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Assessing the tuberculosis situation and control program in national penitentiaries in Cambodia

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January 28 – February 2, 2008

TABLE OF CONTENTS

LIST OF ACRONYMS

AIDS Acquired Immune Deficiency Syndrome
ART Antiretroviral Therapy
AusAID Australian Agency for International Development
CENAT National Center for Tuberculosis and Leprosy Control
CC1 Correctional Centre 1
CC2 Correctional Centre 2
CCJAP Cambodia Criminal Justice Assistance Project
CRS Catholic Relief Services
DOT Directly Observed Treatment/Therapy
DOTS Directly Observed Treatment/Therapy Short Course
FHI Family Health International
GTI/UAB Gorgas Tuberculosis Initiative/University of Alabama at Birmingham
HIV Human Immunodeficiency Virus
ICRC International Committee of the Red Cross
IEC Information Education and Communication
IPT Isonazid Preventive Treatment
JATA Japan Anti-tuberculosis Association
LICADHO Cambodian League for the Promotion and Defense of Human Rights
MoH Ministry of Health
MoI Ministry of Interior
MSF Médecin Sans Frontières (Doctors Without Borders)
NCHADS National Centre for HIV/AIDS Dermatology and STDs
NGO Non Governmental Organization
NTP National TB Control Program
OI Opportunistic Infection
PJ Police Judiciary Prison
PLWHA Person Living with HIV and AIDS
PPM Private-public and Public-public Mix
TB Tuberculosis
UNAIDS United Nations Joint Program on HIV/AIDS
USAID United States Agency for International Development
VCCT Voluntary and Confidential Counseling and Testing
WHO World Health Organization

I. BACKGROUND AND RATIONALE

A. Tuberculosis in Cambodia

Cambodia is among the 22 high-burdened countries prioritized by international technical and donor agencies in the global fight against tuberculosis (TB). These 22 countries contribute 80% of the total number of TB cases globally, estimated at 8.8 million in 2007.
Cambodia's estimated incidence rate of all forms of TB and new smear positive cases is 506 and 206 per 100,000 population respectively, placing it 4th in the world after South Africa, Kenya and Zimbabwe.[1] In 2004, the NTP achieved 100% DOTS coverage. Case notification and case detection rates have increased steadily since. At this time, Cambodia is approaching the target of 75% for detection of smear positive cases (at 66% in 2007) and has surpassed the target for treatment success. Consequently, the country's challenge is to reach the case detection target and sustain the treatment success rate.

B. TB and HIV Coinfection

Despite a decreased HIV prevalence, among adults 15-49 years, in the last years (from 3.3% in 1998 to 2.6% in 2002), Cambodia continues to experience a generalized epidemic. In 2002, it was estimated that 164,000 Cambodian were infected with HIV and that by the end of that year 94,000 had died and another 22,000 developed AIDS. According to NCHADS, it is estimated that more than 50% and 46% of deaths among men and women, respectively, are attributable to HIV infection.[2]

It is also estimated that 64% of the country's population is infected with *Mycobactrium tuberculosis*. Under these circumstances the overlap between the epidemics is more pronounced, resulting in an excess of active TB cases and increased HIV-related TB deaths. Ten years of survey data reveal an increasing trend in HIV sero-prevalence among TB patients, with the latest figure (2005) at 10%.[3] However, in the last national sero-prevalence survey (2007), the preliminary results indicates that the trend is decreasing up to 7.8%, As result of the TB/HIV collaboration, an increasing number of TB patients are tested for HIV (44% of TB patients underwent VCCT in 2007).

C. TB in prisons

Prisons in particular pose a challenge to tuberculosis (TB) control. Prison settings promote transmission of *M. tuberculosis* by sheltering a vulnerable congregate population that often lacks access to effective health services. The rate of active TB among prisoners is many times higher than that among the surrounding civilian population. TB outbreaks in U.S. prisons illustrate, through genetic laboratory testing, accelerated transmission within prison settings. Moreover, disease among prisoners may go undiagnosed for long periods of time, perpetuating disease. Consequently, prisons have developed a reputation as amplifying TB centers.

Without effective TB control, the general TB burden can accelerate and become further complicated by drug resistant disease. Subsequent spread within prisons and beyond may follow. In the worst of cases, outbreaks may involve the transmission of multidrug-resistant TB strains. In these circumstances, recommended treatment schemes used under DOTS are useless. Management of

[1] Global tuberculosis control: surveillance, planning, financing. WHO report 2007. Geneva, World Health Organization (WHO/HTM/TB/2007.376)
[2] Strategic plan for HIV/AIDS and STI Prevention and Care. National Center for HIV/AIDS, Dermatology and STD, Ministry of Health. Second Edition, September 2004.
[3] Tuberculosis Report. National Center for TB and Leprosy Control, Ministry of Health, 2006.

MDR-TB requires therapy for longer periods of time and with second-line drugs that are considerably more expensive, more toxic and less effective. Consequently, mortality is high among these patients.

D. The National TB Control Program in Cambodia and its work in prisons

The Ministry of Health of Cambodia prioritizes TB and is committed to improving TB control activities throughout the country. In 1980 the MoH established the National TB Program and has implemented DOTS since 1994. With strong support from collaborating organizations, substantial progress has been achieved by the NTP related to DOTS coverage, case detection and treatment success. Still, the NTP recognizes and is confronting challenges associated with a high TB incidence and prevalence, limited resources to sustain existing DOTS services, and the need to further expand DOTS (community DOTS, PPM DOTS), strengthen of the laboratory network, implement a quality assurance program, and build staff capacity.[4]

As part of its strategies for service provision, the NTP is promoting case finding among groups at risk for TB including PLHA, TB contacts, and persons in high prevalence area/settings. These risks groups converge in the prisons. This convergence of risk groups calls for an immediate and robust response. The NTP has reached out to establish collaboration with the prison sector for the control of TB. In 2005, CENAT the Cambodian conducted a cross-sectional prevalence survey within two prisons in Phnom Penh (CC1 and CC2) and found 45 active TB cases among 1,275 persons screened using a symptom questionnaire, chest X-ray and sputum smear. Since then, collaborative activities have been coordinated and implemented by CENAT in these two prisons. That same year CENAT provided DOTS training to health staff working in all 24 prisons in the country.

Currently, the NTP is carrying out activities to expand DOTS in sectors outside the MoH through its PPM strategy. This strategy should include prisons, where health services are generally supported solely by the Department of Prisons, MOI and non-governmental and faith-based organizations.

The TBCAP an initiative funded by USAID delivers technical assistance in various areas of TB control to selected countries. The principal global grantee is KNCV Tuberculosis Foundation. Other partners of the consortium include WHO, JATA, MSH, ATS and CDC. In Cambodia TBCAP is a 3-year (2006-2009) project with a total budget of 3 million. The TBCAP project in Cambodia, which supports the NTP, under Project Output 4 ("*Strengthened and expanded DOTS program"*), covers a number of work plan activities aimed at fostering PPM-DOTS; these include TB control in prisons. Under this work plan, and in order to assess the current situation of TB control in Cambodian prisons, Dr Mayra S. Arias from the Gorgas Initiative - UAB visited Cambodia from January 26th to February 2nd, 2008.

II. OBJECTIVES OF PRISON ASSESSMENT

1. To assess current TB control activities in selected prisons.
2. To provide information to facilitate the development of a national strategy and MoU between the Ministry of Interior and Ministry of Health to promote TB control in prisons.

III. METHODOLOGY

[4] Center for Tuberculosis and Leprosy Control (CENAT). National Health Policy and Strategies for Tuberculosis Control in the Kingdom of Cambodia, March 2006.

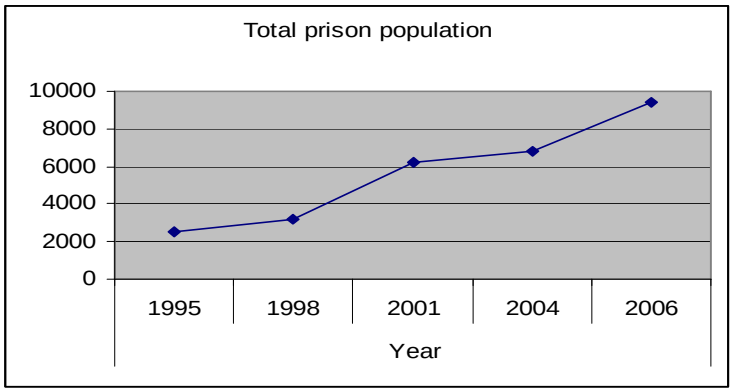
This assessment was conducted through the use of structured in-depth interviews of key personnel from CENAT/NTP, Prison Dept., JATA, WHO, prison and NGO staff. A data collection instrument adapted from *Tuberculosis Control in Prisons- A Manual for Programme Managers* by UAB investigators was used to asses prisons.[5] This modified instrument has been effectively used in previous prison assessments conducted by GTI/UAB in Indonesia and Honduras.

IV. KEY FINDINGS

A. Structural and administrative aspects of detention

Cambodia Prison Department

The Prison Department in Cambodia became an autonomous unit within the General Administration Department of the Ministry of Interior in 2000, after separation from the National Police. The penitentiary system is comprised of the national headquarter unit, three national prisons (CC1, CC2 and CC3), 22 provincial prisons and two municipal prisons. The provincial prisons are supported administratively by the provincial/municipal Governors office, while the national prisons are directly administrated by the Prison Department. The Cambodian prison population has increased at an alarming rate in the last decade. By then end of 2006 the prison census had reached 9,373, which represents an overcapacity of 65% (official capacity is 5665).[6]



Whilst the incarceration rate is rising, the infrastructure of prisons and resources remain extremely deficient. The most pressing problems faced are poor physical infrastructure, overcrowding, substandard prisoners' health, lack of rehabilitation programs and limited funding. The Department of Prisons has to compete with other governmental dependencies for its financing. Currently the budget per prisoner per day is only 1,500 Riels (US$0.30) to cover the cost of food and firewood.

To address some of these issues, the Prison Dept. has accessed aid from bilateral agencies, mainly the Australian government (AusAID), to improve infrastructure of some prisons and reform the legal system. This aid will contribute to improvements in overall prison conditions, including a reduction in overcrowding.

B. Aspects of health care delivery

Prisons in Cambodia have an infirmary or clinic where inmates and prison staff and their families are

[5] Tuberculosis Control in Prisons- A Manual for Programme Managers. Geneva, World Health Organization 2000. (WHO/CDS/TB/2000.281).
[6] International Centre for Prison Studies. King's College London. http://www.prisonstudies.org/. Accessed 02/5/08.

seen. These clinics are staffed with workers with very limited education, and recruitment of qualified staff has been recognized as an important problem by central prison authorities.

The MoH is collaborating with the Prison Dept. to improve health services in selected prisons through training of prison health staff. Thus far, 32 prison health staff have undergone a 2-year nursing training program under the auspices of AusAID and the MoH. Thus far, the MoH has accredited 4 prison clinics as health centers (CC1, CC2, Kandal, Bantey Meanchey), thereby allowing these prison clinics to receive free drugs and basic equipment from the MoH. The Prison Dept. has also continued to work with the MoH and provincial health offices to improve the standards of other prison clinics so that they may also qualify for MoH support. In addition, the prison Dept. relies on assistance from NGOs and prisoners' families to cover other costs, particularly health-related expenses.

C. TB related information

1. *Commitment*

Prison authorities met are aware of the threat of TB in prisons. Dept. of Prison officials and prison directors are sensitized about the need to strengthen TB control activities. Consequently, they strongly support the collaboration with the NTP and OD TB programs so that DOTS is implemented appropriately in prisons throughout Cambodia. Prison authorities at the central level are willing to sign a MOU with the NTP. Motivation among prison health staff is high.

2. *Training*

Health staff in all prisons visited had received DOTS training in 2005, CC1 and CC2 at CENAT and CC3 at the Provincial Health offices. All except for one staff member are still working in the prisons. The staff at CC3 are the only ones that have received refresher DOTS training. Additionally, CC3 staff were trained in sputum smear fixation procedures.

3. TB morbidity and mortality in the prisons visited

	CC1	CC2*	CC3
Total prison population	2,296	572	1,273
TB suspects	79	...	75
Total TB cases	22	2	15
Smear positive TB cases	22	...	14
TB case notification (per 100,000)	958	350	1,178
TB case notification general pop. (per 100,000)	301	232	273

** Data obtained from staff, TB records were not available at the time.*
... Data not available

Overall, the number of suspects identified in each prison is very low. In CC1 approximately 28% of those suspects are diagnosed with smear positive TB (high positivity rate); in CC3 it is 19%. Since the number of TB suspects is relatively low, so too is the absolute number of active cases identified. Still, the case notification rate in these prisons is considerably higher than among the general population where they are located, especially in Kompong Chan.

4. TB case finding

A survey was conducted in CC1 and CC2 in 2005 to identify active TB cases through chest X-ray and symptom screening. A total of 1,275 individuals (both prisoners and prison staff) were screened.[7] Results are listed below.

	Number (%)
Prison population in CC1 and CC2 combined	2,500
Prisoners screened	1,275
Prisoners screened who had an abnormal chest X-ray	125 (9.8%)
Prisoners that underwent sputum smear microscopy (among those with abnormal X-Ray)	79 (63%)
Total TB patients diagnosed (among total number screened)	81 (6.3%)
Smear positive TB patients diagnosed (among those with sputum smear examination)	11 (14%)
Smear negative TB patients diagnosed (among those with sputum smear examination)	68 (86%)
Extrapulmonary TB cases	2
Patients who started TB treatment	45

Within this cohort, 125 had an abnormal chest X-Ray. Among the 125 persons with abnormal chest X-ray, only 79 underwent further sputum smear examination; of these 79 individuals 11 were sputum smear positive; 68 were sputum smear negative. Forty-five patients started TB therapy (11 smear positive, 32 sputum smear negative, and 2 extrapulmonary). Eight of the TB cases were prison security staff members.[8] The high proportion of sputum smear negative TB cases is highly suspicious of HIV coinfection, in this population. Unfortunately, HIV testing was not part of the protocol of the study.

Currently, there are no standardized screening procedures to identify potential TB cases at entry. Health staff, in the three prisons visited, conduct a general examination of all inmates upon entry into the prison. However, this is a general physical examination and anamnesis, including past history of TB. There is no documentation of health staff specifically targeting current TB symptoms (cough, fever, weight loss) during this entry examination. Among incarcerated prisoners, cases are detected through passive case finding, in which prisoners voluntarily seek care from the clinic when symptomatic. There are no standardized procedures for contact investigation to identify secondary cases when an active TB case is diagnosed.

When TB suspects are identified in CC1 and CC2, prison staff request sputum collection cups from CENAT as a supply of cups are not available in these prisons. Sputum samples are collected from suspects and transported to CENAT laboratory for analysis. These samples are collected in batches and transported on the same day.

In CC3, based on symptoms of those patients that voluntarily show up at the prison infirmary, the medical staff collects sputum and fixes it on a slide, and sends the fixed slides to the OD hospital laboratory for AFB diagnosis. The clinic staff collects sputum and fixes slides whenever a TB suspect is identified, but the slides are transported to the OD hospital lab in batches when they have several suspects, usually once per week. Each month they receive supplies for sputum collection and fixing form the OD TB Program. They have never had stock shortages.

In general, there is no delay in diagnosis of TB patients once the samples are submitted. Results are obtained within 3 days and patients initiate therapy promptly.

[7] CENAT/NTP and WHO presentation

[8] Personal communication from Mr. Samkol Sokhan, Prison Dept.

The prison staff report problems in establishing diagnosis when a TB suspect is sputum smear negative. The lack of funds to transport the inmate with the security staff needed to accompany the inmate to the hospital for chest X-Ray examination is the main barrier. The prison does not have funds for this expense. At times the families of the inmates cannot cover the cost either. Under such circumstances the patient goes untreated since the ODs cannot confirm the case. In the case of a PLWHA, MSF (in CC1 and CC2) covers transportation and chest X-ray costs at Monivong and Khmer Russian Friendship hospitals. The OD in Kampong Chan has some funds for transportation of the inmates, but not for the prison staff that is required to escort prisoners out of the prison.

CC1 and CC2 have some funds which they use for transportation of sputum samples and collection of materials from CENAT, but this a limited amount that is not fixed or consistent. Prison staff have requested financial support for transporting sputum samples from CENAT.

5. Treatment and case holding

Antituberculosis drugs are provided free of cost by the OPDs upon identifying a case in the prison. The prison staff collects drugs, which are dispensed at a month's-supply. There is no delay in the initiation of treatment after a diagnosis is confirmed.

It is important to note that the current practice is to treat only patients with a positive sputum smear. Those whose sputum smear is negative and who do not have access to chest X-ray examination (due to financial and security barriers) **do not** receive treatment due to the reluctance of CENAT OPD to consider them as active cases. There is a potential threat for missing and not treating smear-negative TB cases, which can increase mortality and morbidity.

DOT is conducted inconsistently in the prisons visited. In CC1 patients undergo DOT by the prison staff in the isolation cell for the entire duration of therapy. In CC2 female TB patients receive DOT in the prison infirmary and males in their cells (not clear who supervises treatment in the latter group). In CC3 DOT is carried out by the health staff during the intensive phase (first 2 months of therapy), in the isolation room. In the continuation phase (4 months), the TB patients return to their regular cells. Treatment is observed in the cell by the cell leader. During this time the cell leader keeps a week's supply of the TB drugs with him.

Except of CC2, there have not been any interruptions in treatment of those cases undergoing therapy. In CC2, communication with the OD was interrupted in 2007 due to the transfer of the designated health staff member that was trained and sensitized on TB and DOTS. This interruption in communication and transfer of trained staff member led to an interruption in TB treatment by patients. It is unclear is the remaining staff are fully aware of, or understand TB practices.

6. Referrals

In case an inmate undergoing TB treatment is released, the prison staff does not fill out or give the patient a written referral form in CC1. Instead, staff give the patient his treatment card and recommend that he visit his local health center to continue therapy in the community. Prison staff receive no feedback from the local health center on the treatment outcome or follow-up of the patient. In CC2, since 2005, only one patient has been released while taking TB treatment. Because of the unwillingness of the patient to continue therapy in his local health center, he came to the prison monthly to collect drugs. Treatment was not supervised at that time.

7. Recording and reporting

Prison clinic staff have, and fill the following NTP forms and registers: TB suspect book, TB Patient registry and TB patient treatment cards. Theses materials are provided by the OPD. Prison cases are reported by the OPD, among their general, community cases (not disaggregated). The OPD could

identify prison cases using the address section of the patient registry book, for prison cases, the address listed is the prison address.

8. Supervision, monitoring and evaluation

There is inconsistency in the level of supervision by the OPDs to prisons.
Since the DOTS training provided to the prison health staff of CC2 and CC3, the OPD has not conducted any supervision visits to these prisons. Staff have not participated in CENAT evaluation meetings to review the DOST-related strategies, indicators or activities. Prison staff do not receive any form of feedback for CENAT or the OPDs on their performance.

In Kampong Chan the OPD TB supervisor visits CC3 prison once a month to monitor the implementation of DOTS in the prison. The prison staff do not attend evaluation meetings of the NTP.

9. TB/HIV coinfection

Integrated TB-HIV services are neither routine nor systematized in prisons yet. In CC1 and CC2 TB patients undergo HIV testing only when distinctly ill (WHO Stage 3 and 4, according to MSF medical coordinator). In general, the cost of HIV testing and transportation is a prohibitive factor for the prison administration. MSF sometimes covers these costs, or request support from other NGOs (i.e. Maryknoll for CC1) for this purpose. The MSF medical team (counselor, physician, pharmacist) visit these two prisons every 2 weeks to do VCCT and follow-up HIV/AIDS patients, especially those on ART.

In CC3 there are currently 13 female inmates infected with HIV. These inmates receive care (OI and ARTs) from MSF. The TB patient registry has no recorded information on VCCT, HIV status or any other related information specific to these inmates.

The OD in Kampog Chan initiated VCCT in the prison in December 2007. However the OD has capacity to only do a limited number of counseling and testing in the prisons. There is a need to give priority to TB patients. Four TB patients underwent VCCT thus far; 3 of these were HIV positive. The high coinfection rate in this prison warrants increased and sustained VCCT among all TB patients.

10. Infection control

There are no measures or policies related to infection control in the visited prisons. In the prisons visited, TB patients are separated, but for different periods of time. In CC1 TB patients (all) remain separated from the general population for the entire duration of treatment (6 months) in an isolation room. In CC2 and CC3 TB patients are housed in isolation rooms during the intensive phase only.

Notably, HIV/AIDS patients who do not have TB are housed together in the isolation room with TB patients in CC1 and CC2. Whilst in CC1 and CC3 this isolation room is well (naturally) ventilated and illuminated (CC2's isolation room was not evaluated), the threat for TB transmission to HIV-infected individuals remains. In CC3 it is not clear if HIV/AIDS patients are housed with TB patients. In general, no personal protection for staff and other patients is used.

11. Information, Education and Communication (IEC)

TB IEC activities vary among the prisons, but IEC is focused on patients diagnosed with TB. Except for CC3, the general population is not educated about TB etiology, transmission, diagnosis or treatment. No systematic IEC program is implemented. CENAT provides some materials but not regularly.

D. Organizations working in prisons in Cambodia

1. Prison Fellowship Cambodia (PFC)

***-Background*:** PFC was established in 2002 through a MOU between it and the Ministry of Foreign Affairs. PFCis affiliated with its parent organization, Prison Fellowship International, which provides general guidance, but no direct management or funding. The overall goal of PFC is to ensure that the basic needs of prisoners are met.

***-Coverage**:* PFC currently operates in 4 prisons: CC1, CC2, CC3 and Kardar. In the last year it assisted 350 inmates during imprisonment and release.

-Lines of work: Through it project Blue Gate House, PFC works with newly released prisoners in the following areas:

- Basic needs relief (clothing, toiletries, food, and vitamins)
- Free medical services, including referrals to hospitals and other NGOs that provide health care
- Counseling and mediation with the prisoners' families, including confirming the families' address
- Work and training program, teaching skills that will be helpful in finding a job
- Daily meals
- Assistance in finding accommodations
- Referrals to other NGOs and churches

For incarcerated prisoners PFC operates the following types of programs: medical assistance, prison policy, counseling, rehabilitation and education. Within the medical assistance program, PFC facilitates the referral of ill inmates in CC1 and CC2 to Monivon Hospital. When an inmate is suspected of TB, PFC refers him/her to CENAT hospital. When HIV is highly suspected PFC provides referrals to MSF (CC1 and CC2) and Maryknoll (Kandar prison). In general, referring prisoners to facilities outside the prison is very complicated due to security and financial constraints. PFC seeks assistance from other NGOs to cover some of the related costs (transport, X-Ray). The educational programs implemented by PFC include vocational training (motor repair, carpentry, sowing, English) and literacy programs.

-Scaling-up plans: PFC plans to intensify and expand their services in CC3 and Kampong Spey. The population incarcerated in CC3 are sentenced, and incarcerated for long periods of time, consequently many inmates have lost contact with their families. A prison doctor visit CC3 every two weeks, and provides medical check-ups and free medicines.

2. MSF

Background: MSF's has worked in Cambodia since 1979 providing health care to refugees along the Thai-Cambodia border who were displaced during the Khmer Rouge regime. MSF later moved inland as Cambodians were repatriated and helped the MoH to rebuild the collapsed public health infrastructure.

Coverage: MSF works in Siem Reap, Phnom Penh, Takeo, Kompong Cham, and Otdar Mean Chay.

***Lines of work*:** MSF's current work in Cambodia focuses in delivering care for PLWHA. This includes VCCT and a sizeable ART program. It is MSF's largest ART program in Asia, with 7,900 patients on ART as of April 2007. Nationwide it manages a substantial number of patients on ART (44%), including patients treated with second-line antiretrovirals. Other services include counseling, HIV/AIDS education and treatment for opportunistic infections.

MSF has a signed an agreement with the MoI and MoH for the management of HIV/AIDS cases in prisons. Their work in prisons began in 2007 in Phnom Penh, at CC1, CC2 and the Police Judiciary (PJ) prison. MSF's refers patients in their cohorts, who need diagnostic and hospitalization services, to the Russian Friendship Hospital.

The MSF team, which consists of a medical doctor, pharmacist and counselor visit the prisons every two weeks to deliver VCCT and provide follow-up to patients undergoing ART and treatment for opportunistic infections, including TB. Due to limited capacity, MSF can provide VCCT for only 3 persons at a time. Thus, they screen those patients that are evidently sick and suspected of HIV/AIDS (based on WHO Stage 3 and Stage 4 HIV/AIDS defining illnesses). In this context, they provide VCCT among prisoners diagnosed with TB.

MSF has enrolled 55 patients from prisons into their ARV program. Of these 55 patients, 21 (38%) have developed TB and received TB treatment: -8 SS(+), 3 SS(-), 7 EPTB (confirmed), 7 EPTB (not confirmed). At times, MSF has used other clinical criteria for establishing a non-confirmed EPTB diagnosis. The MSF staff follow WHO recommended guidelines when managing coinfected TB/HIV patients.

Notably, MSF collects sputum and sends it for smear (and culture?) analysis to Institute Pasteur-Cambodia. For chest-X-Rays MSF refers patients to the Khmer Russian Friendship hospital. **They treat patients (N=21) diagnosed with TB with drugs that are purchased and delivered by MSF France and not the NTP.** The TB drugs are delivered as fixed-dose combination therapy. These coinfected patients are reported to MSF France and NCHADS only. It is the assumption of MSF staff that these are not reported to CENAT.

Plans to scale-up: MSF plans to collaborate with the Khmer Russian Friendship Hospital and CENAT to upgrade the hospital's laboratory to have increased access to TB services. At this time, MSF has funding up to 2011 for their program in Phnom Penh, this funding covers current activities within prisons.

3. Family Health International (FHI)

Background: FHI established its office in Cambodia in 1998. FHI is funded mainly by USAID and has implemented the IMPACT project, which supports the national government and NGOs at the community level to strengthen care and support systems, prevent HIV transmission, and promote behavior change.

Coverage: FHI works with government, NGO and community partners in all 24 provinces in the country.

Programmatic areas: FHI works in:

- Providing technical assistance to NCAHDS on the design, implementation and data analysis of sentinel surveillance on HIV and STI prevalence and risk behaviors
- Developing, implementation and evaluating interventions to reduce risk behaviors by vulnerable groups including sex workers, uniform services personnel and MSM
- Collaborating with the government and NGO sector to strengthen STI services
- Implementing projects that target orphans and vulnerable children
- Collaborating with the government and NGOs to implement decentralized model of care for PLHA using the Continuum of Care (COC) program, which includes management of TB

FHI as partner of the TBCAP, is the recipient and implementing agency for funds allocated to TB control activities in prisons. Other programmatic areas funded through TBCAP in Cambodia are: human resource development (HRD), quality Diagnosis, TB/HIV collaborative activities, DOTS strengthening (community DOTS, public-private mix and MDR-TB) and IEC/ACSM.

Plans to scale-up: FHI is collecting information from various organizations that are working in, or intend to work in, prisons. This coordinating effort will assist in the planning and implementation of activities with TBCAP funds. It will also allow FHI to identify stakeholders and potential partners.

4. Catholic Relief Services (CRS)

Background: CRS has work in relief efforts for Cambodia for over 30 years. It was among the first respondents to the country's political crisis and in addressing its effects on the country's economical, social, educational and health systems. Currently, CRS is implementing a multi-year HIV/AIDS program with eight international and local partners.

Coverage: CRS's HIV/AIDS program is carried out in six provinces.

Areas of work: CRS is involved in pediatric HIV/AIDS, prevention of mother-to-child transmission, anti-retroviral treatment provision and adherence support, hospice, home-based care, counseling, social support and socio-economic reintegration services, HIV/AIDS-livelihoods integration, life skills training for adolescents and youth, couples prevention and community/government health system strengthening.

Plan for scaling-up: CRS plans to expand HIV programs to prisons based on existing needs and opportunities. To this end, the organization conducted an appraisal of health services in prisons at the end of 2007.[9]

5. Cambodia League for the Promotion and Defense of Human Rights (LICHADO)

Background: LICAHDO is a national NGO established in 1992 that aims to monitor prisons and prisoners rights; disseminate relevant, high-quality, non-partisan information and; lobby for positive reform.[10]

Coverage: The organization has offices in Phnom Penh and 12 provinces. LICAHDO visits 18 of 25 prisons, covering 90% of the total Cambodia population. These prisons are Police Judicial, CC1, CC2, CC3, Toul Sleng Military Prison, Takmao, Kompong Som, Kompong Speu, Kampot, Kompong Chhnang, Kompong Cham, Kompong Thom, Pursat, Battambang, Banteay Meanchey, Siem Riep, Svay Rieng, and Koh Kong).

The LICADHO Medical Office works in a different set of prisons: Takmao, Kompong Cham, Takeo, Prey Veng, Svay Rieng, PJ, Toul Sleng, Pursat, Koh Kong, Kompong Som, Battambang, and Kompong Thom. Some of the other prisons are occasionally visited by other NGOs, such as the Prison Fellowship.

Areas of work: Activities are implemented within seven programs:

- Human Rights Education Office: conducts training to target groups (i.e. government, students, monks) and disseminates information to the general population

[9] Catholic Relief Services. ASSESSING NEEDS AND OPPORTUNITIES FOR HIV SERVICES IN CAMBODIAN PRISONS. October – November, 2007

[10] LICHADO. PRISON CONDITIONS IN CAMBODIA 2005 & 2006: ONE DAY IN THE LIFE. January 2007.

- Monitoring Office: investigates human rights violation cases and guarantees that pre-trail detainees have legal representation
- Medical Office: provides medical care to prisoners and prison health staff in 18 prisons, including facilitating referral of inmates that need services in hospitals
- Project Against Torture: provides comprehensive rehabilitation services to victims of torture and conducts advocacy against this practice
- Children's Rights Project: investigates childrens' rights violations and educates the public about the issue; creates a child protection network
- Women' Rights Office: investigates womens' rights violations, educates the public and advocates for social and legal reforms
- Documentation and resource office: collects and maintains an electronic database

6. Cambodia Criminal Justice Assistance Project (CCJAP)

Background: The CCJAP is funded by the Australian government and implemented in close collaboration with the Dept. of Prisons. In phases I and II (1997 to 2002 and 2002 to 2007 respectively) the CCJAP sought to improve the operational, managerial, institutional and human rights conditions within the criminal justice system of Cambodia.

Coverage: CCJAP operates in Phnom Penh, Kompong Cham, Kompong Chhnang, Kompong Spue, Kampot, Prey Sar and Kandal Province.

Areas of work: CCJAP has focused on the development of police, judicial and prison guidelines, and intensive training of staff. Secondly CCJAP addresses crime prevention and community safety, enhancing investigation capacity of staff and developing a policy support framework (i.e. new Courts Handbook, juvenile justice and victims practices, prisons Corrections Management System, Strategic Plan and budgeting) to improve prisoner health and rehabilitation of prisoners. These activities were complemented with improvement of the police and prison infrastructure, which includes the building of new prisons and refurbishing existing ones. These activities also involved the provision of transportation vehicles, office furniture and equipment, medical supplies and funds for vocational and educational training in 5 prisons. [11] Health clinics have been upgraded at CC1 and CC2 at Prey Sars.

***Plans for scaling-up*:** Currently in Phase III (that ends in 2012), CCJAP will continue to support service delivery in Police, Prisons and Courts but seeks to expand its work into new provinces. It will work with the MoI to develop long term sustainability of the penitentiary and criminal justice systems and the planning and budgeting capacity. In addition Phase III activities will include the training of prison health staff in collaboration with the MoH and upgrading prison clinics (infrastructure and equipment) to meet the required criteria for health posts category by the MoH. CCJAP is also collaborating with NCHADS to increase inmates' access to VCCT.

V. MAIN RECOMMENDATIONS

To the MoH and MoI/Department of Prisons:

1. Seize the current momentum and strengthen rapport between ministries, and with donor and NGO sectors involved in health care delivery, in order to expand and intensify their activities in the prison setting.

[11] http://www.ccjap.org.kh/our_history.asp

2. Facilitate and expedite upgrading additional prison clinics (with adequate training, staffing, equipment and infrastructure) so that these become health posts and have access to MoH drugs and supplies.

3. At the central level, advocate for and guarantee access to standardized TB and TB/HIV services among prisoners throughout Cambodia at the province and OD levels, as well as through partners and donor agencies.

4. Allocate funding for the transport of sputum smear negative patients that need chest X-ray examination

To the CENAT/NTP:

1. Capitalize on the established link between the Dept. of Prisons and CENAT to expand and strengthen DOTS implementation in prisons in all provinces in Cambodia, focusing efforts on systematic supervision, monitoring and evaluation of the prison program.

2. Formalize the collaboration between CENAT and the Prison Dept. through an MOU (see sample MOU in Annex 2) as a policy tool that supports and facilitates DOTS implementation in all prisons. Within the prison sector this is especially necessary given the hierarchical system that exists within the prison sector. Collaboration should start at the top so that DOTS is properly adopted and implemented locally by prisons. CENAT and Prison Dept. need to work closely to finalize, endorse and disseminate the MOU.

3. Disseminate the aim and content of the MOU to prison authorities, NTP staff at all levels and NGO community to increase awareness and commitment to the collaborative efforts of these entities.

4. Mobilize resources to operationalize TB control activities aimed at increasing case detection and notification, and treatment success:

   a. Intensify the finding of TB suspects through TB-specific entry screening (routine and standardized) and contact investigation, in addition to passive case finding (among those who present to health clinics on their own, with TB symptoms). This will require modifying the current forms used for medical examination of inmates at entry into the prison so that information related to TB symptoms, history of past TB disease and treatment is specifically addressed and recorded. It may also require recording information on the contact investigation conducted whenever a TB case is diagnosed in the prison (including number of contacts identified, number of TB suspects among the contacts, and contacts diagnosed with TB disease).

   b. Avoid underreporting of TB cases; ensure that all prisoners diagnosed with TB and who start treatment are reported to and by NTP, regardless of which NGO is giving support to health programs.

   c. Avoid under -diagnosis of TB cases who are sputum smear negative; establish local partnerships and/or mechanisms that would secure the access to chest-X-rays of prisoners, preferably without these having to be transported outside prisons. This may be

accomplished through the use of mobile chest X-ray units that visit prisons to assess sputum smear negative suspects undergoing evaluation of TB. Until this is achieved, ODs, prisons and collaborating NGOs must logistically and financially support the transportation of TB suspects and security staff to designated referral facilities for chest-X-ray and/or hospitalization.

d. Supply prisons with the patients' full course (6 months) of therapy in patient-friendly boxes, which should be kept at the prison clinic. In addition, prisons should have available a stock of supplies, including sputum collection cups. Treatment dispensed on a monthly basis, implies more costs to prisons (transportation to and from OD health center).

e. Create a system to track the referral of TB patients who are released into the community or transferred to another prison facility. This would include a referral registry and monitoring of referrals, through coordination and communication with local and OD offices and with the NGO sector.

f. Implement IEC activities in prisons on a regular basis. These activities should target not only inmates, but security personnel and prison visitors as well. Provincial and district TB supervisors should supply prisons with educational materials (posters, leaflets, flipcharts).

5. There should be on-going coordination and communication among NTP and other partners to develop the National Strategy for TB control in prisons and Standard Operating Procedures (for entry screening, contact investigation, diagnosis, referrals, recording and reporting) with clearly defined roles and responsibilities of different stakeholders. These tools should be endorsed by the MoH and MoI

6. Establish a TB working group for prisons, with multiple stakeholders, that serves as a platform for the coordination of planned and ongoing DOTS-related activities.

7. To ensure the effectiveness and sustainability of DOTS within prisons, the central NTP unit and ODs need to include prisons in their planning and budgeting.

8. Refresher training should be available and continuous for prison staff.

9. Foster collaboration between the TB and NCHADS programs and the key stakeholders at the district level, and define roles and responsibilities for TB/HIV joint activities.

10. Support the implementation of activities to decrease the burden of TB among HIV positive patients and decrease the burden of HIV among TB patients. Specifically, increase screening for active TB among all PWHA to expedite diagnosis and initiation of treatment; increase VCCT in prisons, especially among TB patients. These activities should be reinforced in prisons with a high HIV prevalence. Isoniazid preventive treatment (IPT) should be given to all coinfected patients without evidence of active TB.

11. Promote the sharing and validation of information by CENAT/NTP, NCHADS and other partners (MSF) to establish an accurate TB/HIV surveillance system in order to avoid underreporting or duplication in reporting coinfected cases. Isolation should in no way be seen as punishment and thereby increase stigma.

12. TB patients should not be placed in isolation rooms with PLWHA. Isolation of TB patients needs to be limited to the intensive phase of therapy only, patients do not need to remain

isolated during the entire course of treatment. The use of personal protection among staff is encouraged.

13. Data on prisons needs to be recorded and reported by the ODs so that the trend of TB in prisons and treatment outcomes are monitored. This would allow CENAT to determine the contribution of prisons to case notification.

14. Maintain and strengthen the commitment of prison staff through continued supervision and monitoring of prisons by the local, district and provincial levels (NTP), with corresponding feedback to prison authorities and staff. The NTP at the OD level conducts quarterly meetings under their PPM strategy, with cluster of provinces. During these meetings CENAT reviews data related to case detection and treatment outcomes with collaborators. These meetings also serve to identify problems (including turn-over of staff) and potential solutions. Similar activities can be conducted with prison staff.

15. Further mapping will help in prioritizing potential partners with most impact and benefits for the implementation of DOTS in prisons in each province. These partners can assist in IEC activities, tracking referrals and ensuring that they continue treatment, and supporting expenses that expedite diagnosis (transportation cost to hospitals for chest X-rays).

16. Actively engage the general prison population and other organizations (e.g. Medical colleges) in TB-specific IEC activities.

17. Document lessons learned from the planning, implementation, and evaluation of the DOTS and TB/HIV collaborations to inform decision-makers at the national level and guide the development of future policy.

To donor agencies, TBCAP partners and NGOs:

1. TBCAP/USAID should support ongoing technical assistance to the NTP for TB control in prisons, specifically for the development of a National Prison Strategy, SOP, supervision and monitoring tools (information system) and operations research, which will complement and enhance current efforts.

2. NGOs and donor agencies should continue to support the Prison Dept. and public health programs (CENAT and NCHADS) to deliver coordinated TB and TB/HIV care to prisoners and prison staff.

3. All efforts towards improving TB and TB/HIV programs in prisons need to be mainstreamed under CENAT and a National Strategic Plan for TB control in prisons. Planning, monitoring and evaluation of interventions implemented by/through NGOs should include CENAT and the Prison Dept. and be conducted in a cohesive and cooperative manner.

4. Funding should be allocated based the needs identified by stakeholders, and strategies and activities outlined in a National Strategic Plan and workplans.

5. Close and continued communication among partners is strongly encouraged, including a common advocacy strategy.

VI. ANNEXES

Annex 1. Persons met during the visit

CENAT/ NTP
Dr. Team Bak Khim, Deputy Director CENAT
Dr. Khloeung Phally, Deputy Chief of Traning, Supervision and Research
Mr. Miuun Sardeoun, South OD
Un Sophoas, South OD
Chey Vichet Mony, Kompong Cham Provincial TB Supervisor
Chan Lin, Ponhea Krek OD TB Supervisor

WHO/TBCAP
Dr. Pilar Ramon-Pardo, Senior Advisor TBCAP/WHO

Prison Dept.
Mr. Samkol Sokhan, Deputy Director General
Mr. Tham Keng, Prison Dept. Counterpart
Mr. Miuh Sardeun, Chief Correctional Bureau

FHI
Dr. Peter Cowley, Country Director
Dr. Laurent Ferradini, Assoc. Director, Care and Treatment
Ms Caroline Francis, Associate Dir. Prevention, Mitigation, SBC and M&E
Dr. Song Ngak, FHI Technical Officer

JATA
Dr. Sukiyama, Project Leader
Dr. Dr. Saint Saly, TB Advisor

MSF
Dr. Som Leakhena, Medical Coordinator Assistant

Prison Fellowship Cambodia
Mr. So Vuthy, Co-project Leader

LICAHDO
Mr. Man Sothera, Medical Coordinator

CC1 Prison
Mr. Mong Kim Heng, Prisons Director

CC2 Prison
Mr. Chat Sineang, Prison Director
Ms. Pok Karina, Prison Medical assistant

CC3 Prison, Kampong Chan
Mr. Ros Sunhak, Prison Medical Assistant
Nhoek Chanthoeun, Prison Medical Assistant

CCJAP
Ms. Cheryl Clay, Correction Advisor

GTI/UAB Cambodia
Dr. Phalkun Chheng, Project Coordinator

Annex 2.

DRAFT
Memorandum of Understanding (MoU)
For Partnership in Implementation of the Tuberculosis Control Program in prisons in the Kingdom of Cambodia

1. Parties

The National Tuberculosis Control Program (NTP), Ministry of Health, Kingdom of Cambodia, represented by the National Center for Tuberculosis and Leprosy Control (CENAT), in Phnom Penh (hereafter referred to as the "CENAT") and

The Prison Department, general Administration Department of the Ministry of Interior, hereafter referred to as "Prison Department" agree to cooperate in the implementation of the NTP and DOTS activities in prisons in the Kingdom of Cambodia.

2. Background

The NTP is carrying out activities to expand the Directly Observed Therapy Short-course (DOTS) in sectors outside the MoH through its Pulic-Private/Public-Public Mix (PPM) strategy. This strategy encompasses prisons, where TB morbidity is higher than in the general population and health services are generally substandard due to limited budgets and competing needs. Joint activities have been implemented by the Prison Department and CENAT in the national penitentiaries in Cambodia.

The collaboration aims to strengthen these efforts and promote the integration of a TB control program in prisons that is closely linked to the civilian (NTP/MoH) program at the different levels of service throughout the country.

3. Duration and Renewal

This MoU will be in force from the date of signing and it will remain valid until _____(day)_____(month)_____(year). This MoU can be extended for further periods with the consent of both parties in writing.

4. Principles of Collaboration

Implementation of the Tuberculosis Control Program will be according to the national CENAT/NTP guidelines. Implementation of the program will eventually ensure availability and accessibility of quality TB services in prisons, specifically the implementation of sound and effective DOTS. Coordination between parties, mutual respect, trust and recognition of mutual expertise will be ensured within the overall national development framework. Implementation of the program will be in the national penitentiaries and district prisons. It will strengthen the integration of DOTS into the current prison health services.

5. Contribution of the NTP

A. Provide national guidelines for the Tuberculosis Control Program in prisons.
B. Ensure coordination/cooperation of relevant authorities (MoI, MoH) with other partners (non-governmental organizations, donors)

C. Supply guideline and operational manuals, and other relevant publications, TB drugs, laboratory reagents, other consumable, recording and reporting forms, advocacy-communication-social mobilization materials on a regular basis.
D. Ensure access to referral facilities for consultation and hospital care of cases.
E. Ensure laboratory services and support quality control of laboratory services through cross checking of slides.
F. Provide overall systematic supervision, monitoring and evaluation of the DOTS program in prisons
G. Provide feed-back to the Prison Dept. authorities and prison health staff.
H. Provide training to the relevant prison personnel.

The Dept. of Prisons, subject to government policies will:

6. **Contribution of the Prisons Dept.**

A. Implement the program according to the national guidelines in above mentioned areas
B. Assume financial responsibility for the training of own personnel and normal implementation of the program, i.e. all running costs except those mentioned in clause 5.
C. Work in coordination/cooperation with the relevant authorities, ensuring information and awareness of each other's work.
D. Implement the program as in the best of experience and capacity and in cooperation with the health referral network.
E. Proper use of drugs, laboratory reagents and other supplies according to requirement, keeping adequate record on their consumption and submit timely indent for quarterly supply with consumption report.
F. Facilitate the monitoring and evaluation of DOTS implementation, jointly with local health authority at each level.
G. Support supervisory and other visits by the NTP whenever necessary.
H. Support and conduct DOTS activities and execution of special initiatives undertaken by providing human resources and other necessary input.

7. Guarantees

A. Either party can terminate this agreement at any time with sixty days notice in writing indicating reasons for same to the other party. In-kind non-perishable goods will be returned to the NTP at the point of termination of this agreement.
B. In case of dispute, a final decision will be made by the _____.
C. Failure to implement the program as agreed upon in clauses 4,5,6 may lead to termination of this agreement.

This memorandum of understanding is signed today, the
____(day)_____(month)_____(year).

For the Prison Dept. **For the NTP**

_____ _____