Ministry of Health
National Tuberculosis, Leprosy and Lung Disease Program

TiBa

A magazine for NTLD-P

ISSUE 1 / Jan. 2019 - March 2019

Pediatric TB

Catalyzing Pediatric TB innovation launched in Kenya

UHC

Social support measures for TB patients in place

2018 TB Quarterly Report

ACF

Facility based screening scaled up

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5th Kenya International Scientific Lung Health Conference

Abstract Submission Deadline
February 28, 2019

DATE	June 25 - 28, 2019
THEME	**Business Unusual:** A Multi-Sectoral Approach to Lung Health
VENUE	The Nairobi Hospital Convention Centre (TNHCC)
REGISTRATION FEES	Locals: **KES 10,000** (USD100) Internationals: **KES 15,000** (USD150)

REPUBLIC OF KENYA
MINISTRY OF HEALTH

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

inside

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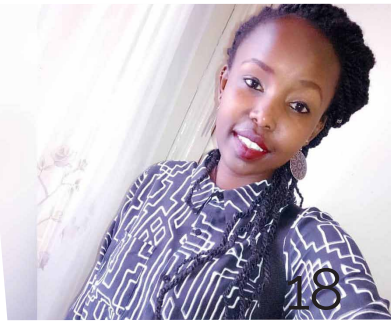

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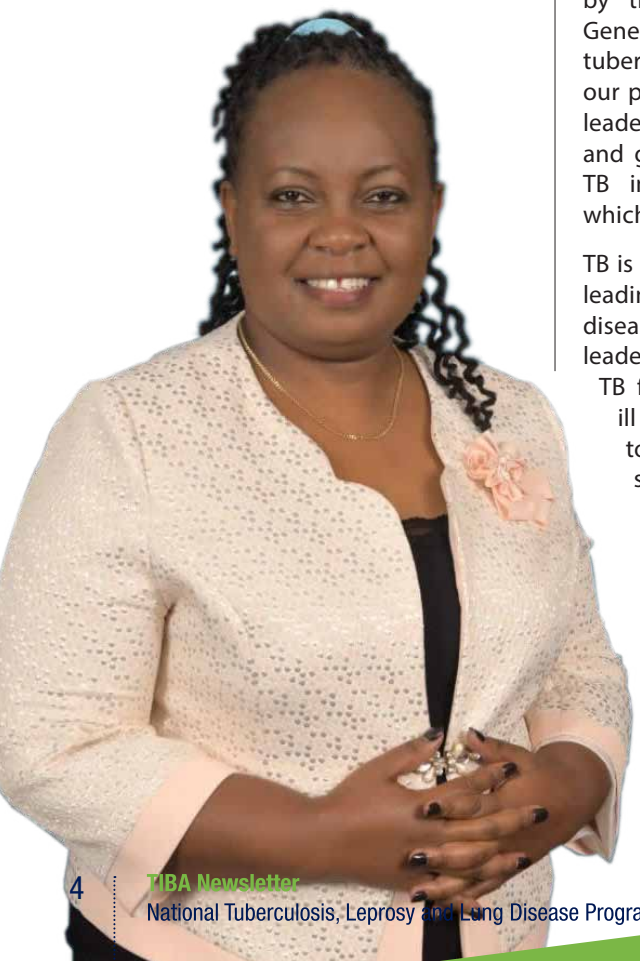
Word from the Head, NTLD-Program

Welcome you all to the first edition of TIBA – the official Newsletter of the National Tuberculosis Leprosy and Lung Disease Program (NTLD-P). I take this opportunity to thank the NTLD-P fraternity, our partners and other stakeholders for the positive engagements towards ending TB in Kenya.

As coordinators of the NTLD-P, we always strive to accomplish the Programme's goals. Nevertheless, we sometimes have to look back and assess our achievements as well as determine if we are on track towards attaining our set objectives. The National Strategic Plan for Tuberculosis, Leprosy and Lung Health -2015/2018 spells out our ambitions and aspirations as a country. Our assessment, therefore, should be geared towards its full implementation.

This edition of TIBA reviews some of the Programme's recent activities and achievements.



It is worth noting that the current Strategic Plan is coming to an end. We are in the process of developing a new National Strategic Plan (NSP) 2019/2023. With the support from the National Government through the Ministry of Health, The National Treasury, Global Fund, World Health Organization (WHO), USAID and other Key partners, a number a key stakeholders' forums have been held towards delivering the NSP. The secretariat is finalizing on the NSP and we look forward to the launch in March 2019.

Last year, Kenya was privileged to be represented by President Uhuru Kenyatta during the United Nation High Level Meeting (UNHLM) at the United Nation General Assembly in New York. During the meeting, President Kenyatta re-affirmed his commitment towards supporting the End TB strategy which is aimed at ending TB by 2035. In line with the political declaration approved by the high-level meeting of the General Assembly on the fight against tuberculosis on 26 September 2018, our president has pledged to provide leadership to accelerate our national and global collective actions to fight TB including drug resistant forms which are preventable and treatable.

TB is still a perilous challenge and the leading cause of death from infectious disease in the world. Our top political leadership has committed to prevent TB for those most at risk of falling ill through scaling up of access to testing for TB infection and systematic screening of relevant risk groups. It has further committed to find the missing people with TB, improve and strengthen policies and public health systems, develop community-based health services, use digital technologies that could be integrated into existing health systems and provide special attention to the poor and the vulnerable groups, like infants, young children, the adolescents, young men, the elderly people and communities like those in prisons

In addition, by committing to enable and pursue multi-sectoral approach, strengthen support and capacity-building, advance new research and innovation, promote regional efforts and collaboration, as well as mobilize sufficient and sustainable financing, our top leadership reinforces its pledge not just towards eliminating TB in Kenya but also in its course towards the provision of universal access to quality prevention, diagnosis, treatment and care to all Kenyans.

The launch of universal health coverage, now Afya Care, in selected counties indicates the government's aim to promote the right to the enjoyment of the highest attainable standard of physical and mental health in line with our health policy. This will go a long way in supporting our NSP which is also geared towards quality, affordable, prevention, diagnosis, treatment, care and education related to TB.

In conclusion, I wish to thank our government and Partners for financial and technical support offered towards the realization of the 2015-2018 NSP. In particular, we are grateful to the Global Fund, TB ARC, USAID, CDC, STOP TB PARTNERSHIP, KAPTLD, MSF-FRANCE and AMREF. Thank you for your support.

Enjoy reading TIBA.

Dr. Kamene Kimenye

Technical Assistance in support of counties

Dr. Kiogora Gatimbu, Head of Commodity Security, NTLD-P inspecting commodities at Marikani Health Centre during a TA mission in Kilifi County

By Mbetera Felix

Kilifi County has intensified active case finding (ACF) in all its sub-counties. According to Mr. Vincent Iduri, County Director of health, there are currently 21 drug-resistant patients who are on treatment. Close to 80% of the patients are on a short-term regimen and receive monthly stipends of KES 6,000 from the National TB Program.

However, during a Technical Assistant (TA) to selected counties, it was noted that Kilifi has the highest burden of leprosy cases with 40 cases reported in 2017.

"It is not that leprosy cases have increased but the surveillance system has drastically improved thus it's easy to identify these cases," said the director.

The TA team which was led by Dr. Kiogora comprised of officers from the National Tuberculosis Leprosy and Lung Disease Program, National Tuberculosis Reference Lab, Kilifi County health officers and Center for Health Solutions.

The five-day exercise which was funded by the Global fund saw the team visit key health facilities in all the Kilifi sub-counties which included Ganze, Kaloleni, Kilifi North, Magarini, Rabai, Malindi and Kilifi South.

The TA was aimed at tracking the progress of ACFs, identify the challenges faced by counties in the war against TB and raise the search for the missing TB cases. In addition, the TA team also assessed the quality of health care and noted best practices for dissemination to other hospitals.

Key participants from Kilifi county included Mr. Deche Sanga, County Tuberculosis and Leprosy Coordinator; Mr. Godana Mamo, Regional Coordinator TB ARC; Mr. Gerald Maina, Sub-CTLC; Mr. David Mutunji, County medical lab; Mrs. Sadaka Charo, Community Health Volunteer; Dr. Terry Kamau, Pharmacist, Patience Mulaa – sub-county Phamtech and other county health officials.

The TA identified great progress in the ongoing war against TB. The Omari project in Malindi town for example, has a good model of care for drug injectors and some of the sub counties have committed and dedicated health care workers. In addition, nutrition assessment is being done among most patients, there is a good patient follow up being done, some of the laboratories have good access control and the equipment well maintained. The good working relationship between County Tuberculosis and Leprosy Coordinators (CTLC) and Sub-county TLCs was also noted.

However, numerous challenges that could inhibit the success of the program were also identified. Some of the key gaps include poor sample networking, inadequate commodity management, low stock of TB commodities attributed to not using patient numbers for quantification and initial loss to follow-up at about 20%. Others include lack of mortality audits, high death-rate among Extra Pulmonary TB patients and lack of specific staff assigned to TB bench in nearly all sub counties.

The TA also covered Nyeri, Bomet, Uasin Gishu, and Nairobi counties. A detailed report will published soon after consolidating the findings from the visited counties. ■

> It is not that leprosy cases have increased but the surveillance system has drastically improved thus it's easy to identify these cases.

Kenya Commemorates 2018 World TB day in Style

Health CS Mrs. Sicily Kariuki (C), U.S. Ambasador, Robert Godec and former Nairobi County Health CEC Hitan Majevdia during the World TB Day celebrations.

The Ministry of Health commemorated the 2018 World TB Day in style with participants visiting Mama Lucy Kibaki hospital and Mathare Youth sports ground. The occasion is usually marked on March 24 of every year. With a yearly campaign tagline "light up the world for TB", Last year's theme was: *"Leaders wanted for a TB free world, You can make history, End TB".*

Last year's world TB day was cohosted by the National Tuberculosis Leprosy and Lung Disease Program, Nairobi county government and partners. The chief guest during the occasion was the Cabinet Secretary for Health, Mrs. Sicily Kariuki. Other key dignitaries present included representatives from World Health Organization, USAID and other key partners.

Former Nairobi County Health Hitan Majevdia addressing the gathering.

Dr. Peter Cherutich, Deputy Director of Medical Services addressing the gathering.

Screening of citizens at Huduma Centre during 2018 World TB Day.

U.S. Ambasador, Robert Godec awarding the winning team.

Dr. Kamene and Health CS Mrs. Sicily Kariuki at the Mama Lucy Kibaki Hospital lab.

All invited guests gathered at Mama Lucy Kibaki Hospital for a courtesy call and later visited various departments to get a view of the TB services offered. These included the TB Clinic, the laboratory, the X-Ray room and the Comprehensive Care Clinic. In spite of some slight structural and operational challenges, most invitees were impressed by the services offered.

The guests also watched a live football match organized by the Mathare Youths Association (MYSA) at the MYSA play ground in Embakasi East sub county with the aim of reaching out to the youths. During the match, the sports gear and balls were branded with TB messages which targeted the youths as they carry the biggest burden of the disease.

The Cabinet Secretary later made her maiden public address reiterating her commitment to fight the reemerging scourge. The presence of the high level dignitaries also signified the committed collaboration and partnership geared towards eliminating TB.

Similar activities were carried out in all the 46 counties. TB screening and Health education were as well intensified in all the Huduma Centres in the country. Those targeted were mainly the young populaces who seek various services in the Centres. ■

> The presence of the high level dignitaries also signified the committed collaboration and partnership geared towards eliminating TB.

TB/HIV AND TB/DIABETES (TB/DM) UPDATES

By Dr Elizabeth Onyango | *NTLD-P*

TB/DM TRAININGS

Diabetes and Tuberculosis (TB) are both chronic diseases with high socio-economic impact at the individual, household, community and health systems levels. The susceptibility to TB is increased by impaired host defences in individuals, such as those with diabetes.

The NTLD-P and Division of Non-Communicable Diseases has since the year 2016 been rolling out bi-directional screening of TB and Diabetes; screening of all TB patients for Diabetes and screening of all Diabetes patients for TB. TB/DM Training of Trainers training of 25 healthcare workers from 10 counties, was conducted from 15th to 17th May, 2018 in Nakuru Town. The training was supported by Global Fund.

The high burden TB/DM counties were selected as well as considering regional balance. The trained counties were: Nairobi, Mombasa, Kisumu, Nakuru, Uasin Gishu, Kiambu, Kisii, Garissa, Meru and Busia. The trainings were further cascaded to the counties where at least 20 healthcare workers form Nairobi, Mombasa, Kisumu, Nakuru, Uasin Gishu, Kiambu and Meru were trained. After trainings, the counties were issued with TB/DM Bidirectional Screening SOPs, algorithms and posters which were printed through the support of Global Fund.

DEVELOPMENT OF TB/HIV CLINICAL JOB AIDS AND IPT (ISONIAZID PREVENTIVE THERAPY) SOPS

The goal of collaborative TB/HIV activities is to decrease the burden of TB and HIV in people at risk of or affected by both diseases. Kenya identified the five "Is" of TB/HIV management which are Intensified case finding, Isoniazid preventive therapy, Infection prevention control, Integration of TB and HIV services and Immediate antiretroviral therapy.

The NTLD-P has been conducting trainings on core TB and TB/HIV targeting health care workers. However, job aids on clinical management of TB/HIV co-infections are either outdated or lacking altogether in most facilities. Following the roll out of IPT for PLHIVs in 2015, there was need to standardize its implementation.

To this end, a 5 day workshop (30th July-3rd August, 2018) was held at Gelian Hotel, in Machakos County to develop job aids for clinical management of a TB/HIV co-infected patient, and to revise Isoniazid Preventive Therapy (IPT SOPs). Participating were partners (WHO, AMPATH, APHIA PLUS, CHS TB ARC and CDC), MOH (NTLDP, PPB, and NASCOP), PPB and County Governments of Nairobi, Bungoma, Siaya. The process involved getting participants into various thematic groups - screening, diagnosis, treatment, TB preventive therapy, Follow up, Infection Prevention and Control, Special populations.

TB/HIV AND TB/DM ECHO SESSIONS

20/3/2018 – Dr. Martin Mwangi of NCD gave a presentation on TB/DM linkages and integration and how each disease impacts the other. Key issues arising from the sessions were: TB/DM M/E indicators and tools; nutritional commodities for DM patients; which program to supply DM diagnostic kits; use of newer MDR molecules (Delamanid and Bedaquiline) and their interactions with antidiabetic drugs.

12/6/2018 – Dr. Wagude (physician in Siaya County Referral Hospital) gave a TB/HIV ECHO presentation. There were a total of 46 spokes and retention was high. Actual participants were more than 46 because each spoke had 2-3 participants. There was a case presentation and discussion followed by didactic learning on TB/HIV.

3/7/2018 - Dr. Elizabeth Onyango gave a TB/HIV ECHO presentation on didactic management of TB/HIV co-infected patients with special emphasis on ARVs.

TB/HIV TECHNICAL WORKING GROUP (TWG) MEETING

On Monday, 26/3/2018 TB/HIV TWG meeting was held at the Silver Springs Hotel, Nairobi and focused on the following areas: Building consensus on the key elements and contents of TB LAM policy guideline; Optimizing ART in TB/HIV coinfection; Updates on IPT among PLHIVs and Experience of community TB/HIV integration including community M/E framework.

RESEARCH/SURVEYS

In August 2018, NTLD-P together with NASCOP and TB/HIV partners, developed protocols for the following studies: Assessment of IPT outcomes among PLHIVs and Evaluation of TB/HIV service integration models. These studies which are supported by the Global Fund will be conducted in 2019 upon receiving the required approvals. ■

Development of the 2019-2023 NSP

By Drusilla Nyaboke | *NTLD-P*

The National Strategic Plan (NSP) development process started off in earnest with a series of weekly secretariat meetings. The process which is still ongoing departures from the conventional process. It started off with reviewing large pool of available new evidence with the aim of identifying gaps and strategic priority interventions for the next five years.

In Kenya, health is devolved and the county governments have a crucial stake in health care delivery. As a result, two separate county stakeholders' forums were held to share the findings of the data synthesis and the NSP draft zero. The NSP process is cognizant that the interventions have to be customized to county contexts. Inputs from the stakeholders' forums which were enriching and provided key pointers for the county frameworks will be a key resource during the development of the specific County Annual Work plans.

Funding gap for TB control activities is an area that the National TB program has grappled with for a long time. The NSP process, thus, went an extra mile to develop a costed strategic plan which will guide the choice of interventions.

The process is being supported by the Ministry of Health, Global Fund, World Health Organization and a number of partners. ■

Tuberculosis Quarterly Report - Q3 2018

By Aiban Rono | *NTLD-P*

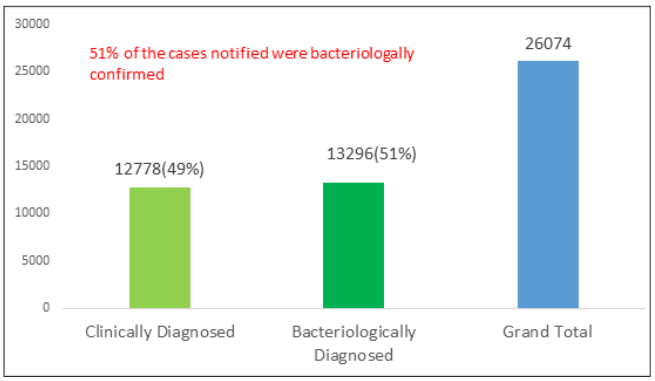


Figure 1: TB Case Finding Summary.

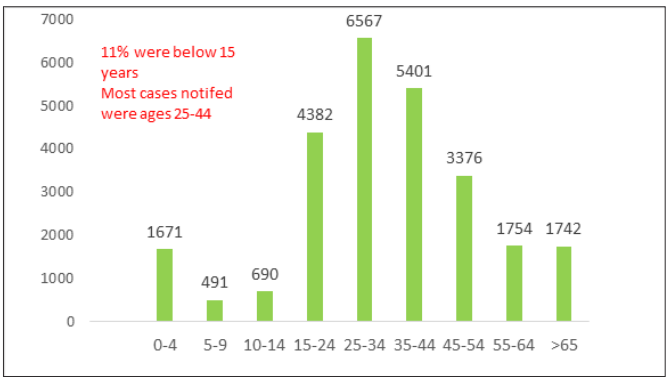


Figure 2: TB case Notifications per Age group.

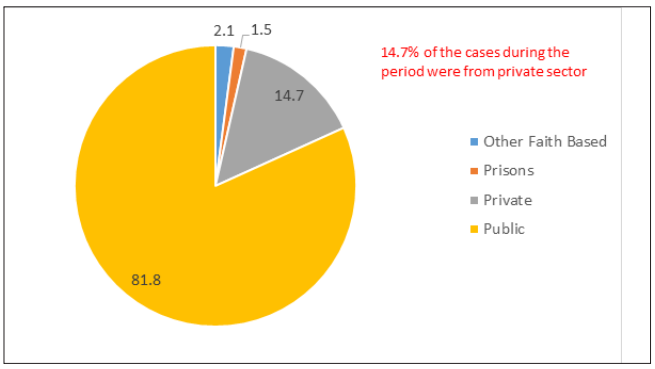


Figure 3: Percentage Sector contribution.

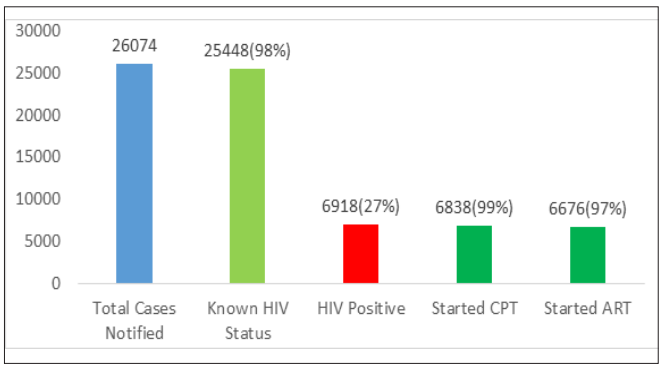


Figure 4: TB/HIV care cascade.

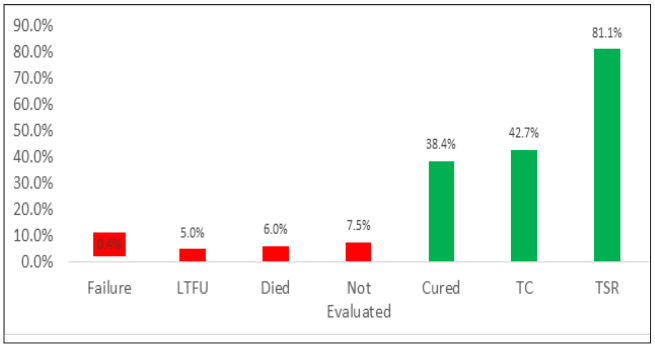


Figure 5: Treatment outcomes (All forms of TB) Q7 2017 cohort.

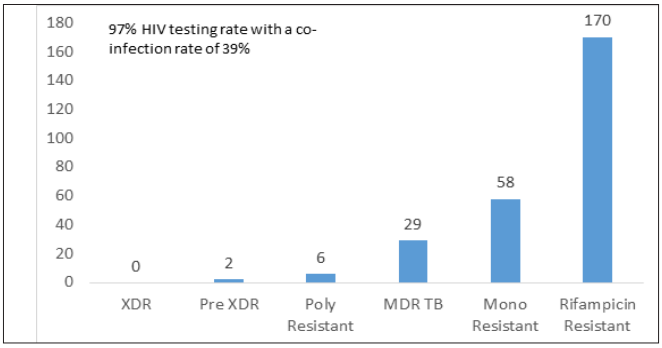


Figure 6: DR TB Case Finding.

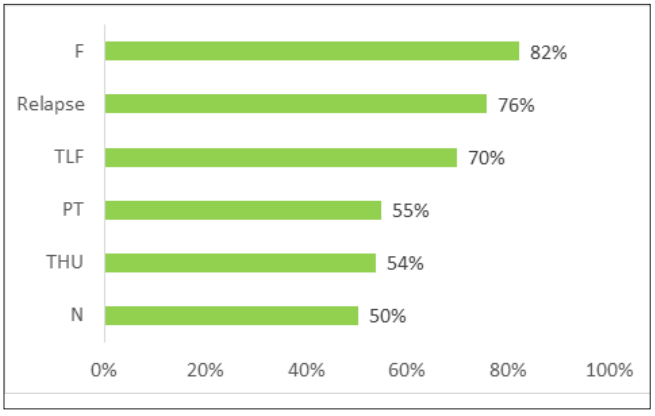


Figure 7: Drug susceptibility Testing (DST) by Patient Type.

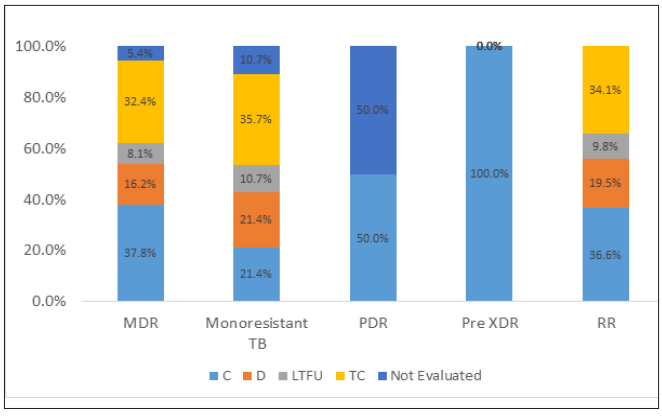


Figure 8: Treat outcomes for DR TB cases 2016 Q3 cohort by resistant pattern.

QRM Q3 2018

Participants at Eagle Palace Hotel, Nakuru

Dr. Kamene Kimenye, Head, National Tuberculosis Leprosy and Lung Disease Program (NTLD-P) has called for thorough supervision in all facilities. She called on all County TB Coordinators to ensure that supervisions are done comprehensively and on regular basis. In her opening remarks during the National TB Quarterly Data Review Meeting (QRM), Dr. Kamene noted that the recently held Technical Assistance had shown that the quality of patient care had gone down due lack of follow up smears among most patients.

According to Aiban Ronoh, the team lead that reviewed data for Kakamega and Elgeyo Marakwet counties, there is a need for all county coordinators to lead by example and ensure the data submitted is clean, consistent and mirrors the TIBU patient management system. His sentiments were echoed by Dr. Kiogoroa, Head of Commodity Security, NTLD-P.

The QRM was aimed at keeping track on the gains made towards eradication of TB in Kenya. The four-day exercise which was held at Citimax and Eagle Palace Hotels in Nakuru, Lysak Haven hotel in Machakos and Sirikwa hotel in Eldoret coverd all the 47 counties in clusters. Each cluster had a two-day session with NTLD-P specialists and focused on data for 2017 quarters to the third quarter of 2018. The exercise also included treatment of outcomes per quarter, for 2017 and first quarter for 2018.

The objectives of the QRM included; discussing TB data for year 2017 Qs and share reports of county QRMs, reflecting on progress made with regard to meeting targets set in the TB and Monitoring and evaluation plan, follow up on lost patients, discussing the quality of data presented and development of Quality Improvement Plans for challenges encountered in Q1-Q4, 2017 and Q1, 2018. The deliberations also looked at the findings and challenges on M&E, Care and Treatment, Lab and Diagnostics, Commodity, Nutrition, Preventive Health and Promotion as well as Admin, Finance and Procurement. ■

TB ARC II Joint Work Planning

Participants at the Great Rift-valley Lodge, Naivasha

TB ARC II and National Tuberculosis Leprosy and Lung Diseases Program (NTLD-P) held a Joint work planning workshop for Year 1, 2018-2019. The exercise which took place at The Great Rift Valley Lodge, Naivasha, in November 2018 was a collaborative approach geared towards building consensus on key strategies and outcomes for TB control activities in the county. It took into consideration Kenya's TB control needs and strategic direction for the next one year. It also ensured that there is leverage on existing TB control infrastructure to promote bold and new strategies that are people-centred, data-driven, and target oriented to achieve the most significant impact for investment towards reducing incidence and number of deaths due to TB in Kenya.

TB ARC II is a five-year USAID-funded activity that aims to improve TB case finding by increasing access to high quality, patient-centred TB, DR-TB and TB/HIV services; preventing TB transmission and disease progression through strengthening TB service delivery platforms; and accelerating research and innovation with the ultimate goal of decreasing incidence and TB-related morbidity and mortality in line with the 90-95-0 End TB targets.

Apart from Centre for Health Solutions and the NTLD-Program, other members present were staff from Populations Services Kenya (PSK), Kenya AIDS NGOs Consortium (KANCO) and Stop TB Partnership-Kenya. ■

F&Q review meeting held

The NTLD-P held a Forecasting and Quantification (F&Q) review workshop from 29th October to 2nd November, 2018 at East Mark Hotel in Nakuru. The five day workshop was aimed at incorporating Rapid Communication from World Health Organization into the F&Q and link all updated patients estimates (PMDT, TWG & PF) to each other.

During the exercise, Dr. Joseph Sitienei called on the program to prioritise on key issues when planning and make use of innovations to find solutions towards eradicating TB in Kenya. He further called on NTLD-P staff to read widely and publish papers with the aim of generating knowledge and documenting key processes that are geared towards TB eradication in Kenya. ■

Dr. Sitienei, Head, National Strategic Public Health Programs (Malaria, TB & HIV) during the F&Q

UHC: Social support measures for TB patients in place

By Wendy Nkirote & Dr. Omesa Eunice(*NTLD-P)*

Millions of Kenyans are unable to access quality health care which is their constitutional right, largely because they cannot afford to pay for health services. According to the Ministry of Health, about 83% of Kenyans lack financial protection from health care costs, and about 1.5 million are pushed into poverty each year due to expenditure on health. It is further estimated that 16% of the sick do not seek care due to financial limitations, while 38% are forced to sell their assets or borrow in order to finance their health-related bills.

In the first quarter of 2018, the Kenyan economy showed a steady growth of 5.7%. However, the proportion of Kenyans living on less than international poverty line (US$ 1.90 per day) has declined from 43.6% in 2005/06 to 35.6% in 2015/16.

The Government has identified the National Health Insurance Fund (NHIF) as the main vehicle towards the achievement of Universal Health Coverage (UHC), with the goal to cover 100% of the population by 2022. Currently only 17 % of Kenyan households are covered by health insurance of any type, while the rest of the population relies either on donor aid, government spending or out of pocket spending for accessing health care.

The National TB program, over the years, has put major effort towards ending TB in Kenya. Despite the gains made against the TB epidemic in Kenya, in 2017, an estimated 169,000 people fell ill with the disease and only 50% of them were tested and enrolled on treatment. In addition, TB was responsible for an estimated 29,000 deaths becoming the 4th largest cause of death that year.

Moreover, TB disproportionately affects the most marginalized and powerless members of society, including the poor, people living in low income urban settlements, children, and people living with HIV. Though preventable and curable, TB continues to cause untold suffering, loss of life, and financial catastrophe for thousands of people in the country. The barriers to ending TB are complex and include economic, programmatic, and biological factors. Eliminating the disease will thus require both biomedical and socio-economic interventions.

TB is a chronic condition with long duration of treatment. During a treatment phase, patients will require transport to health facilities for follow-up schedules, a household treatment supporter, and time off duty for effective treatment. They may, therefore, lose their jobs or income especially if they have casual jobs.

The first Kenya TB patient cost survey 2017 revealed that the economic burden incurred by TB patients and their households in Kenya per episode of Drug Resistant TB (DRTB) in seeking diagnosis and treatment was on average KES 145,109.53, and that of Drug Sensitive TB (DSTB) was KES 25,874. In addition, the proportion of TB patients and their households facing catastrophic costs due to TB was 86.4% for DRTB and 26.1% for DSTB. Also, a huge socio-economic burden imposed to households due to TB especially among the DRTB patients with 62.5% losing their job, 59.6% separated from their spouses, 53.7% incurred food insecurity, 27.8% had to sell their asset, use savings or obtain a loan to finance TB health care and 14.5% had children who dropped out of school.

In addition to the catastrophic expenditures, there are broader social and economic influences that could be driving the Kenyan TB epidemic. These broader influences include the level of undernourishment with over half (53%) of the TB patients being malnourished at the onset of treatment, the level of poverty, with 46% of people living below the national poverty line in 2016; and low coverage of health insurance, with coverage of only 13.6%, leading to financial barriers to accessing health services.

An analysis of therapeutic food support among the undernourished TB patients notified in 2017 showed that only 36% of the eligible patients received the food support. TB also leads to disability with 30% of DRTB patients on treatment developing hearing loss due to adverse drug reaction, 10% of DRTB patients who have been treated severally developing lung damage by the end of treatment.

To achieve zero catastrophic cost the program has put in place social support measures for the TB patients to cushion them from being impoverished. This includes enrolling DR TB patients into NHIF, adoption of the short-term regimen for all eligible MDR TB patients, transport allowance to health facility for MDR TB patients, free diagnosis, treatment and follow up tests. Further, 46% of DRTB patients have been enrolled on NHIF and 65% have received transport allowance.

During the United Nations General Assembly high-level meeting, on 26th September, 2018 His Excellency the President, Uhuru Kenyatta, committed to accelerate efforts in ending TB in Kenya. It is envisaged that the commitments will enhance effectiveness and long term sustainability UHC towards eradicating TB in Kenya. ■

According to the Ministry of Health, about **83%** of Kenyans lack financial protection from health care costs, and about **1.5 million** are pushed into poverty each year due to expenditure on health.

Active Case Finding

NTLD-P Scales up Facility Based ACF

Participants during an AMREF training workshop on ACF in Mombasa

By Josphat Mutua | *NTLD-P*

The National Tuberculosis Leprosy and Lung Disease Program (NTLD-P) has scaled up facility based Active Case Finding (ACF). This is aimed at early TB diagnosis and treatment. Facility based ACF is the systematic screening for TB among all patients in health facilities regardless of showing TB symptoms.

Studies have shown that there are various leakages in the care cascade ranging from low index of suspicion among Health Care Workers (HCWs), inadequate leadership at the facility level, weak linkages and low priority of sputum processing amongst others. As a result, Facility ACF seeks to compensate on these shortcomings and maximize on the care cascade.

The ACF scale up has adopted a three part approach. Under the Sensitization of County Health Management Team (CHMT) approach on ACF, CHMTs are tasked with spearheading health matters in each of their respective counties. They are further seen as important gatekeepers. It is thus crucial to obtain their buy-in to ensure ACF sustainability as they can incorporate key indicators to check on during their routine supervision

The second approach is the Sensitization of sub county Trainer of Trainers (TOTs). For an accelerated and more focused scale up, NTLDP has focused on obtaining a pool of trainers at the sub county level who have intimate knowledge of the facilities in their jurisdiction. A total of 5 persons with a unique skill mix of managerial, patient management and record keeping were targeted per sub-county and sensitized on ACF in order to scale it down to high volume facilities under them. Currently, the focus as supported by the budget is on two high volume facilities per sub county. The program, however, envisages that with more support from other local implementing partners, more facilities will be targeted on the same.

> “Facility ACF seeks to compensate on these shortcomings and maximize on the care cascade.

With the facility level sensitization as the third approach and the lowest level of sensitization, the sub county TOTs are tasked with visiting the high volume facilities to sensitize them on ACF. This is normally held in form of Continuous Medical Educations (CMEs) and/or departmental meetings at the facility level, and information percolates to a wider number of HCWs who are responsible for screening of patients across various service delivery points.

The Program has piloted the ACFs in 10 TB high burden counties in the country which include Mombasa, Nairobi, Kiambu, Nakuru, Meru, Kisumu, Kakamega, Machakos, Homa Bay and Turkana. ■

World deadliest disease:

Why we need to act now and fast!

Photo Courtesy

President Uhuru Kenyatta and Health Cabinet Secretary, Sicily Kariuki during the UNHLM in New York alongside Dr. Kamene, Head NTLD-P.

By Mbetera Felix | *NTLD-P*

Tuberculosis which is the world's deadliest infectious disease kills more people than Aids and malaria combined. This is according to World Health Organization (WHO).

Already, nearly over 50 million people have died since 1993 when the disease was declared a global health emergency. In 2017 alone, it is approximated that 10 million people fell ill with TB of which 1.6 million people died from the disease. Astonishingly, WHO has announced that TB will claim 1.6 million lives in the next one year. This is indicative of how the world has neglected TB.

Whereas the United Nation's (UN) first High Level Meeting on tuberculosis should be considered as a positive step forward, a lot is left to be desired.

> How many lives were supposed to be lost first before we acted?"

50 MILLION

Approximate number of people have died since 1993 when TB was declared a global health emergency.

What took so long? How many lives were supposed to be lost first before we acted? Is it because the most affected with TB are the poor thus the consideration of TB as " the disease of the Poor"? With so many deaths already, world leaders should have been instantaneously galvanised into action. But that wasn't the case.

The declaration calls by heads of states and governments at the UNHLM shouldn't be on paper only. As part of the reaffirmations of the Sustainable Development Goals (SDGs) aimed at ending the TB epidemic by 2030, world leaders need to act decisively to eradicate the disease.

In Kenya, TB still remains a major cause of morbidity and mortality. Even though It affects all age groups, research has shown that its greatest toll is in the most productive age group of 15 to 44 years. This should worry us as a nation. Major strides have already been noted, for example, the NTLDP has been strengthen over a period of time, the quality of program data has also improved through the use of electronic reporting and recording systems like "TIBU", community involvement in TB control has been improved and most health service providers have also been engaged in the control of TB.

However, the biggest obstacle is the concurrent HIV epidemic and the complicity of managing extremely drug resistant TB as well as multi-drug resistant TB. In fact, it has been noted that TB is the most common cause of death among people with Aids as it strikes when the body's resistance is low. The WHO has further shown that in 2017, approximately 300,000 people died from Aids related-TB

In line with the big four agenda, the government needs set more resources towards eradicating TB. This will as well contribute in creating national health security. Words are also not enough. All key stakeholders and partners including the government should work together to actionized the promises made during the UNHLM. ■

Pre-seeking TB care and Community Engagement

The cornerstone in the End TB strategy

By Drusilla Nyaboke, Samuel Misoi, Lucy Njeru & Elvis Muriithi (*NTLD-P)* Rose Wandia (CHS)

Kenya recently conducted the National Tuberculosis (TB) prevalence survey 2015/16 where results showed that 65% of the people with TB symptoms did not seek care, the majority of whom were men. Whilst these statistics are grim, they provide clear strategic direction on where to enhance the efforts. For a long time, the emphasis has been on patients who visit health facilities and this only represents a tip of the iceberg.

Further, 75% of the participants reported that the symptoms were not severe enough to warrant seeking care. "Among the respondents in a TB Knowledge Awareness Perception (KAP) Survey 2014, knowledge that TB is an airborne disease was mentioned by 74%, cough of 2-3 weeks as suspicious of TB by 40%, awareness that TB services are free by 66% and 81% were able to identify where TB services are provided". This points to a gap in TB awareness at the community level and urgently calls for renewed targeted efforts to increase awareness for the demand for TB services and mitigate the bottlenecks to accessing care.

According to the Economic Survey Report, poverty levels are high with 48% of people living below the poverty line. This points to cost constraints in accessing care and would further contribute to poor health-seeking behaviour as people are faced with the decision of providing essentials or paying for health-related expenses.

The National Tuberculosis Leprosy and Lung Disease Program (NTLD-P) Communication Strategy 2015 recommended enhanced TB awareness targeting the general public through various platforms to create demand for TB services through enhanced health care seeking behaviour. This is in the wake that majority of those people with TB who are missed are men in the productive age group; poor health-seeking behaviour partly compounded with societal gender pressures have been identified as crucial factors.

Community TB prevention is a cornerstone in the End TB strategy; with increased numbers of people with TB symptoms still in the communities who are not seeking care and further only 14% of children on Isoniazid Preventive Therapy (IPT), calls for aggressive contact tracing efforts.

Largely, a multi-pronged approach to addressing these critical issues ranging from bold policies, enabling environment, behaviour change, intensified TB awareness creation and differentiated communication approaches are needed.

Limited TB awareness and updated information levels in communities

In the last few years, whilst a number of resources have been expended in the

development of various Information Education Communication materials, there still exists a considerable gap regarding TB awareness. Misconceptions and myths amongst populations concerning TB also contribute highly to poor health-seeking behaviour. A more proactive approach would be the need to zone various audiences by age, gender, other external factors (geographical, political, economic, religious, cultural) and adopt innovative delivery mechanisms which can be evaluated.

TB symptoms not perceived as serious

Generally, due to the limited awareness on the cardinal signs and symptoms of TB, many people either do not recognize these symptoms promptly or do not take requisite action whenever they experience them. While yet others assume these symptoms to be the common respiratory ailments and seek self-medication. This results in a patient delay in seeking care and enhances continued active transmission further compounding the TB menace.

Stigma and Health Care Workers attitude

Stigma still remains a massive impediment to TB care and treatment due to its high correlation to HIV. Health Care Workers' (HCW) attitude continues to fuel this problem as potential patients may not be encouraged to visit such facilities. Further, stigma among TB patients in the community (household members, neighbours) also adds to this inequality. This results in a negative impact in drug adherence for those already in care and further worsens the poor health-seeking behaviour.

Poor Access to Health Facilities

Due to the variations in expansivity of counties (geography), the catchment area for facilities is different. In some counties, people have to cover longer distances to access the nearest health facility and may end up incurring huge expenses along the way. Inadequate distribution of health care facilities to serve the population is one of the barriers to accessing health care. This serves as a deterrence for most people who may want to access these facilities but are limited in one way or another. This, therefore, calls for unique context-specific approaches to enhance health seeking behaviour

Lack of differentiated communication

Clear communication is vital for both awareness and advocacy at all levels in the care continuum; policymakers, health care workers, community and patients. Proper and timely communication impacts the quality and sustainability of service provided and it ensures a continuous feedback loop. It is important to realize and appreciate that packaging and delivery of information to various stakeholders is different, unique, and should be targeted as well as customize

Poor quality of care

Quality of care remains a core tenet in care provision; in facilities where this is lacking (HCW knowledge, facility equipment, adequate health workforce), this may negatively impact on the care-seeking behaviour of the surrounding community. It is imperative to attain a critical balance between the quality of care in the facilities and awareness creation efforts as they are closely interrelated.

> The National Tuberculosis Leprosy and Lung Disease Program (NTLD-P) Communication Strategy 2015 recommended enhanced TB awareness targeting the general public through various platforms to create demand for TB services through enhanced health care seeking behaviour.

Further, requisite services such as TB diagnosis (Xpert and chest X-ray) should be available in these facilities to encourage prompt health care seeking hence minimizing avoidable patient delays.

Community Health system linkages

The interface between community and health facility is essential for seamless service delivery; each component provides a vital conduit for optimum care. CH-Volunteers and functional community units have majorly cemented this link; with the implementation of this largely varying across various contexts and hence disadvantaging some potential patients. Incorporation of households into community units and a further allocation CHVs to a manageable number of households coupled with adequate linkage to the nearest health facility provides the most plausible practical solution.

Limited access to TB prevention

TB control efforts have enumerated vital groups that should be targeted for prevention; mainly tracing of TB contacts for index patients and provision of IPT among the target populations. The success of these two activities depends mainly on infiltration into the community.

Further, socioeconomic barriers (poverty levels, housing design) add to the susceptibility to TB disease. Some people end up living in dilapidated structures with poor ventilation which may be overcrowded and thus provide a favourable medium for TB transmission.

Priority interventions under Integrated, patient-centered care and prevention

There is thus need for early diagnosis, universal drug susceptibility testing, screening of contacts and high-risk groups, treatment of all including drug-resistant (DR-TB) and patient support. Besides, collaborative TB/HIV activities, management of co-morbidities, preventive treatment of persons at high risk, and vaccination against TB will play a significant role in reducing TB cases in Kenya.

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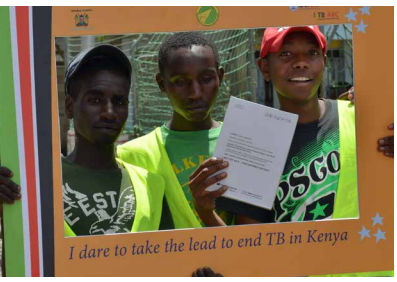
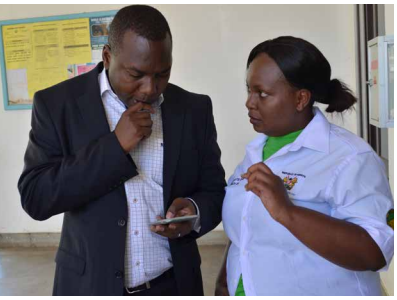
NSP

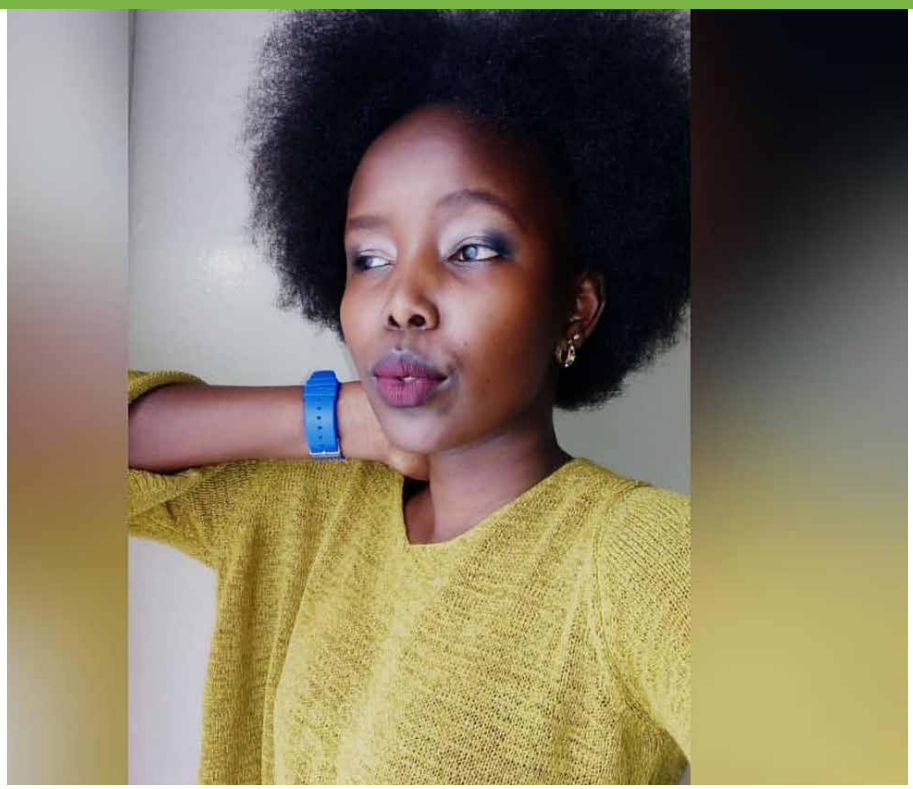
TB ARC II work planning

2018 World TB Day





TA in Kilifi County



The agony of a wrong TB diagnosis

By Mbetera Felix | *NTLD-P*

Friday September 28, 2018, was a typical day for Julie Gakenia. The 20 year-old was bubbling with life and had a promising future. The fourth-year Bachelor of Business Information Technology student at Kenya Methodist University, Nairobi Campus, had accompanied her mum to their local Umoja market in Umoja estate. Little did she know that darkness was about to cover their glowing smiles.

There was a medical outreach camp at Umoja market. A group of Community Health Volunteers (CHVs) from a government health center in Umoja was educating and screening the public on tuberculosis (TB). Due to curiosity, Julie's mum took four sputum mugs from a CHV. Two for herself and two for her daughter. She took them back home and returned them to the health center as she had been requested.

The experience at the health facility lab made mama Julie feel like an outcast who had contracted a contagious disease.

"The two lab technicians were unfriendly. Their attitude was very negative and unwelcoming," she narrates. "They would cover their noses and mouths using their lab coats when I took our sputum specimens to the lab. In addition, they kept shouting and pointing where I should put the specimens and asked me to leave immediately," she adds. "It was very stigmatizing yet I wasn't sick. And I was just submitting the specimen to the lab out of my volition". One could tell the agony in her voice.

> "I was shocked! I did not know what to do or where to start from," Julie's mum said...I wasn't sure how I was going to break the news to my daughter" she added.

The test results were out by Wednesday October, 3. Julie's mum got a phone call from the health center. She received the dreaded news that her daughter's tests were positive. She was required to accompany Julie immediately to the health center for further tests and medication.

"I was shocked! I did not know what to do or where to start from," Julie's mum said. " I wasn't sure how I was going to break the news to my daughter" she added.

However, she gained courage and told her daughter that they were required to return to the center immediately as the results were not good.

Julie was at home when she got a call from her mum. The news that her test was positive and she was required to be at the health center for further tests nearly gave her a heart attack. Like her mum, she didn't know what to do. " I just started crying wondering what to do next," she said.

She later joined her mum in the market and went to the center where she underwent HIV, blood sugar and weight tests after counseling. All this time she was asking herself a million and one questions. She felt as if the world was crushing on her. Not even her mum's solace and assurance were enough to soothe her pain. The tests, however, turned negative. The clinicians in the health facility opened her medical file and she was put under medication immediately.

Although she took four tablets the first day, she was still astounded at how things had turned around so fast. Some hours back she was ebullient with her friends, and now she is under medication.

"I was not sick, neither was I feeling sickly at all and did not have any TB symptoms," she argued. "The thought of taking the TB medicines for 6 months was killing me inside" she added.

Her mother was even more worried but she could not show her daughter. "I was supposed to leave town for a while, and I could not imagine leaving my daughter alone under such circumstances," she said. "The doctor had advised me to make sure that my daughter eats well. I was very broke and knowing her love for chips which doctors warned her against, I knew it would be a tall order for her to take the medicines and eat well if I wasn't around," she added.

Still confused, they went home. Her mother was very uneasy. She didn't want her daughter to see her in that state and went for a walk. She thought of how she was going to take care of her sick daughter without money. She found herself in her niece's house. Her niece advised her to seek a second opinion and take her daughter for further tests. That evening, they could not sleep. It was their longest night ever. They had made up their mind to seek a second opinion and could not wait for daybreak. What they did not know was that they were just about to start the most tortures week of their lives.

On October 4, they went to Medipath Laboratories in town for the tests. Julie underwent three sputum and Mantoux tests which cost KES 2,300. The reception at the lab was friendly. She was required to submit her sputum specimen on daily basis for three consecutive days.

On Monday, October, 9 they went for the results. All the three sputum analysis were clear with mucus and "No Acid Fast Bacilli was seen". The Mantoux test was however positive with a 9mm reading. According to the doctor, that could have been a false-positive result as someone can react to the test even when they are not infected with TB. The causes of such false-positive reactions may be as a result of non-tuberculous mycobacteria or previous administration of BCG vaccine.

> I feel bad my daughter and I had to go through such torment... The doctor at KNH assured us that my daughter is okay and we shouldn't worry at all. Imagine taking all these medicines for six months yet you are not sick. I thank God for our good health..."

Still disturbed and not convinced with the results, Julie and her mother decided to rush to Kenyatta National Hospital(KNH) for further consultation. They had some fears. Medipath laboratories had partially confirmed as well as higgledy-piggledy them even further. At the KNH TB clinic, two sputum tests plus a chest x-ray were done. The tests were also negative. The X-ray revealed that there was no pulmonary or mediastinal lesion was seen.

Julie was not sick. She did not have TB. Their fears had been confirmed.

"I was confused, I felt like crying, screaming" Julie said. "My mum's eyes were teary as well. What we went through the last two weeks was very agonising." She adds. Her shy smile captures her relief and thousands of hidden mixed feelings and emotions.

"I feel bad my daughter and I had to go through such torment," Julie's mum interjects. "The doctor at KNH assured us that my daughter is okay and we shouldn't worry at all. Imagine taking all these medicines for six months yet you are not sick. I thank God for our good health..." she adds.

Julie's story is just but one of misdiagnosed TB cases. Misdiagnosis is still happening in Kenya and many people are at risk of going through the same. Taking medicines for six months for a non-existent medical condition is unimaginable! Many who cannot afford to seek further medical consultations and tests are at a greater risk.

With funding from Global Fund, the National Tuberculosis, Leprosy and Lung Disease Program (NTLD-Program) has been implementing strategies to reduce the number of TB misdiagnosis cases. Through Active Case Finding (ACF) framework, NTLD-Program ensures that all reported cases undergo vigorous and multiple tests before patients are initiated on medication. Lab technicians and CHVs are also being capacity built on ACF and patient management. This is aimed at reducing stigmatisation and enhance professionalism as well. ■

THE UNSEEN HERO

By Njango Njung'e | *STOP TB Partnership - Kenya*

Mama Joyce recently lost her 12-year-old daughter Joyce Wangechi to Multi-drug- resistant TB (MDR-TB).

The thing about being affected by a disease and not infected by it is; most people do not really care to know how you are doing. After all, you do not have it as bad as the person infected with a disease such as Tuberculosis (TB). Martha Njoki, or Mama Joyce as referred to more often, knows this all too well.

Mama Joyce recently lost her 12-year-old daughter Joyce Wangechi to Multi-drug-resistant TB (MDR-TB).

"Death is bad, but sickness is worse, especially the kind that ravages the body and leaves one a shell of the person they were," she says as she describes her experience taking care of her MDR-TB infected daughter; who was so ravaged by the disease that she could no longer breathe without the assistance of an oxygen concentrator.

She narrates the constant anxiety and fear she felt while taking care of her sick child, that no matter where she was it was all she could think about.

From the onset when young Joyce fell sick, the journey of diagnosis then treatment ensued- visiting seven hospitals in pursuit of treatment. Until the time of her daughter's heartbreaking death, Mama Joyce was by her daughter's side, serving her diligently, caring for her and sacrificing so that her daughter could have what she needed to get better. Joyce was admitted to Kenyatta National Hospital for seven months. A few months after her discharge, Joyce passed away.

She describes the ordeal with unshed tears in her eyes, perhaps remembering the struggle to keep her daughter alive, and failure to do so.
Shortly after her daughter was diagnosed with TB, her husband was also found to be suffering from the same. The burden of his care fell solely on Mama Joyce's shoulders, and like the good wife and mother she is, she took up the responsibility of caregiver with such grace and poise that I cannot help but be in awe.

"After visiting Joyce in Kenyatta hospital and tending to her, I would then head back home to Tassia where I would find my husband lying on the couch, weak from TB, and tend to him also," she reminisces.

She was tired and hungry most days, having walked a long distance from the hospital to town after using her fare to buy her daughter milk, or whatever else she was craving at the time. One of the biggest challenges she faced during this period was lack of money. She say the only thing harder than taking care of a sick person is taking care of a sick person while penniless.

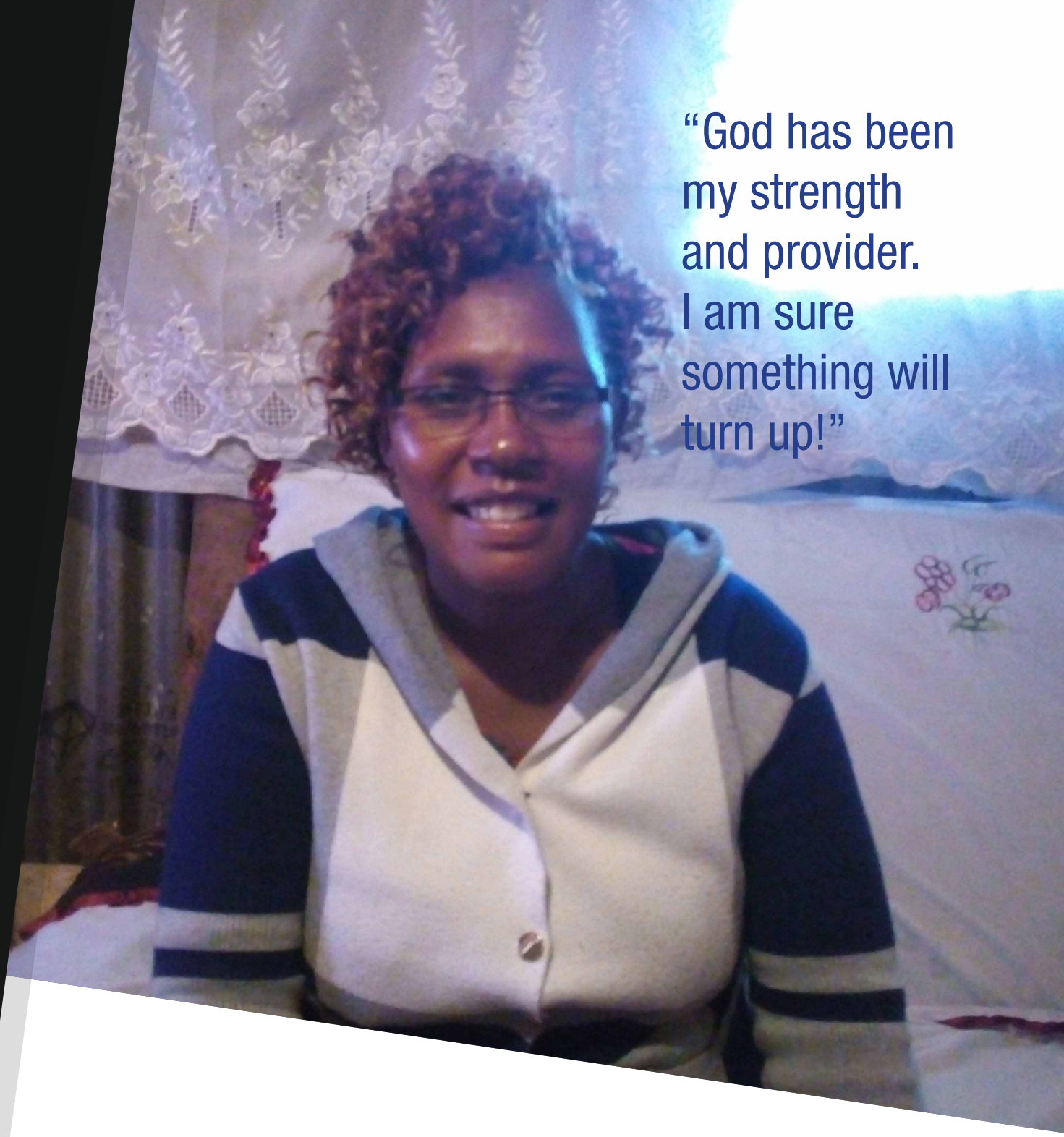
She had to close her vegetable stand and take care of Joyce full time. She knew it would be hard but she was more than willing to do the work for the well-being of her daughter.

Martha says the most important lesson she learned while taking care of her sick ones was the need to treat the sick with dignity. "Let us be gracious as we serve the sick and be mindful of the suffering they face, treat them well as they have self-pity and self-loathing, especially with a disease such as TB."

Sadly, despite all her efforts she still lost her daughter. While she looks well outwardly, she is not whole yet.

"I still wake up anxiously when the lights are off, worried for Joyce," she says remembering how blackouts were particularly torturous when she had to connect her daughter's machine to the

"Death is bad, but sickness is worse, especially the kind that ravages the body and leaves one a shell of the person they were,"



"God has been my strength and provider. I am sure something will turn up!"

generator, and having to walk kilometers to buy diesel most nights when it run out of fuel. She also cannot bear to see children in school uniform, particularly those from Joyce's former school. All it does is remind her of the daughter she loved so dearly and lost.

"Now I am left with a hefty hospital bill to pay, and no daughter," she says bitterly. Martha and her husband still have a bill of KES 1.2M (USD12,000) at Kenyatta National Hospital. She is now looking for gainful employment to enable her to settle the hospital bill.

Despite this looming bill, she remains hopeful and says, "God has been my strength and provider. I am sure something will turn up!" Her strength and perseverance is a thing of beauty. Despite adversity, Martha Njoki remains a beacon of hope and unshaken faith. ■

"Now I am left with a hefty hospital bill to pay, and no daughter," she says bitterly. Martha and her husband still have a bill of KES 1.2M (USD12,000) at Kenyatta National Hospital. She is now looking for gainful employment to enable her to settle the hospital bill.

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Pre-seeking TB care and Community Engagement

Enhance TB awareness in the community

The enhancement of public awareness on TB facts at all levels, laying particular emphasis to target populations and specific contexts, regarding health determinants, age, and gender specific to ensure targeted reach and impact towards sustained health-seeking behaviour and uptake is also vital. This has to take a departure from the traditional methods and embrace innovations (media cafes, community dialogues) and technology such as digital or social media (new media) and print media which should house an interactive platform for immediate feedback and referral.

The impact of enhanced information levels on TB should be continuously monitored to feedback on the communication loop for improvement. Also, a critical area that needs intensified attention are the informal settlements.

Improve Health seeking behaviour and uptake

Recent studies have pointed out the poor health-seeking behaviour among men partly compounded by their gender roles. Attractive gender-sensitive approaches are needed if this population has to be reached; programs focusing on the workplace have been touted to have a high impact as they meet men at their preferred environment. Further, identification of peers/CHVs who connect with such population helps create an environment of familiarity thus generating buy-in and trust.

Strengthen the linkages between the health facility and the community

The policy integration process should be enhanced whereby TB interventions and activities are embedded into the existing community health strategy structures to ensure timely and sustained linkage of community members to the health facilities. Meaningful engagement of TB Champions in the communities to spearhead TB agenda has been shown to yield and create buy-in. Therefore, support has to be bi-directional in that people referred from the community get prompt and required care at the nearby health facilities. Furthermore, there is a need to implement the existing health policies and guidelines that address the use of TB data at the community level as part of strategies that would promote health

Practical steps to realize interventions (innovative approaches)

Stakeholders thus need to focus on training of CHVs on TB screening, sample collection and fixation strategies to improve on diagnostic access, involvement of informal service providers such as traditional healers to refer presumptive TB cases, deliver IEC materials in local dialect, and engage Opinion leaders/Community gatekeepers like MCAs, Chiefs and Religious leaders as TB ambassadors.

Further, TB screening and management should be integrated with outreaches like Beyond Zero and *Malezi Bora*. There is also need to use the Community Health Strategy volunteers and Community Health Extension workers to improve the screening at the community level. The screening should also be targeted to special populations, TB health education should be streamlined to routine school health education programs and public *barazas*, the engagement of people with TB and other comorbidities should be intensified and advocacy to strengthen community-based policies and interventions through civil society organizations should similarly be encouraged.

Priority interventions under bold policies and supportive systems

It is thus critical for all stakeholders to consider high-level advocacy for political commitment at National and county levels. This should target adequate resources for tuberculosis care and prevention; inclusion of TB activities in County Integrated Development Plans. The review of the community strategy to include meaningful engagement of TB Patient groups and communities, civil society, and public and private health care providers should also be put into consideration.

Moreover, stakeholders should consider the development of a policy framework for aligning the engagement of CHVs across all actors. The optimization of the platforms for Universal Health Coverage (UHC) policy, regulatory frameworks for notification, vital registration, rational use of medicines and infection control will also play a significant role. As a country, there is a need to leverage existing structures and schemes for Social protection, poverty alleviation, and actions on other TB determinants. School Health policy should not only be mandatory and but also institutionalized. Of significant importance is the initiation and sustainability of a TB and Lung Health differentiated communication package focusing on online TB Campaign platform and Community Awareness forums. Lastly, it will be prudent to develop and implement a TB integrated workplace policy and framework. ■

“Recent studies have pointed out the poor health-seeking behaviour among men partly compounded by their gender roles. Attractive gender-sensitive approaches are needed if this population has to be reached; have been touted to have a high impact as they meet men at their preferred environment.

Catalyzing Pediatric TB innovation launched in Kenya

By Mbetera Felix | *NTLD-P*

Catalyzing Pediatric Tuberculosis (CaP) Innovation has been launched in Kenya. The project which is aimed at scaling up diagnosis and treatment of tuberculosis (TB) in children was launched by Unitaid, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and the National Tuberculosis Leprosy and Lung Disease Program (NTLDP).

According to EGPAF, over 230,000 children died from TB in 2017 worldwide. In Kenya, close to 70% of the estimated children with TB were missed. Through the project, and with support from Unitaid, EGPAF and NTLDP, it is expected that children's lives will be saved by using innovative diagnostics, drugs and models of care.

Kenya has an overall TB case detection of 60% with an estimated 22,000 pediatric cases. Only 7,000 cases were identified in 2017. CaP TB targets to identify approximately 1,300 pediatric TB cases, initiate at least 5,600 children on latent TB infection preventive treatment and ensure at least 1,200 TB cases are treated.

TB is the fourth leading cause of death in Kenya and the first in the world. The program aims to address the gaps in childhood TB on diagnosis and treatment particularly in Homabay and Turkana counties which are most affected.

According to Dr. Muleshe, Head, Care and Treatment, NTLD-P, the program has recognized the high prevalence of the TB epidemic in Kenya and there still exist significant challenge in diagnosis and management of pediatric TB.

Photo Courtesy / @EGPAF

"Through the program, we are hoping to increase TB case detection among children and ensure that all positive cases are treated immediately," said Dr. Muleshe. "Since we rolled out Genexpert, we have recorded a more accurate and specific diagnosis of TB among children in Kenya."

As a key implementing partner to the Ministry of Health, EGPAF has been supporting the scale-up of prevention of mother-to-child HIV transmission, HIV diagnosis, care, and treatment, as well as integration of HIV/TB services in Kenya. It will therefore use it's expansive network built through pediatric HIV testing and diagnosis to use innovative solutions to tackle childhood TB in the county. CaP TB is funded by Unitaid, and will run from 2018 through 2021. ■

230,000

Approximate number of children who died from TB in 2017 worldwide, according to EGPAF.

"Through the program, we are hoping to increase TB case detection among children and ensure that all positive cases are treated immediately," said Dr. Muleshe.

Key partners strategize on how to reduce TB in Kenya

Participants during the TB ARC II workshop.

Key implementing partners have held a meeting to chart ways of reducing the TB burden in Kenya through the TB ARC II project. The project is funded by the American people through USAID Kenya.

During the meeting, Dr. Kamene, Head NTLD Program, said that there is a need for Kenya to strive towards leaving the list of the high burden TB countries globally. "Let us do something unusual in the next five years. Find everyone with TB and treat them", she said.

Mrs. Evelyn Kibuchi, Chief National Coordinator, Stop TB Partnership - Kenya, argued that there is need for a multi-sectoral approach towards ending TB. She called for the involvement of the non-medical sector in contributing to the National TB targets within their core mandates and competencies. In addition, Dr. Brenda Mungai, the Chief of Party, Centre for Health Solutions (CHS), also called for the flagging of opportunities for partnership so as to identify missing cases and reduce TB burden in Kenya

TB ARC II program is aimed at reducing the incidences and number of deaths as a result of TB in Kenya. Through partnership and networking, it is envisaged that there will be quality and better diagnostics as well as innovative solutions which will result in better healthcare for the benefit of patients. ■

Mrs. Kibuchi, Chief National Coordinator, Stop TB Partnership - Kenya.

Dr. Brenda Mungai, the Chief of Party, Centre for Health Solutions (CHS).

Street Dance With A Difference

Last year's season II of Base Yangu, Dunda Yangu attracted many participants as expected. The competition which was launched in 2017 under the theme "Street Dance With A Difference" is a street dance project that targets young people in slum areas of Nairobi.

During the event, health services that are youth targeted are usually provided by specialist from the health sector. The services include Tuberculosis screening, Family planning, Sexually Transmitted Infections screening and HIV Testing services.

Season II took place at the Youth Empowerment Centre in Dagoretti, Kiboro grounds in Mathare and Star of Hope ground in Mukuru. The program is part of AIDS Healthcare Foundation's creative responses aimed at addressing HIV infections among young people, through the infusion of dance.

The project also incorporates open forum discussions on HIV Prevention, Stigma reduction, HIV Care and Treatment, Sexual Reproductive health, TB and are educated on the relationships between HIV and TB. The winning dance group walked away with a grand prize and an opportunity to serve as youth ambassadors. ■


Photo Courtesy


Photo Courtesy

International trade fare outreach


Photo Courtesy

Nairobi Governor, H.E. Mike Sonko at the NTLD-P booth.

The National Tuberculosis Leprosy and Lung Disease Program participated in last year's Nairobi International Trade Fair. The seven-day event which is the largest Trade Fair in the East Africa region runs from late September to early October on yearly basis and was held at Jamhuri Park/ Showground.

During the Fair, exhibitors usually display and demonstrate their products and services to visitors thus giving an opportunities to visitors to meet and learn from each other. Last year, the NTLDP's booth attracted a huge number of visitors including Nairobi Governor, H.E. Mike Sonko, local leaders and the public. Through the exhibition, visitors were able to learn about the Program and the fight against Tuberculosis. ■

Fighting TB through music

By Njango Njung'e | *STOP TB Partnership - Kenya*

You might have heard his music on radio or during the World TB Day stadium performance earlier this year. Steve Otieno is a twenty-four year old TB advocate and musician. His is a sad story of loss and pain, and a strong will to survive. Steve had a brush with TB earlier than most of us.

At the tender age of two, he lost his dad to TB and at three years old, he lost his mum to TB as well. He was then taken in by his grandmother who raised him till he was seven, before she also passed away. He was later taken in by his aunty who lived in Kibera. Sadly, she also passed away when he was nine. Faced with such loss and disappointed with life, he ended up as a street boy; unloved, lonely, and fighting to survive each day.

Later he was approached by well-wishers from an SDA church in Olympic, Kibera who took him to an orphanage in the area. He continued with his studies to class 8, and was lucky enough to be sponsored by Christian Church Fund to further his studies to Form Four.

Steve always knew music was his path and thus participated in Music festivals and other music outlets. After school, he wrote his first song 'TB ina Tiba', which unfortunately did not garner as big an audience base as he had hoped. He wrote an English version of the same song which he dubbed 'Save the World' in order to reach a wider audience even beyond Kenya.

Even then, he was very passionate about TB and wanted to play a role in advocacy, he just didn't know how to go about it. He then decided to consult the internet. He googled TB related organisations in Kenya and discovered Stop TB Partnership-Kenya. (STP-K)

On the STP-K organisation website, he drafted and sent his story. Evaline Kibuchi, Chief National Coordinator STP-K soon contacted him and it was then that he actively became involved in advocacy.

When asked, Steve says the loss of his family has taught him to be strong and resilient. He views his parents' demise as an opportunity to both educate and sensitize people about TB using his music as the channel "Nothing is hard. A single step makes a distance," he says.

Steve aspires that his music penetrate the grassroots and the crevices of community, so that everyone is can be aware that while TB is a killer disease, it can be treated. ■

Photo Courtesy

Steve Otieno, TB advocate, and musician.

Steve Otieno performing during *Dunda Yangu, Base Yangu*, a street dance event aimed at health promotion.

> When asked, Steve says the loss of his family has taught him to be strong and resilient. He views his parents' demise as an opportunity to both educate and sensitize people about TB using his music as the channel "Nothing is hard. A single step makes a distance."

Reaching the Youth through Sport

By Mbetera Felix | *NTLD-P*

Amref Health Africa in Kenya has organized Mulika TB Maliza TB Football Tournament which is aimed at reaching out to the youth. It is envisaged that the tournament will create awareness, conduct TB screening and testing and link people identified with TB to health facilities for further management. In addition, HIV testing and counselling services will be provided.

The four-day tournament took place in Makadara Sub-county, Nairobi County. The preliminaries were held on Saturday, 17, and Sunday, 18 November, 2018 at Jericho and Hamza grounds. The semi-finals took place on November 24, 2018 and third runners up and finals on November 25, 2018 at Camp Toyoyo.

Key partners who supported the tournament whose theme was "Mulika TB Maliza TB" included the Ministry of Health's National Tuberculosis Program, Nairobi County Health Management Team, KICOSHEP-Kenya, Movement of Men against AIDS in Kenya (MMAAK) and the Local Organising committee is planning to have a football tournament

According to Gloria Wandei, the coordinator of the tournament, TB case finding among the youth is still a challenge in the country despite the government and partners laying down strategies in place to find the missing TB cases. "We hope to reach out to a great number of youth through sports. This is the first of many sporting events we have planned" she said.

Over decades, sporting activities have been embraced and liked by many, with majority being the youth. The use of sports like football to promote awareness and empower the youth with messages on how to prevent and manage TB can contribute significantly in reducing vulnerability to TB infection and even to lessen the adverse impact of TB on those affected. During this tournament, health services like Health Education, TB Screening, HIV Counselling and Testing will be provided for free.

Kenya is among the 30 high TB burden, and 14 TB/HIV and MDR-TB high burden countries and TB is the 4th leading cause of death in Kenya. The National TB Prevalence Survey (2016) found that about 50% of the country's estimated people with TB are currently missed by health service facilities. The survey also found that the highest burden of disease was in the 25-34 age group. Males had a higher TB prevalence rate compared to females, and most importantly, individuals with TB symptoms in the community are not seeking care as may do not perceive their symptoms severe enough. ■

DR. MASINI

Dr. Enos Masini **is the former Head of the National Tuberculosis Leprosy and Lung Disease Program (NTLD-P). He has vast experience in the management of TB in Kenya and Africa. Further, he has grown in leaps and bounds to serve as the TB and Malaria advisor at the World Health Organization (WHO).**

He shares with us his journey through is career progression and why TB issues are of interest to him.

By Mbetera Felix | *NTLD-P*

Tell us a brief history about yourself (Who is Dr. Masini?)

My name is Enos Masini, 44 years old and a proud father of girls.

What is your profession & What does your profession entail?

I'm a medical doctor specialized in public health. I have worked for the past 18 years in various roles in public health. I joined the National Tuberculosis Leprosy and Lung Disease Program (NTLD-P) 10 years ago, as the provincial TB Coordinator, Eastern Southern Region, then as a TB/HIV focal point at NTLD-P and finally as the head of the Program. I later left the program in June 2017 to join the World Health Organization (WHO) Kenya, where I currently serve as the TB and Malaria advisor.

Why did you choose the profession (For how long have you been in the profession as a doctor)?

I think there was particular reason for selection medicine as my career. But along the way, I have realised the important role health care workers play in the betterment of people's livelihoods.

What is you speciality and why have you chosen this field of speciality? Are you still practicing fully as a doctor?

My speciality is Public Health. I don't do clinical practice anymore. The last time I did was 13 years ago in Kathiani Hospital, Machakos County. The choice of public health was accidental; I was not selected to do Masters in Surgery, so I joined the Masters in Public Health instead!

Why does issues around tuberculosis interests you?

All issues around TB interest me but I have a particular interest in work that involves introduction of new medicines, tools and diagnostics for TB that can help diagnose and treat more people with TB, e.g.

expanding the access to GeneXpert; use of new TB drugs like Bedaquiline etc.; use of shorter duration regimens for treatment of latent TB infection; and, engaging the private sector in TB control.

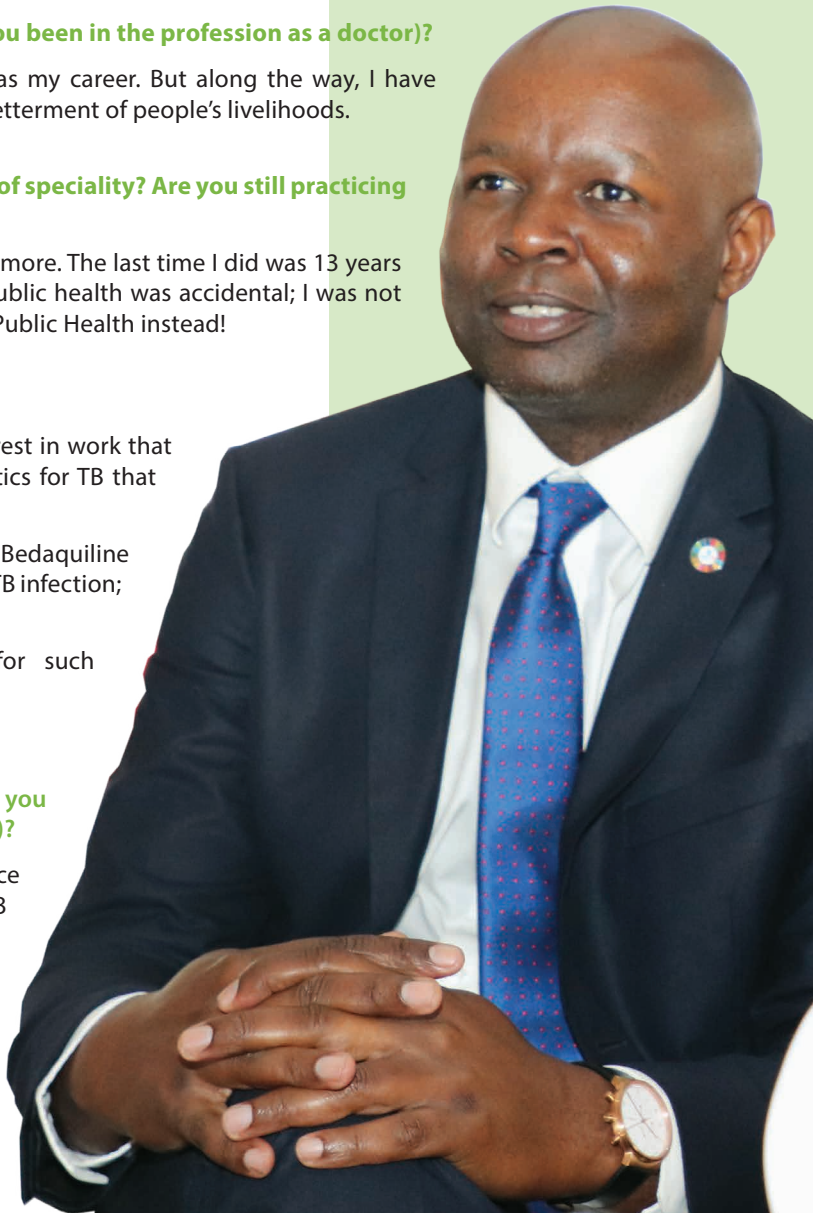
I will always advocate and support implementation for such approaches.

As the head of NTLD-P;

(a) What legacy would you associate yourself with while you were head of the Program (some of your achievements)?

Completing the TB Prevalence 2016 and Drug Resistance Surveys 2015 that are providing evidence on how to end TB in Kenya.

In addition to expansion of GeneXpert diagnosis for TB and enrolling over 600,000 people on TB preventive therapy (isoniazid preventive therapy).



Of course this was achieved by the support of many other colleagues from NTLD-P, counties, partners, civil society organizations and TB patient communities.

I am also happy that colleagues who worked under me have expanded their careers- Dr Kamene then DR-TB focal point is now head of program, Dr Immaculate Kathure, then child TB focal point is at USAID.

(b) What enabled you to achieve this much?

I found a solid TB program, well grounded. My predecessors Drs Kioko, Sitienei, Chakaya did a marvellous job. Drs Kioko and Sitienei respectively helped me deliver on IPT and prevalence survey. I remain indebted to them. In addition, a technically competent team at NTLD-P, dedication from counties (CTLCs, CMLCs, pharmacists, ACTLCs among others), support from partners like Global Fund, USAID, CHS, AMREF, CDC (and their implementing partners), civil society organizations and TB patient communities also played a huge role in my achievements.

(c) What challenges did you face as the head of the Program?

At the time, the country was undergoing transition from a centralized government to devolved governance. Health became a devolved function, however it was not certain how communicable diseases will be managed and which level of government takes up which role. Defining the space of TB control in this dynamic was very challenging.

(d) What would you recommend done to mitigate against these challenges?

Strengthening engagement of county governments in the national TB response. This can be achieved through optimization of high level engagement between the NTLD-P and Council of Governors and working with them to invest more in ending TB based on their counties' context. I am happy that this approach is being prioritized by Dr Kamene, the current Head of NTLD-P.

You are currently working with World Health Organization on issues related to TB, what exactly is your role in the fight against TB with WHO?

WHO is a normative agency, meaning, it primarily supports development of policy and their translation to service deliveryl. In Kenya, we are specifically supporting the adoption and implementation of new policies that will help the country end TB.

Currently, I'm focused on supporting the development of the TB Strategic Plan 2019-2023, adoption of new innovative "strategic initiatives" to find missing people with TB.

Congratulations on your new post. Tell us about your new role and what it means to us as country?

Thank you.

I'm moving to a new role as Africa Region Advisor for TB at UNOPs/ Stop TB Partnership in Geneva. I look forward to work with colleagues at National TB Programs to better design and implement actions from Post TB UN-HLM meeting. Of course my role will still revolve around partnering and collaborating with National TB Programs.

What is a "Must Do" for the Program and the country currently/going forward to ensure we End TB by 2035?

First, working across various sectors (like transport, education, housing etc) to expand the TB response and include high level government officials, relevant ministries, county governments, NGOs, CSOs, affected communities etc. is key. Further, there is need to adopt new initiatives to help find missing people with TB including MDR-TB and children. Lastly, prioritizing and expanding access to TB prevention treatment – especially for all eligible household contacts including children and PLHIV should be put into consideration.

Do you as a leader/doctor have any weakness or strengths?

Yes of course.

Weakness - I frequently get stuck in a particular way of doing things. This frequently stifles the innovations of the teams that I lead. It is called stagnancy. Especially in my earlier days as the Head of NTLDP, I made decisions that were popular, and often not the best.

I don't take criticism so well, so that tends to shut-out people who meaningfully want to contribute

For strengths, I will leave others to judge me

What is your routine on a daily basis?

I am an early riser. I wake up at 4:30 a.m. My parents were pastors and they taught me to start my day prayers which I diligently do.

I get to work by about 6 a.m. and I use the early hours to read and catch up with pending work

As a professional with such a huge portfolio how do you balance your family time and work?

I have challenges with that but I get reminded of the importance of family, so I plan and create time.

Are there things you wish you did differently?

Personal issues yes, but professional no.

What is your advice to the young TB champions working with the Program?

The NTLD-P provides awesome opportunities for career growth. I would advise them to work hard and achieve tangible results in their areas, create networks that will enhance their career, and not to be contented with the present – career grows only when you are out of conform zones! ■

> The NTLD-P provides awesome opportunities for career growth.

Health determinants:

Holistic approach to Tuberculosis

By Leah Kamweru | *NTLD-P*

Health determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychological, behavioral, biological or social in nature. Individual behaviour and Social environment dynamics like discrimination, income, and gender play a big role. In addition, Physical environment where a person lives and crowding conditions are considered critical. Biology and genetics isuses like age and sex as well as access to quality health services including insurance cover, also determine the health outcome of an individual or communities.

To control Tuberculosis (TB), a communicable disease, it is imperative to involve proponents of medical and psychosocial approaches which are holistic at all level of policy engagement. Such inclusion will ensure representation of a broad worldview and formulation of bold policies that consider all aspects of disease causation, hence improve health care seeking, treatment and care at the national leadership, health facility and the community levels.

Social determinants

According to WHO, the social determinants of health are the conditions in which people are born, grow, live, work and age with. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities, the unfair and avoidable differences in health status seen within and between countries.

To prevent and control TB, the health sector needs to address critical social determinants of health which can not be "tested and treated scientifically" with drugs yet are crucial to eliminating the scourge. Failure to address some of these determinants results to soaking down the efforts gained by the National Tuberculosis Leprosy and Lung Disease Program, and other stakeholders in prevention and treatment control over the years.

Achieving a healthy and conducive environment is a shared responsibility that requires all levels of political commitment and collaboration to establish partnerships with other sectors, and civil society to carry out a broad spectrum of interventions concurrently. Individual and community empowerment, as well as health literacy, is considered a key component to address social determinants of health. However, the contribution in this area is relatively weak and should be strengthened to ensure sustainability.

Similarly, Urban development and town planning are key to creating supportive social and physical environments for health. Where building regulations have been overlooked, considering compliance with building standards should be emphasized as well. ■

10 Facts on Tuberculosis

Fact 1	2017- estimated **10 million** people fell with TB worldwide. **5.8 million** men, **3.2 million** women and **1.0 million** children.
Fact 2	2017- **1.6 million** people died of TB (**0.3 million** people living with HIV). TB is one of the **top 10 causes** of death and leading cause from a single infectious agent (above HIV/AIDS) Worldwide.
Fact 3	2017- **1 million** children fell ill with TB globally. **230,000** died of TB (including children with HIV associated TB). Childhood TB is often overlooked by health providers and can be difficult to diagnose and treat.
Fact 4	2017- **16%** of people died of TB, down from **23%** in 2000. TB is the leading killer of people living with HIV.
Fact 5	Globally, TB incidence is falling at about **2%** per year.
Fact 6	2017 – The **30** high TB burden countries accounted for **87%** of new TB cases
Fact 7	2017- There were estimated **558,000** new cases of Multidrug-resistant TB (MDR-TB) with resistance to rifampicin (the most effective first-line drug), with which **82%** had MDR-TB. MDR-TB remains a public health crisis and health security threat.
Fact 8	TB treatment saved about **54 million** lives globally between 2000 and 2017, however, diagnostic and treatment gaps persist. The treatment success rate people with TB was **83%** in 2016.
Fact 9	Of the estimated **10 million** cases, only **6.4 million** were detected and notified in 2017 leading to a gap of **3.6 million** cases.
Fact 10	For TB care and prevention, investments in low-and middle-income countries fall almost **US$3.5 billion** short of the **US$10.4 billion**.

Courtesy/WHO

The editor welcomes articles from readers and other stakeholders

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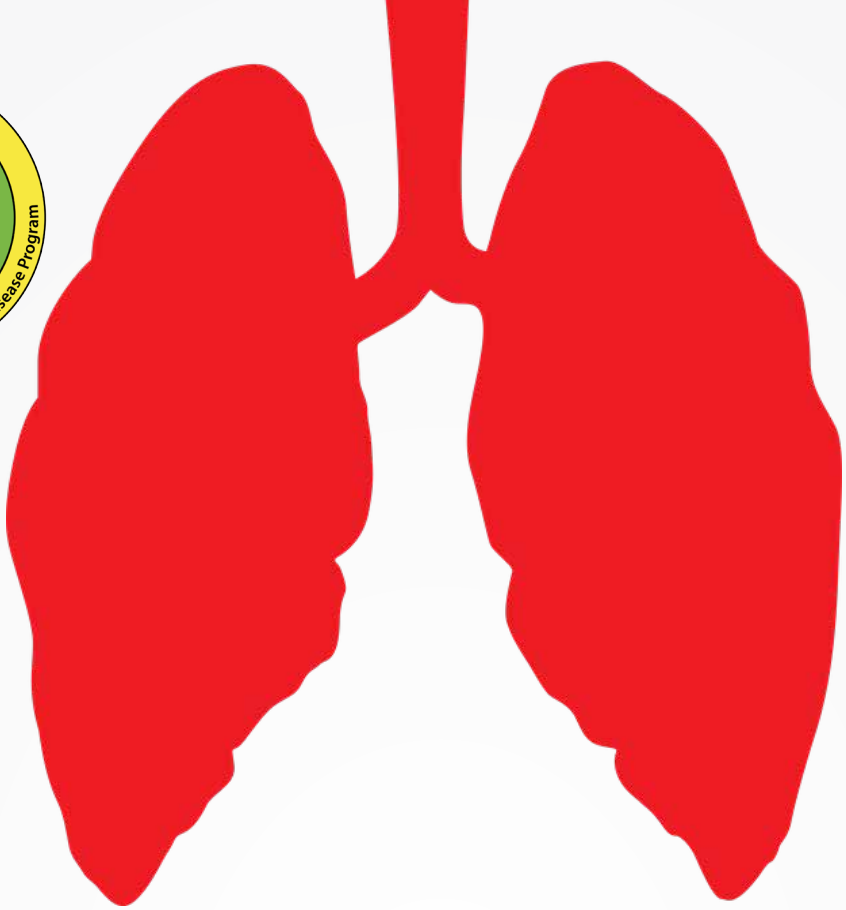
HARAMBEE



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