
| People with diabetes | - Yes | <ul style="list-style-type: none"> - “Both the health center and referral hospital always encourage TB patients. The doctors tell the patients to help disseminate TB treatment services (to their fellow villagers) and encourage potential TB patients to come forwards for treatment as soon as possible. Doctors tell them to come to take medication on time and regularly.” - “Doctors don’t discriminate, regardless of political inclination. The principles are not violated.” |
| Former people with TB | - Yes | <ul style="list-style-type: none"> - “The health providers do not discriminate based on wealth status – people are called to get the medication in order. They provide the services regardless of age. In case of emergency, some patients may be treated first.” - “TB treatment service does not discriminate, and there is no violation of the principles. The elderly are treated, irrespective of their age.” |
| People with TB | - Yes | <ul style="list-style-type: none"> - “TB treatment services are provided equally. If there were any discrimination, there would be TB everywhere in the village.” - “TB treatment services are provided equally, regardless of gender and age.” |
| People living with HIV | - Yes | <ul style="list-style-type: none"> - “No. There is encouragement from the providers.” - “The principles are not violated; doctors follow the procedures and are friendly.” |
| Elderly people | - Yes | <ul style="list-style-type: none"> - “(Doctors) do not violate the principles. TB patients are treated, regardless of their wealth or power.” - “TB treatment services are provided equally for all and they are provided regardless of gender and age.” - “There is respect of the rights. There are good words and some bad words, indeed.” |
| TB contacts | - Yes | <ul style="list-style-type: none"> - “TB treatment services are provided equally, regardless of age, gender and marital status.” - “TB patients have the rights to receive treatment equally because the treatment is for all, and there is respect for rights, whether one is young, old or transgender.” |
| PWID/PWUD | - Yes | <ul style="list-style-type: none"> - “TB treatment services are provided regardless of marital status, gender, profession, and age. Every TB patient is treated.” |
| Prisoners | - Yes | <ul style="list-style-type: none"> - “They (health providers) don’t discriminate. They guide (us) on medication and hygiene.” |

| | | |
|------|-------|--|
| VHSG | - Yes | - “TB treatment services respect, promote and protect (the rights of people with TB) as the treatment is provided regardless of age, gender, livelihood, and wealth status.” |
|------|-------|--|

Abbreviations: PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.
Source: Compiled by authors based on focus group discussion results.

The health providers were generally positive about their treatment services too, although the remarks are not gender-specific (Table 24).

Table 24: Whether treatment services respect, promote and protect rights of women, girls, men, boys, transgender people and selected KPs – perspectives of TB service providers

| Stakeholders | Treatment services respect, promote & protect rights of women, girls, men, boys, transgender people and selected KPs | Selected Remarks on Services |
|------------------------------|--|--|
| Provincial Health Department | - Yes | <ul style="list-style-type: none"> - “There are health staff who use good language and some who display inappropriate behavior. The treatment services (sic) usually treat everyone equally.” - “There is promotion through DOTS. We allow them to choose the provider that is convenient (close) to them.” - “When we’ve seen a TB case, we explain to him/her the treatment process.” |
| Health Operational District | - Yes | <ul style="list-style-type: none"> - “We advise (staff) not to discriminate the patients. We respect and encourage the patients. We don’t only treat TB. If they are diagnosed with other diseases such as diabetes and HIV, we help seek the treatment services for them too.” - “There is promotion of their rights. If they forget to come pick up their medicine, our staff member calls them. There is non-disclosure too, and we don’t disseminate their TB status to the community they live in. We control their sputum regularly and encourage them to take the medication. At the end of the treatment, we check their sputum again to ensure they are treated.” - “In some instances, we even beg the patients to get treated otherwise they would quit due to the (strong) side effects. It is inevitable at either the health center or hospital that there are instances where doctors and patients may use big words to each other.” |
| Health Center | - Yes | <ul style="list-style-type: none"> - “There is respect of their rights. There are instances when inappropriate behavior is displayed. Some patients may use bad words because of the strong side effect, and health staff may use bad words too, but to make them take the medication.” - “(We) encourage them to take the medication until they are cured to avoid spreading (the disease) to their family members.” |

Abbreviations: DOTS, directly observed treatment, short-course; HIV, human immunodeficiency virus; KP, key population; TB, tuberculosis.
Source: Compiled by authors based on focus group discussion results.

Care and Support Services

Table 25 shows that, in general, the TB care and support services respect, promote and protect the rights of selected KPs, irrespective of their gender. According to the central NTP officers, the following are illustrative. For the elderly and disabled, they can access the community DOTS to avoid having them travel long distance to the health centers. For

children, the TB medicines can be administered to them by their mothers or school teachers. For Buddhist monks, there is DOTS service available to the pagoda. However, there is no target intervention for transgender people. The issues were also discussed extensively with the KPs, and there is no report of mistreatment or indication of violence of their rights. Table 28 below presents their thoughts and remarks on this issue:

Table 25: Whether care and support services respect, promote and protect rights of women, girls, men, boys, transgender people and selected KPs – perspectives of TB service recipients

| Stakeholders | Care & support services respect, promote & protect rights of women, girls, men, boys, transgender people and selected KPs | Selected Remarks on Services |
|-----------------------|---|---|
| People with diabetes | - Yes | <ul style="list-style-type: none"> - “Doctors advise on diet for diabetics.” - “Doctors encourage (us) to take medication regularly and do not quit.” - “As for TB services, patients receive equal treatment, regardless they are female, male or transgender.” |
| Former people with TB | - Yes | <ul style="list-style-type: none"> - “The doctors encourage patients to come to take medicine regularly. I see it with my own eyes. There is no violation.” - “They doctors were attentive – for the doctors at the center I was treated. I don’t know about other centers.” |
| People with TB | - Yes | <ul style="list-style-type: none"> - “The doctors record in the patients’ logbooks every month.” - “The sputum is tested and monitored once every month until the patients are cured.” - “Care and support services are provided equally – to the elderly and youths alike. Doctors prescribed additional medication or dosage if there is another strand of disease.” |
| People with HIV | - Yes | <ul style="list-style-type: none"> - “There is no violation. Doctors encourage taking medication regularly.” - “Doctors take care of treating us.... As for people with TB and HIV, they go receive their medicine at another place.” |
| Elderly people | - Yes | <ul style="list-style-type: none"> - “Doctors respect and promote (our rights) – they advise and educate us (at the health center), and there is no indication of violation.” - “Especially they provide the medicine regularly and hand out facial masks for protection too.” |

| | | |
|----------------|-------|---|
| TB contacts | - Yes | <ul style="list-style-type: none"> - “The doctors provide (us) advice such as taking regular bath and avoiding fermented food.” - “Doctors (regularly) monitor our health, and if we are not well or have other illness, they may prescribe additional medicine or treatment.” |
| PWID/PWUD | - Yes | <ul style="list-style-type: none"> - “Doctors provide treatment and encourage them (people with TB), regardless their gender (transgender)...and age (for the elderly).” - “Care and support services don’t discriminate (people with TB) regardless of their marital status, gender (MSM, lesbian), age and profession.” |
| (Ex)-prisoners | - Yes | <ul style="list-style-type: none"> - “(We) were advised to take regular medication and wear masks.” |
| VHSG | - Yes | <ul style="list-style-type: none"> - “Care and support services include provision of food. Doctors told (people with TB) to take medicine regularly.” - “Care and support services are good since there are two village support group members per village.” |

Abbreviations: DOTS, directly observed treatment, short-course; HIV, human immunodeficiency virus; KP, key population; MSM, men who have sex with men; PWID, people who inject drugs; PWUD, people who inject drugs; TB, tuberculosis; VHSG, village health support group.

Source: Compiled by authors based on focus group discussion results.

The healthcare providers concurred that the services they provided were generally good, and there was no indication of violence of the rights of people with

TB regardless of their gender and other social or economic statuses. Table 26 below presents their thoughts and selected remarks on the issues.

Table 26: Whether treatment services respect, promote and protect rights of women, girls, men, boys, transgender people and selected KPs – perspectives of TB service providers

| Stakeholders | Care & support services respect, promote & protect rights of women, girls, men, boys, transgender people and selected KPs | Selected Remarks on Services |
|------------------------------|---|---|
| Provincial Health Department | - Yes | <ul style="list-style-type: none"> - “There is no violation – there’s only encouragement. There are instances of (health service providers) being a bit of an alarmist. An issue may be that our services are not comprehensive.” - “There is equal treatment, regardless of whether (the people with TB) are male or female.” - “There is advice on side effects. They are advised to contact or come to see doctors quickly if they observe any serious side effects. Their family members are tested for TB as well if there is any suspicion.” |

| | | |
|----------------------|-------|--|
| Operational District | - Yes | <ul style="list-style-type: none"> - “As for care services, whenever they come to receive medication, our health staff or the village support group volunteers provide them advice on diet, living environment, preventive measures, and TB and encourage them (to take medication regularly).” - “After taking medication, we provide them with encouraging words (to stay on medication)... If they need to stay at the referral hospital, they have their daily ration too – i.e. 2,000 riels per day.” |
| Health Center | - Yes | <ul style="list-style-type: none"> - “Yes. If the support service is not good, it may bring about mental health problems to them. There is no violation; we advise them on prevention in order to avoid spreading to other people.” - “There is advice on diet – they can eat anything as there is no diet restraint for people with TB. We advise them to take enough rest and take the medication regularly.” |

Abbreviations: KP, key population; TB, tuberculosis.

Source: Compiled by authors based on focus group discussion results.

Whether there is any record of treatment success rate of adult and children with TB on ART

There was no record of number or percentage of treatment success rates of adults and children with TB on treatment 12 months after initiation of ART in the central database.

GENDER CONSIDERATIONS PER COMMUNITY

Existence of gender-related policies and whether they guide policy interventions in TB response

Cambodia has long prepared the National Plan for Gender (or more precisely, women). The current plan, Neary Rattanak 2014-2018, deals on two key issues: promotion of equality and equity between the sexes. The preparation of the plan was multi-sectorial in nature, involving the participation of MoH as well.

There was some indication that the plan has influenced the policy interventions in the TB response. In its program planning and in numerous meetings, the Center often engages representatives from MoWA. Besides, there were many instances in the NSP where gender, the elderly and children were considered in the program interventions in the TB response, as discussed somewhere above.

Gender-Based Violence (GBV)

In response to chronic gender-based violence, especially one that was perpetrated towards women, the MoWA issued the National Action Plan on Violence against Women 2014-2018 in 2014, and like Neary Ratanak 2014-2018, the preparation of the plan was multi-sectorial in nature, including participation from MoH. However, like Neary Ratanak, the plan has not been used to guide policy interventions in the TB national response, and the NSP made no mention of GBV too.

Whether the TB response addresses attitudes of public service providers about violence against women and gender-based violence

According to the health providers, at both national and sub-national levels, the TB response focuses mainly on health issues and deal with mainly health professionals, including village health support groups – i.e. mainly on treatment of TB and to a lesser extent TB-HIV co-infection and TB and diabetes, and there is no inclusion of ‘non-health-related issues’ such as violence against women and gender-based violence. However, whether the health providers may get training on these themes from other intervention programs were not explored in this assessment.

Whether integration of TB and SRHR service and commodities exists

According to some national stakeholders, integrated health services through collaborative arrangements with providers of other health services such as

material, neonatal and child health services and other related services including general medicine existed. The newly adopted TB hospital linkage activities are available at 5 hospitals supported by FHI 360.

V. CONCLUSION AND RECOMMENDATIONS

In light of the findings from this assessment and in close consultation with all relevant stakeholders through a validation workshop and the NTP, the assessment would provide the key recommendations as below:

First and most important of all, there is an urgent need to improve the current national and sub-national routine TB reporting system and database management system. These systems are supposed to capture all the key data that are essential for understanding of the disease epidemiology, program interventions, program monitoring and evaluation, and policy directions and with data for key indicators identified and broken down, among others, into gender, age and location (province and district), where appropriate. Relatedly, effort should be made to strengthen and update the TB management information system and the capacity to manage the data and database to ensure that: (1) the data are properly and safely stored; (2) the data are effectively used to inform program intervention and policy formulation; and (3) the quality of the data is closely monitored and maintained to ensure that it reflects the reality.

Second and as planned in the NSP, the regular conduct of the national TB prevalence survey planned for 2019 and other important surveys enlisted in the plan is important to understand and update the TB situation in Cambodia. These surveys should be prioritized and conducted regularly, according to the schedules proposed. Ad hoc and regular surveys on other key issues such as nation-wide KP estimation and behavior of service consumption among the KPs as well as the general population and the quality of TB service provisions should also be considered. Efforts should also be made to better understand the TB epidemiology and the situation of people living with TB nation-wide and/or among selected KPs to better understand the constraints and challenges and to identify the opportunities and service gaps so as to improve program intervention and long-term planning through conduct of relevant research, including into gender and TB, to inform policies and practices.

Third, while the NTP should be applauded for the inclusion of gender consideration into its national TB response to some extent, more effort can be made to integrate or permeate gender consideration into the circle of its operation, including budgeting

and activity planning, budget allocation, program implementation, and program monitoring and evaluation.

Fourth, there has been linkage of and collaboration between TB services to other key health services mainly HIV and AIDS, diabetes, MNCH, and TB in prisons, and these initiatives and effort should be applauded. However, there is a general view that the collaboration needs to be better enforced, strengthened and funded. It is also recommended that effort shall be made to integrate and/or link TB services to other key services such as drug rehabilitation, SRHR services, and campaign to end GBV and other forms of violence or discrimination.

Fifth, as can be seen above, misperception among the general population (and even the KPs themselves) about TB still exists, and reportedly there is some degree of stigma and community discrimination (which is sometimes related to the misperception) as well. Besides, while there are some sources of financial support to cover the TB treatment-related costs for some target groups such as the poor and the elderly (although TB treatment itself is free of charge) such as the social equity fund and other social fund run by NGOs, the sources are widely known to the potential users and are thus under-utilized by potential health service seekers (CENAT, 2014). There is also a need to improve TB prevention services and practices among the general population, and especially the KPs, in order to relieve the treatment burden. Therefore, effort should be made to conduct wide dissemination about TB and TB services to the general population and especially the KPs through conduct of public campaign or community forums; traditional and new media such as radio talk show and spot, TV talk show and spot and social media campaign; integration of TB knowledge and understanding through comedy shows; and wider use of VHSG for dissemination and awareness raising. Effort also needs to be made to strengthen the inclusion of basic TB knowledge into the general education curriculum, especially the second-level primary education or junior secondary education.

Sixth, big strides should be made to raise the awareness of gender and TB among the health providers, including VHSG. This awareness is even more important in light of the integration and linkage of TB services to/with other health or health-related

services. Activities and initiatives to better integrate and permeate the gender and TB may include, but are not limited to, preparation of necessary gender-related guidelines within the context of TB response and provision of the related training, and integration of key aspects of gender and TB into the pre-service curriculum for health workers and IEC/BCC guidelines. In this regard, there is a need to mobilize financial, technical and, if necessary, political support from the stakeholders to integrate gender into TB services and for the conduct of related training.

Seventh, whereas the involvement of other sectoral stakeholders, including from MoWA, in the preparation of TB plans and policies and sometimes their implementation should be applauded, there is a need to better use national plans and policies adopted by other relevant sectors, including gender and the elderly to inform and/or guide TB program planning, program implementation, and policy formulation.

Eighth, over the decades, the national program has implemented numerous intervention programs, and there are many good programs and practices. These good (pilot) programs and practices such as the childhood TB program should be better documented and expanded or adapted to cover other KPs to increase wider treatment coverage and improve cost efficiency in program execution.

Finally, all the key stakeholders, including CENAT, should be applauded for working together and collaborate on many fronts to fight TB. The current platforms for inter-agency cooperation and collaboration should be continued to be utilized for further program cooperation and collaboration, sharing good practices and lessons learned from program intervention, and discussion of other pertinent issues. However, effort shall be made to re-enforce and strengthen the effectiveness of many of the current collaborative platforms, where necessary. The platforms may also be used to integrate and permeate gender into TB program intervention and policy formulation through, for instance, the invitation of government institutions and NGOs working on gender to be their members or attend the meetings, where necessary. A few mechanisms for community involvement in the TB response such as C-DOTS have been known to be effective and efficient to fight TB. These mechanisms for civil society organizations and the KPs to get involved in the provision of TB services need to be strengthened, enforced, and funded in the fight to end TB by 2035 in Cambodia.

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VII. ANNEX

Annex1. Term of Reference (ToR)

Implementation of a project: KP and Gender Assessment of the National TB intervention Programs in Cambodia

With the direction of the National Center for Tuberculosis and Leprosy Control (CENAT), KHANA together with other partners will conduct a key population and gender assessment in the national tuberculosis response in Cambodia. To support and monitor the assessment, the Project Steering Committee (PSC) and a sub-technical working group for key population (KPTWG) and gender (GTWG) assessment will be established.

Project Steering Committee (PSC)

1. The members of the committee will include representatives from:
2. CENAT/National Tuberculosis Program (NTP) (Chair of the Committee)
3. National Center for HIV/AIDS, Dermatology and STD (NCHADS) and Ministry of Women Affairs (MoWA)
4. TB non-governmental organizations (KHANA, CATA, RACHA, RHAC, CHC, FHI360, CRS, and Op-ASHA)
5. UN and donor agency (WHO and USAID)
6. Community and key population representative
7. Others

The PSC will help to steer a project from the beginning to the completion. The PSC will support to ensure the technical leadership and involvement from relevant stakeholders and beneficiaries. It is made up of key representative of the national programs, donor, organizations and community representative who have particular expertise to lend to the project. The PSC's roles may include the following key tasks:

- Identifying the priorities in the project's expectations
- Providing advice about changes to the project as it develops
- Monitoring the quality of the project as it develops;
- Providing inputs to the development of the assessment protocol, tools and report
- Attending PSC's meeting (at least 5 times for the whole of project period)

Sub-technical working groups for KP and Gender

The two sub-technical working group will combine. The key roles of the sub-national working are to assist the preparation, implementation and report, together with the support of the national and international technical assistants. Their key roles are to:

- Attend the working group meeting
- Provide technical inputs to the assessment's design, preparation, implementation and report at the working group meetings
- Assist in coordinating the assessment team to prioritize the needs
- Assist in rationally prioritizing recommendations according to results
- Support the assessment team in the collection of additional information and data as needed

Member of Sub-technical working group for KP and Gender

1. CENAT/National Tuberculosis Program (NTP) (Chair of the Committee) and another 4 members
2. National Center for HIV/AIDS, Dermatology and STD (NCHADS)- two presentative

3. General Department of Prison (GDP)
4. Ministry of Women Affairs (MoWA)- two representatives
5. TB non-governmental organizations (KHANA, CATA, RACHA, RHAC, CHC, FHI360, CRS, and Op-ASHA)
6. UN and donor agency (WHO and USAID)
7. Community and key population representative
8. Others

PSC and sub-technical working group meetings

The below are the suggested series of meetings for both PSC and sub-technical working groups. The ad-hoc meetings will be convened by the Chair of PSC.

| No | Key activity | When |
|----|--|--------------|
| 1 | Review and finalize the term of reference of the committee and sub-technical working groups. Technical guidance on the assessment framework and tools on KP and Gender | 25 Sept 2017 |
| 2 | Attending the stakeholder meeting to review protocol, framework and tools | 27 Sept |
| 3 | Review protocol, tools and framework before submission to NECHR | 29 Sept |
| 4 | Review and input to the prioritization of KP resulted from the stakeholder meeting | 20 Oct 2017 |
| 5 | Review and provide technical guidance and inputs on the report outline | 17 Nov |
| 6 | Attend the mid-field reflection on the data collection | 30 Nov |
| 7 | Review and provide technical advice and inputs on the preliminary findings | 5 Dec |
| 8 | Attending the validation workshop on the assessment results | 7-8 Dec |



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