REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL STRATEGIC PLAN

FOR TUBERCULOSIS, LEPROSY AND LUNG HEALTH

2019 – 2023

EXECUTIVE SUMMARY

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

OVERVIEW

The National Strategic Plan (NSP) for Tuberculosis, Leprosy and Lung Diseases 2019 - 2023 represents an evolution in the Government of Kenya's response to these scourges. New data acquired over the past four years will drive a targeted and prioritised approach. This NSP reflects a patient-centred approach to planning and evidence-based prioritisation of resource allocation to close the gaps along the patient pathway to quality care. The NSP is operationalised through a partnership framework aligned to each stakeholder's comparative advantage. The activities embodied under this NSP will address systemic and root causes of the gaps along the patient pathway, suggesting the complementary roles of county and central governments, departments across the Ministry of Health, partners and other sectors.

This NSP lays out the strategic and technical direction for the elimination of TB and leprosy nationally. It presents the full aspiration of the country, including outcome and impact targets that align with international goals, and the full portfolio of activities needed to reach these goals. It assumes a fully funded NSP. In acknowledgement of likely funding gaps, an evidence-based optimisation of resource allocation is presented alongside alternative impact targets given reduced funding scenarios; i.e. a) 2018 - 2019 funding levels from domestic and international sources; and b) 2018 - 2019 funding plus 25 percent. An upcoming supplement to the NSP will document the full operational plan behind this NSP and articulate the county-specific commitments that will contribute to the attainment of national goals.

THE PROBLEM

Tuberculosis is the leading infectious disease killer in Kenya. A 2015/2016 prevalence survey revealed that the burden of tuberculosis (TB) in Kenya was 426 cases per 100,000 population – suggesting there was more than twice as much TB as previously estimated. This was a wake-up call for the country. After five years of declining case notifications, the results of the prevalence survey prompted intensified efforts to understand where people with TB were being missed by the system and to mount innovative responses. In both 2017 and 2018, TB case notifications increased by more than ten percent, respectively, over the previous year. Still, nearly half of all estimated TB cases were not diagnosed, notified and or treated in 2018. Among children with TB, nearly two-thirds were not diagnosed; and nearly 80 percent of people with drug-resistant TB were missed.

Kenya is a low endemic country for leprosy and has achieved and sustained national elimination status for several years. However, there are still six high burden counties that accounted for 73 percent of notified cases from 2014-2016. The majority of these cases were multi-bacillary, some had grade 2 disabilities, and included children under 15 years of age, signifying continuing recent community-based transmission of infection. The NSP reflects a focus on earlier identification of people with leprosy and quality care.

Respiratory illness is the leading reason for healthcare seeking in Kenya. It accounts for a considerable burden of morbidity and mortality in all age groups with ten percent of self – reported reasons among patients seeking outpatient services complain of respiratory symptoms, this is the most frequent complaint. This translates to an annual eight million outpatient visits from respiratory symptoms among health facilities that report on the routine health management information system, DHIS2. Among the respiratory diseases, the most frequently occurring that result in significant morbidity and mortality are lower respiratory infections, drug susceptible TB, drug susceptible HIV/AIDS – TB and chronic obstructive pulmonary disease.

TWO-THIRDS
Approximate number of people with symptoms for TB and had not yet sought treatment. Of these, the majority (82 percent) did not seek care because they felt the symptoms were not serious.

THIRTY FIVE PERCENT
35%
Percentage of people on treatment who were non-adherent.

ONE-THIRD
Approximate proportion of those seeking care in the formal private sector.

TWENTY SEVEN PERCENT
Percentage proportion of TB-affected households facing catastrophic total costs (that were more than 20 percent of their annual household expenditure).
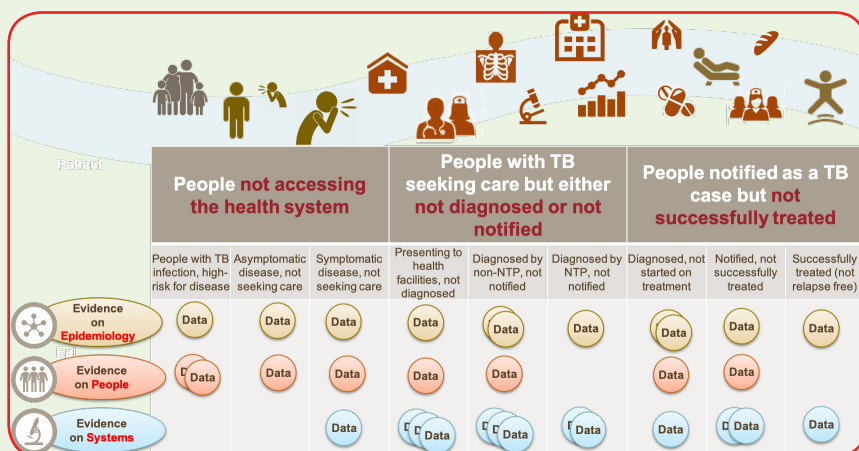
TWENTY PERCENT
Percentage of people with TB who were diagnosed, and not notified into TIBU – an electronic TB patient-management and recording system.
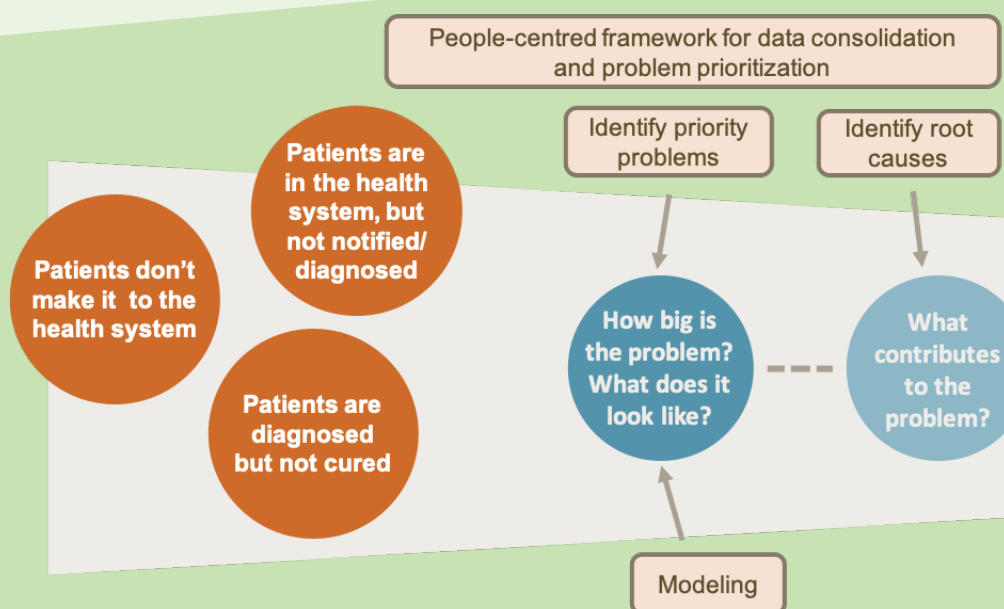
FOURTY THREE PERCENT
43%
Percentage of people who accessed a facility with TB diagnostic services or specimen transport

STEP 1

Pathway Category	Pathway Sub-Category	Population	Priority
1. Epidemiology	Drug Sensitive	Pulmonary	
		EPTB	
		Pediatric	
		Special Populations	
	Drug Resistant	-	
	TB HIV	-	
2. People who are not in the health system	High-risk for TB infection or breakdown to disease	-	
	Asymptomatic disease, not seeking care	-	
	Symptomatic disease, not seeking care	-	
3. People with TB in the health system, but not notified/diagnosed	Presenting to health facilities; not diagnosed	-	
	Diagnosed by private sector, not notified	-	
	Diagnosed by public sector, not notified	-	
4. People with TB are notified, but not cured	People diagnosed with TB but not started on treatment	-	
	On treatment without treatment success	-	
	Complete Rx, w/out durable, relapse-free cure	-	

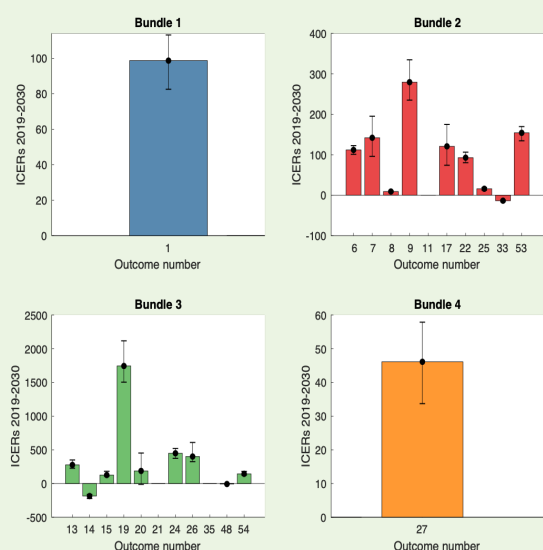**Priority** [Green: Low Priority, Red: High Priority]

2.0 ———————————————— 5.0

Existing data from 15 studies and reports were consolidated along the patient pathway and reviewed by stakeholders with a view to understanding where service delivery is well- or mis-aligned with the needs of people with TB, leprosy and lung diseases. Successes to be sustained were quantified. Gaps in the programmatic response were identified and prioritised.

People-centred framework for data consolidation and problem prioritization

Patients don't make it to the health system

Patients are in the health system, but not notified/diagnosed

Patients are diagnosed but not cured

Identify priority problems

Identify root causes

How big is the problem? What does it look like?

What contributes to the problem?

Modeling

STEP 5

1) Increase Contact Trace in Index Cases to 90%

6) Increase TB detection within the health system
7) Increase GeneXpert access from 49% to 80% by 2023
8) Increase diagnostic sample referral network to 80% for all L2, L3 and L4 health facilities
9) Increase number of TB culture laboratories by seven sites
11) Adopt chest x-ray and other new WHO guidelines
17) Increase the proportion of new and relapse notified TB patients who receive DST to 95%
22) Increase TB detection children to 70%
25) Increase HIV/TB detected to 90%
33 to 34) PPM
53) Increase TB case detection rate from 51% in 2017 to 80% by 2023

13) Reduce LTFU from 5% to <3% among all TB patients
14) Reduce death rate to <5% among high risk groups
15) Increase TSR from 83.1% to 90%
19) Increase DRTB treatment success rate to 80%
20) Increase proportion of eligible DRTB patients on new molecules to 90%
21) Reduce the proportion of DR TB patients' households that incurred catastrophic costs to 43%
24) Increase TSR in paediatric to 90%
26) Increase TSR in PLHIV to 85%
35) To reduce by half the proportion of households affected by TB facing catastrophic costs
48) To reduce Initial loss to follow up from 21% to 0% by 2023
54) Increase TSR in KP a to 90%

27) Sustain IPT over 90%

Modeling was completed of the epidemiological impact of reaching each of the outcome targets. For each outcome target, estimates of impact were considered alongside the combined costs of the activities articulated in the operational plan and designed to enable the targets to be met. The resulting incremental cost-effectiveness ratios (ICERs) helped the programme to review the cost-effectiveness of pursuing each outcome target. The programme defined the most impactful set of activities, given available resources.
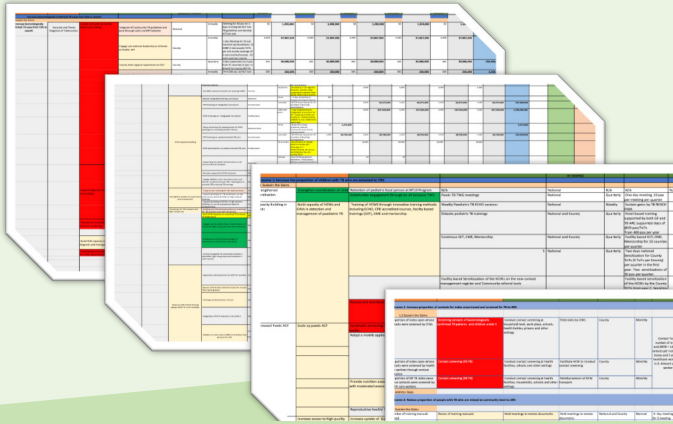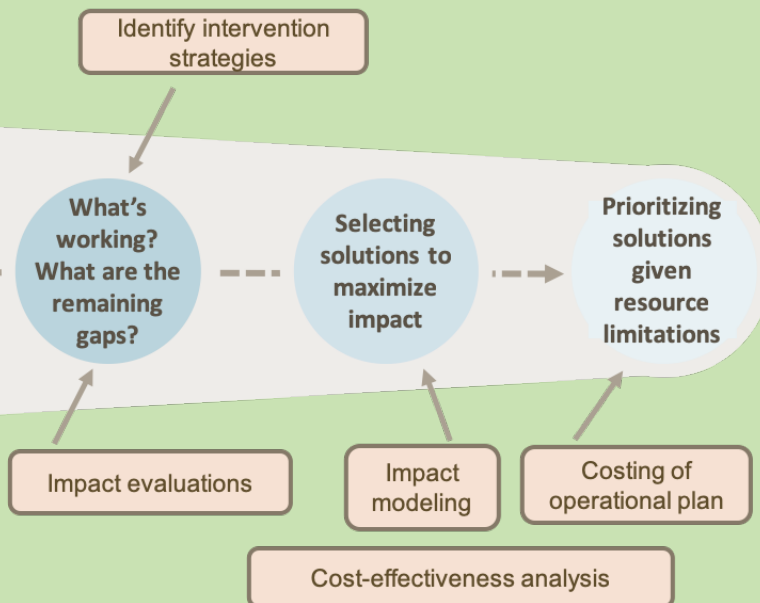
Step 2. Based on the prioritisation from step 1, outcome targets were set to sustain the gains and address gaps experienced by people with TB, leprosy and lung diseases.
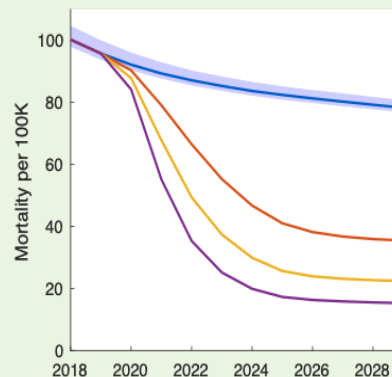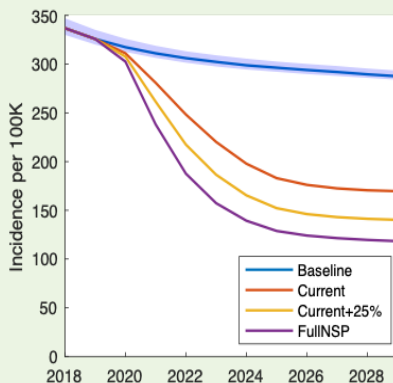
Step 3. A task force of stakeholders defined packages of activities that would be needed to attain the outcome targets. Root cause analysis informed the determination of needs and exploration of interventions.

Step 4. The full operational plan was costed

THE APPROACH

Identify intervention strategies

What's working? What are the remaining gaps?

Selecting solutions to maximize impact

Prioritizing solutions given resource limitations

Impact evaluations

Impact modeling

Costing of operational plan

Cost-effectiveness analysis

Using the results of the cost-effectivenss analysis as well as priorities defined in step 1, the activities of the operational plan were priotiized to optimise the impact of the programmatic response. Activities and their assocatied costs were allocated into one of three funding tiers: fully funded NSP (i.e. all activities); resource availability consistent with 2018 levels, and 2018 levels + 25%.

THE RESPONSE

The National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019 – 2023 (NSP) provides the framework for a multi – sector partnership for Kenya to overcome tuberculosis (TB) and leprosy as public health and social challenges. This NSP outlines the goals, objectives, strategic interventions and activities over a five-year period, considered within the Kenyan Health Sector vision and mission for the period 2014 – 2030. National and county governments, civil society actors, private sector, development partners and other stakeholders collaborated in its development.
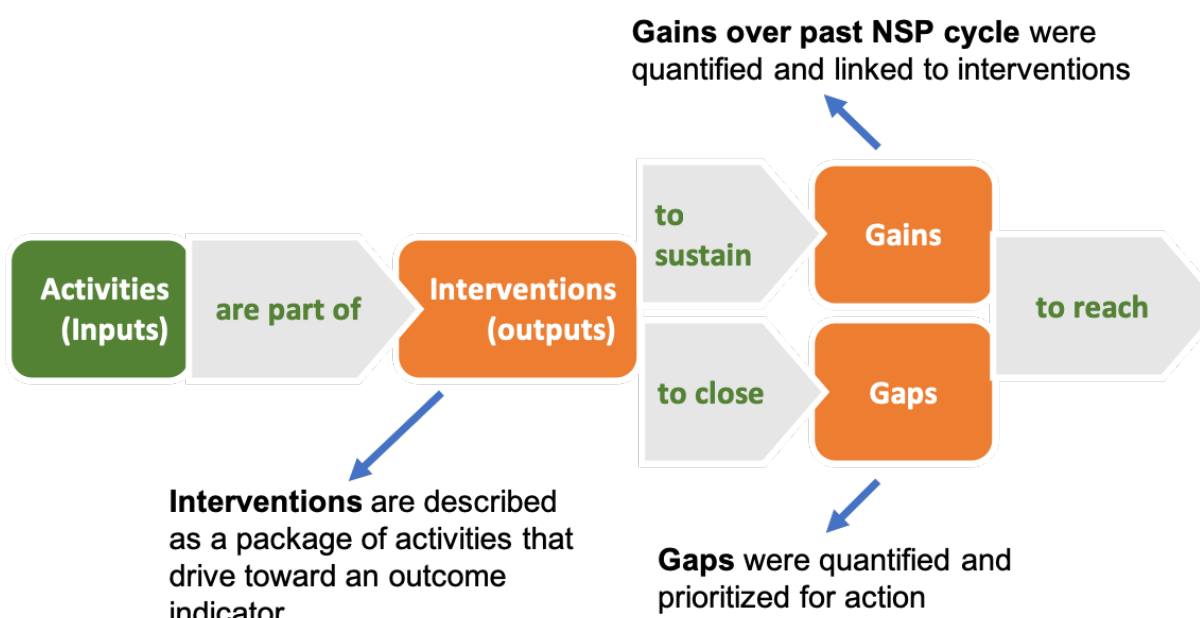
VISION

A Kenya free of TB and leprosy, and reduced burden of lung disease.

MISSION

To ensure provision of quality care and prevention services for all people in Kenya with TB, leprosy and lung diseases.

Gains over past NSP cycle were quantified and linked to interventions

Activities (Inputs) → are part of → Interventions (outputs) → to sustain → Gains → to reach

to close → Gaps

Interventions are described as a package of activities that drive toward an outcome indicator

Gaps were quantified and prioritized for action

STRATEGIC FOCUS

Close the gaps along the care continuum to find and cure ALL people with TB

Differentiated response by counties to address TB in local contexts

Optimise the implementation of TB, leprosy and lung health services within UHC
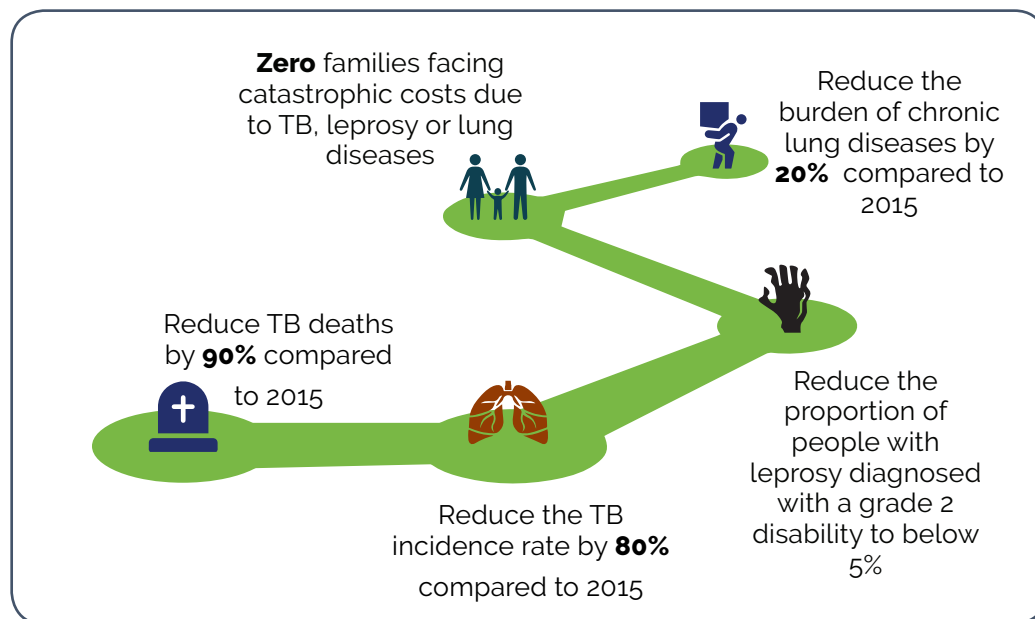
Prevent infection, active disease, morbidity and mortality due to TB, leprosy and lung diseases

Patient-centred approach that promotes quality of care

IMPACT TARGETS BY 2030

Zero families facing catastrophic costs due to TB, leprosy or lung diseases

Reduce the burden of chronic lung diseases by **20%** compared to 2015

Reduce TB deaths by **90%** compared to 2015

Reduce the proportion of people with leprosy diagnosed with a grade 2 disability to below 5%

Reduce the TB incidence rate by **80%** compared to 2015

Impact targets related to declines in:
1) Incidence
2) Mortality
3) Catastrophic costs
were defined via modeling for three funding scenarios

Outcomes → **that combined, will achieve** → **Impact**

Outcome targets were defined and prioritized based on a review of data via the patient-centred framework

PRIORITY OUTCOME TARGETS BY 2023

597,000 people diagnosed and treated for TB

55,000 children diagnosed and treated for TB

542,000 adults diagnosed and treated for TB

4,500 people diagnosed and treated for MDR-TB

900,000 people at risk of TB received TB Preventive Therapy

PRIORITIES FOR ACTION

1st **PRIORITY**

Meet people who are seeking care anywhere in the health system with quality TB, leprosy and lung health services.

Differentiate the package of priority activities according to local patient care-seeking patterns and infrastructure

This NSP represents the first time county-specific operational plans were developed as an input to the national plan. Each county considered the local surveillance and programmatic performance data, patient pathway analysis, and MATCH (population and facility mapping) analysis as they determined local priorities and approaches.

Close the diagnostic gap

This NSP represents the operationalization of three new national policies in support of appropriate and timely diagnosis, namely: 1) expanded use of x-ray screening for TB; 2) Xpert as the preferred confirmatory test; and 3) all confirmed TB patients to receive drug-sensitivity testing. These policies will put pressure on the existing infrastructure. The NSP calls for an optimisation of the diagnostic network, in line with the modeling analysis completed in 2018, to ensure each person who accesses care can immediately be screened and tested for TB. The optimisation has informed the repositioning of existing technology and suggested specimen transport networks. It will also guide plans for efficient expansion of Xpert and x-ray technology. The NSP anticipates the efficiencies that may be gained by the rapid introduction of new diagnostic tools when they become commercially available, especially LAM for screening and stool-based preparations for Xpert to diagnose paedatric TB. In the meantime, the NSP plans for all healthcare facilities to have either Xpert capacity on-site (where efficient) or a specimen transport arrangement to a qualified laboratory. Successful implementation of these policy shifts will require enhanced collaboration between communities, care facilities and laboratories. Such collaboration will require enhanced capacity among health staff and laboratories, as well as connected patient management data systems to follow patient progress.

Close the private sector gap

This NSP represents a bold strategy to network all care providers into a cohesive web of support for people with TB, leprosy and lung diseases. Recognizing the variability of private providers across the country, the NSP defines six distinct models of private sector engagement. The establishment of supporting systems will be prioritised, namely strategic purchasing of private sector services, contracting for linkages to public sector capacities (such as diagnostic technology) and commodities (such as drugs), and enhanced functionality of the data system to link patient care with notifications and payments. The activities capitalize on the concurrent expansion of Universal Health Coverage and the potential for national health insurance to incentivize private providers to deliver quality care.

Close the public sector gap, especially for special populations

This NSP reinforces efforts to identify TB among key populations that may be accessing care in specialized facilities and are missed for TB care. In particular, the NSP prioritises reaching children being seen by paediatricians and in MNCH services, people living with TB being seen for ART care, and those with DS-TB and DR-TB who may be seeking care for concomitant disease such as diabetes. This NSP sustains the gains made with routine HIV-testing of TB patients and anticipates early adoption of LAM for screening HIV-positive people for TB. The NLTD-P acknowledges that a paucity of data about the magnitude and characteristics of the TB burden among special populations, as well as impact data regarding what works to best serve them, must be overcome during this NSP period to enable more evidence-based approaches in future.

Close the treatment adherence gap

This NSP represents the first time that treatment adherence has been categorically prioritised within a national response to TB and leprosy. This NSP addresses some of the known root causes of poor adherence, including the indirect cost of care, side-effects, and lack of information. A multi-sectoral approach has been adopted to enable patient support to occur through national social protection programmes, such a nutrition and financial subsidies. Concurrently, the NSP calls for elimination of the fees associated with diagnostic testing for TB, including chest radiography. An evolution of the data management system, TIBU, into a patient care management system is anticipated to enable early detection and differentiated care responses for those people facing barriers to continued treatment.

2nd PRIORITY

For people at risk for TB disease; screen for TB and treat TB infection

Close the gap of pre-care seeking

This NSP represents a paradigm shift in the strategies used to reduce TB prevalence in the country. While maintaining a focus on the provision of quality treatment for all those ill with TB disease, this NSP also aims to identify people with TB even before they seek care. This NSP represents an ambitious scale-up of contact tracing for TB screening and the use of preventive treatment of TB infection among contacts, health workers and people with HIV. This NSP embraces the adoption of the new, shorter regimen (Rifapentine and Isoniazid for three months) for the treatment of TB infection and presents an ambitious partnership with community health volunteers, large employers, and the Ministry of Education to enable contact tracing for workplace, school-based and household contacts of TB patients, as well as among people with HIV. The move away from monotherapy is expected to overcome provider hesitation to treat TB infection. The NSP also anticipates the early adoption of new TB screening tests as they become globally endorsed and commercially available.
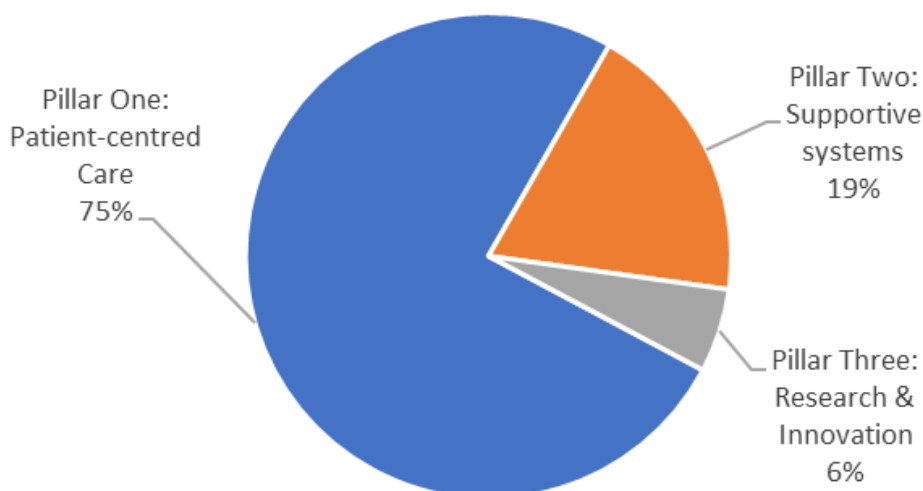
3rd PRIORITY

Mainstream TB, leprosy and lung diseases within UHC and national health insurance.

As Kenya takes strides towards attaining UHC, cost efficiencies can be gained where there is full inclusion of TB, leprosy and lung disease prevention, diagnosis and treatment services in the UHC Essential Benefit Package (EBP). This will enable the full engagement of health workers across the health system in screening and caring for people with TB as a core component of primary health care. This will provide financing of health promotion, prevention and community health services which are platforms needed to find missing TB cases. Similarly, inclusion of TB, leprosy and lung disease in the benefits package under the National Health Insurance Fund (NHIF) could facilitate seamless access to appropriate diagnosis and quality treatment. Insurance reimbursements, if well structured, may motivate reporting from and compliance with national care standards by private providers.

Funding Requirements

The cost of implementing this NSP is 29.8 billion Ksh (298 million USD)

Pillar One: Patient-centred Care 75%

Pillar Two: Supportive systems 19%

Pillar Three: Research & Innovation 6%

PRIORITISED RESOURCE ALLOCATION

Funding Gap

At 2018-2019 funding levels, it is estimated that KES 14.6 billion will be available. This is made up of domestic (KES 5.6 billion) and donor (KES 9 billion) sources during 2019-2023. Given the **50% funding gap** for implementation of the full NSP, an evidence-based process for prioritisation of resource allocation was completed.

Funding Source	Total (KES, millions)
GOK MOH Printed Estimates	2,765
GOK Co-Financing through Treasury	2,000
GOK HR and Admin	834
Donors (Global Fund and USG)	8,994
Total Available Funding	**14,593**
Funding Gap	**15,207**
Full cost of NSP	**29,800**

Scenario 1: Funding at 2018 Levels

Under a scenario where the programme must operate with 2018 - 2019 funding levels, the most **essential components of care** were prioritised. These included **diagnostic commodities, medicines, salaries, and core surveillance functions**. If funded as planned, these core investments would require 70% of the available 14.6 billion Ksh. Without sufficient funding to enable implementation of all activities aimed at generating demand for services, linking people with presumptive TB to care, or improving the quality of service delivery, it is unlikely that target numbers of people will be screened, tested or treated. As such, commodities were budgeted at 75% of targeted quantities under this scenario, while nutritional support for patients was budgeted at 50% of need.
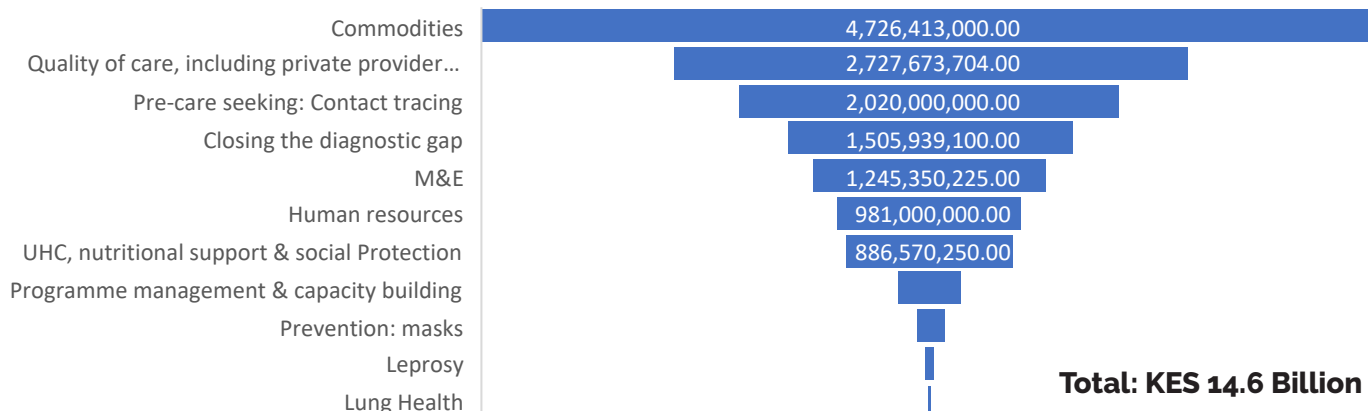
The programme next prioritised investments aimed at **sustaining the gains** made across all target populations. Based on the prioritised gaps and ICER results, the programme wanted to make fiscal space for intensified action in a few key areas. Careful review of the intervention impact data and cost drivers led to a decision to minimally fund some activities; such as capacity building activities and programmatic monitoring meetings, while other activities were left out completely and are captured in the higher funding scenarios.

In addition, the program aims to enhance the use of data for improving patient care, specifically by linking and scaling existing TB-related data systems and introducing **digital monitoring** of people with TB across the care cascade. The programme recognizes the importance of maintaining **up-to-date policy norms** and normative guidance materials. The work to update and disseminate new standards of practice, the diagnostic algorithm, and improve care strategies are included in this scenario.

Only a **limited number of new areas of work** will be possible under this funding scenario. The programme prioritised 3 new / intensified workstreams: **closing the diagnostic gap, operationalizing routine contact tracing, and engaging the private sector** through full implementation of the 2018 PPM Action Plan. To close the diagnostic gap, the main areas of work include systematizing specimen transport networks, expanding the use of x-ray and Xpert in line with global recommendations, and rolling-out facility-based screening for TB.

Budget by cost category (2018-2019 funding levels)

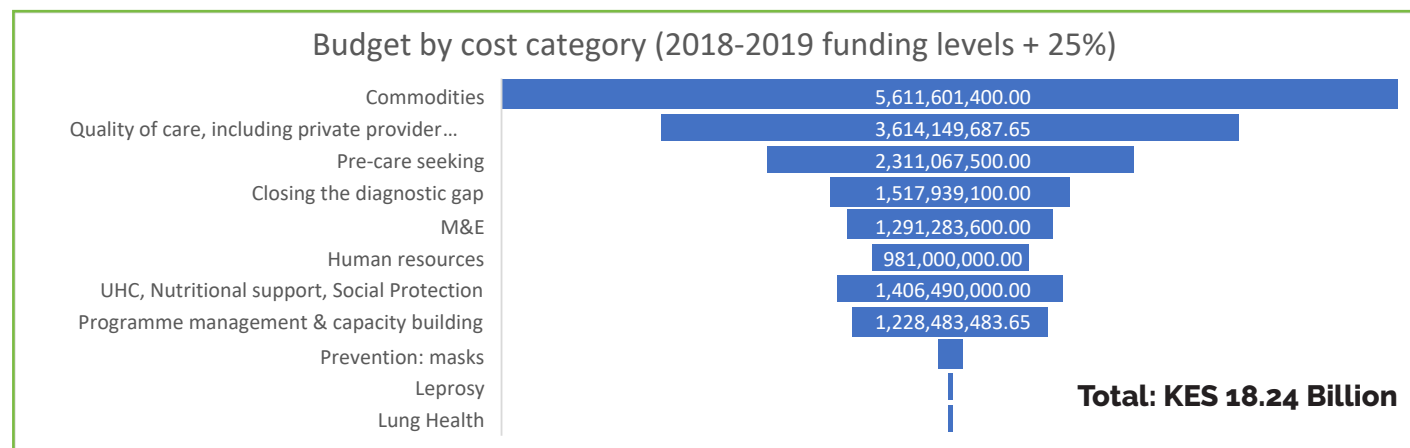| Category	Amount
Commodities	4,726,413,000.00
Quality of care, including private provider...	2,727,673,704.00
Pre-care seeking: Contact tracing	2,020,000,000.00
Closing the diagnostic gap	1,505,939,100.00
M&E	1,245,350,225.00
Human resources	981,000,000.00
UHC, nutritional support & social Protection	886,570,250.00
Programme management & capacity building	
Prevention: masks	
Leprosy	
Lung Health	

Total: KES 14.6 Billion

Scenario 2: 2018 - 2019 funding levels + 25% additional investment

With 25% more investment, the NTLD-Program would have KES 18.24 billion to allocate toward its operational plan. Under this scenario, commodities were budgeted at 85% of targeted quantities, while nutritional support for patients was budgeted at 70% of need.
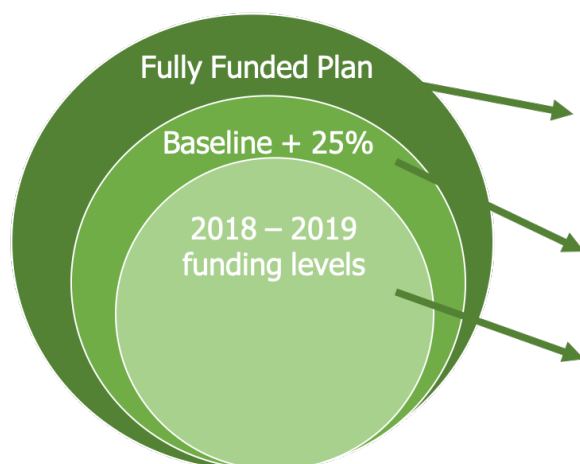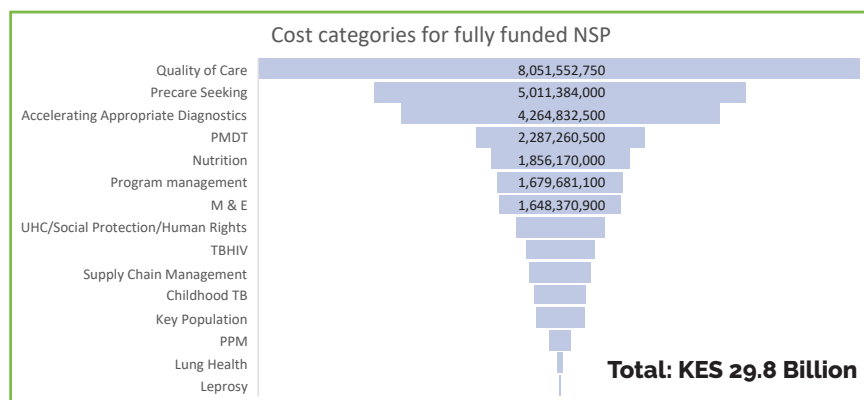
In addition to the interventions prioritised under Scenario 1, the ICERs suggested the value of intensifying diagnosis and treatment of TB among children, and increasing treatment success rates for children, PLHIV, people with drug-sensitive and drug-resistant disease; and reducing the loss-to-follow-up post-diagnosis and during treatment.

As such, the full package of interventions targeting improved diagnosis and care for children is included in this scenario. Activities to strengthen the **capacity** of health care workers and **empower patients**, engage **community health volunteers** and civil society for contact tracing and awareness raising, optimise the inclusion of TB in emerging **UHC** platforms, **increase social protections** for patients, and evaluate **differentiated care models** are among the interventions added, aiming to directly improve patient-centred care.

Budget by cost category (2018-2019 funding levels + 25%)

Category	Amount
Commodities	5,611,601,400.00
Quality of care, including private provider…	3,614,149,687.65
Pre-care seeking	2,311,067,500.00
Closing the diagnostic gap	1,517,939,100.00
M&E	1,291,283,600.00
Human resources	981,000,000.00
UHC, Nutritional support, Social Protection	1,406,490,000.00
Programme management & capacity building	1,228,483,483.65
Prevention: masks	
Leprosy	
Lung Health	

Total: KES 18.24 Billion

Scenario 3: Full Funding

Under this scenario, the programme and partners would implement the entirety of the NSP as described in the national and county-level operational plans. This will require KES 29.8 billion.
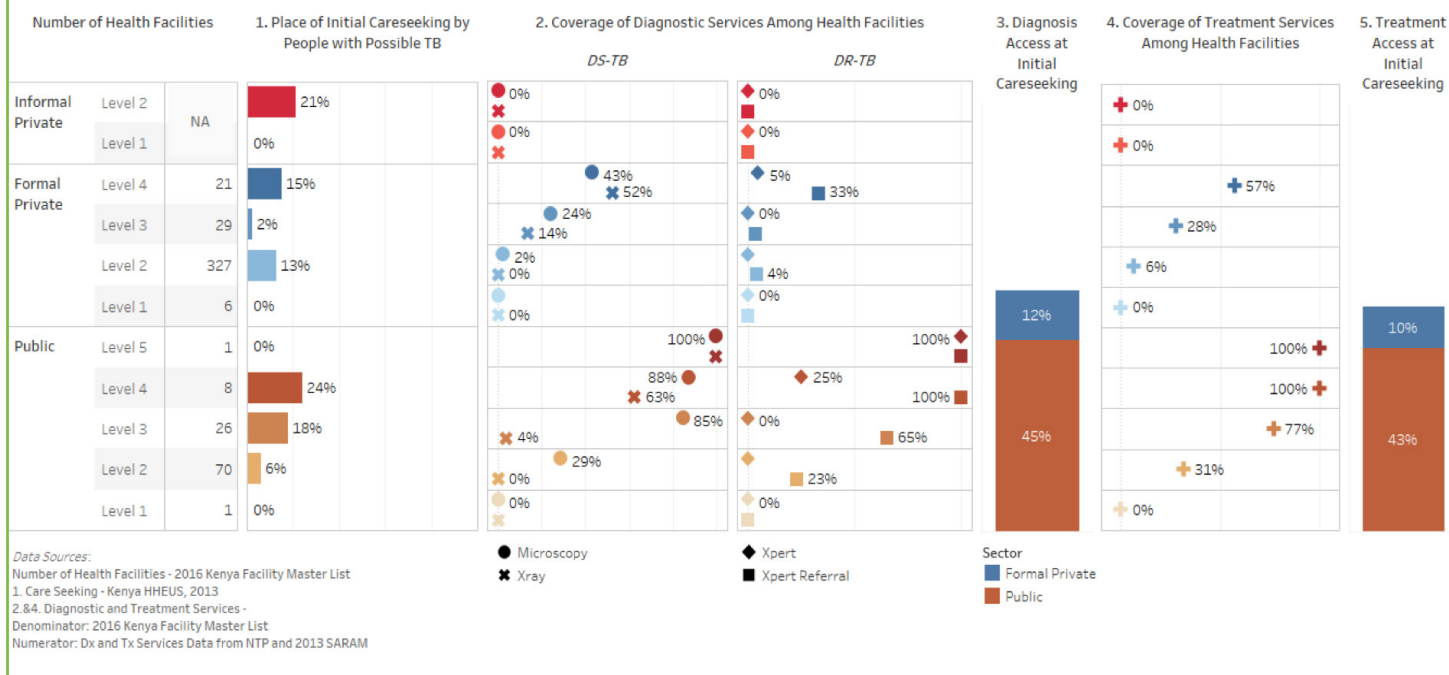
Cost categories for fully funded NSP

Category	Amount
Quality of Care	8,051,552,750
Precare Seeking	5,011,384,000
Accelerating Appropriate Diagnostics	4,264,832,500
PMDT	2,287,260,500
Nutrition	1,856,170,000
Program management	1,679,681,100
M & E	1,648,370,900
UHC/Social Protection/Human Rights	
TBHIV	
Supply Chain Management	
Childhood TB	
Key Population	
PPM	
Lung Health	
Leprosy	

Total: KES 29.8 Billion

Fully Funded Plan

Baseline + 25%

2018 – 2019 funding levels

| Scenario	Cost	Impact Targets
Fully funded	29.8 bn	1) 90% reduction in TB deaths 2) 80% reduction in TB incidence 3) Zero TB-affected families face catastrophic costs 4) 20% reduction in chronic lung disease 5) <5% leprosy disability, grade 2
2018 - 2019 funding levels + 25%	18.241 bn	1) 74% reduction in TB deaths 2) 54% reduction in TB incidence 3) 10% TB-affected families face catastrophic costs 4) 15% reduction in chronic lung disease 5) <7% leprosy disability, grade 2
2018 - 2019 funding levels	14.593 bn	1) 58% reduction in TB deaths 2) 44% reduction in TB incidence 3) 20% TB-affected families face catastrophic costs 4) 10% reduction in chronic lung disease 5) <10% leprosy disability, grade 2

KIAMBU COUNTY PROFILE

Classification	Year			
	2018	2017	2016	2015
New Pulmonary Clinically Diagnosed	2,357	2,317	2,518	1,676
New Pulmonary Bacteriologically confirmed	1,472	1,061	717	1,107
New EPTB	795	701	588	548
Previously Treated	365	261	227	367
Childhood	463	322	272	215
Total	4,989	4,340	4,050	3,698

Classification	TSR	Cure rate	Death	Failure	LTFU	Transfer out
New Pulmonary Bacteriologically confirmed	82%	63%	4%	1%	5%	7%
New Pulmonary Clinically Diagnosed	80%	-	7%	-	5%	8%
New EPTB	77%	-	8%	-	4%	11%
Previously Treated	73%	56%	8%	2%	12%	3%

Kiambu - Patient Pathway Analysis

Map showing an optimised diagnostic network by 2023
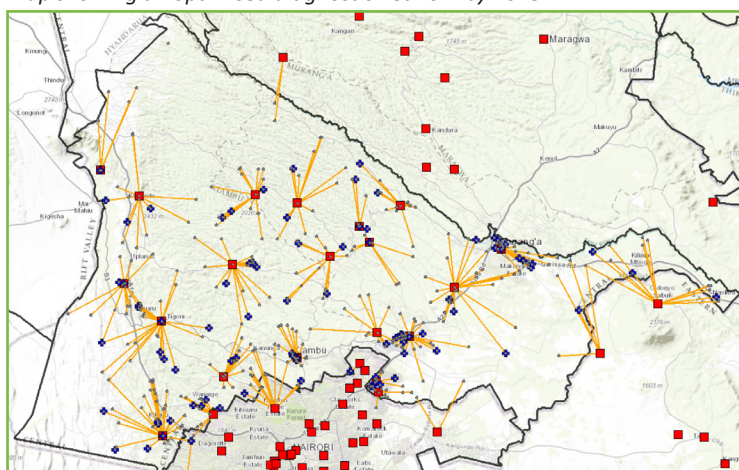
TB/HIV Indicators				
HIV Indicator	2018	2017	2016	2015
HIV Testing	98.2%	98.4%	91.9%	97.8%
Pos	25.2%	27.1%	27.8%	29.6%
ART uptake	93.1%	93.4%	82.4%	94.6%
CPT uptake	99.5%	99.7%	89.8%	99.8%

GeneXpert Site
Microscopy Centre
Specimen Transport Routes
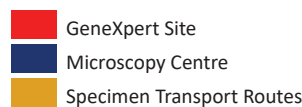
KIAMBU COUNTY MONITORING AND EVALUATION FRAMEWORK

Indicator	Frequency	Source of data	Baseline 2017	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023
Number of notified cases of all forms of TB- (i.e. bacteriologically confirmed + clinically diagnosed), includes new and relapse cases	Quarterly	TIBU	85,188	102,800	112,800	122,000	111,900	102,300
Number of notified TB cases (all forms) contributed by non-national TB program providers – private/non-governmental facilities	Quarterly	TIBU	18%	19%	23%	27%	30%	34%
Proportion of notified TB cases with rifampicin resistant who received Second Line DST results	Quarterly	DST Register	48%	50%	60%	70%	80%	90%
Proportion of diagnostic testing sites that monitor performance indicators and are enrolled in an EQA system for all diagnostic methods performed	Quarterly	EQA Quarterly reports	85%	86%	87%	88%	89%	100%
Cure rate for bacteriologically confirmed cases (both New and Relapse)	Quarterly	TIBU	69%	70%	80%	80%	85%	90%
Sputum conversion rate at the end of intensive phase of treatment for bacteriologically confirmed cases	Quarterly	TIBU	75%	80%	85%	90%	90%	90%
Treatment success rate- all forms: Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated	Quarterly	TIBU	81%	85%	90%	90%	90%	90%
Case fatality ratio (All forms of TB)	Annual	TIBU	6%	<5%	<5%	<5%	<5%	<5%
Number of TB cases with Rifampicin-resistant TB (RR-TB) and/or MDR-TB notified	Quarterly	TIBU/ TB4 register	577	1046	1111	1165	1155	935
Number of cases with RR-TB and/or MDR-TB that began second-line treatment	Quarterly	TIBU/ DR TB register	577	1046	1111	1165	1155	935
Proportion of new and relapse notified TB patients who receive DST	Quarterly	TIBU	46%	50%	60%	70%	80%	95%
Drug resistant TB treatment success rate	Quarterly	Quarterly report TB case registration at sub-county/TIBU	73%	75%	77%	78%	79%	80%
Proportion of eligible DRTB patients on new molecules	Quarterly	Quarterly report TB case registration at sub-county /TIBU	13%	30%	50%	70%	85%	90%
Proportion of children with TB among notified TB cases	Quarterly	TIBU	35%	43%	51%	59%	68%	70%
Proportion of eligible children on TB preventive therapy to 90%	Quarterly	TIBU	39%	49%	59%	69%	79%	90%
Pediatric TB treatment success rate	Quarterly	TIBU	85%	86%	87%	88%	89%	90%
Treatment success rate among HIV – positive TB cases to 85%	Quarterly	Quarterly report TB case registration at sub-county/TIBU	79%	80%	81%	82%	83%	85%
Proportion of PLHIV initiated on TB Preventive Therapy	Quarterly	MOH731	65%	70%	75%	80%	85%	90%
Treatment success rate among TB/DM patients	Quarterly	Quarterly report TB case registration at sub-county /TIBU	N/A					
Proportion of notified leprosy patients with disability grade 2	Annual	Annual report	35%	30%	25%	20%	10%	<10%
Proportion of notified leprosy cases who are children	Annual	Annual report	6%	6%	5.50%	5%	4.50%	3%
Proportion of private sector providers engaged in comprehensive TB services	Annual	Limited data	N/A					
Proportion of notified TB cases (all forms) contributed by non-national TB program providers – private/non-governmental facilities			18%	19%	23%	27%	30%	34%
Number of counties engaging informal sector providers in TB care and prevention	Annual	ISP providers reports	7	15	23	31	39	47
Proportion of notified TB cases evaluated for nutritional support	Annual	Annual report	80%	84%	88%	92%	96%	100%
Proportion of eligible malnourished TB cases who received nutrition support	Annual	Annual report	47%	57%	67%	77%	87%	95%
Mortality rate among malnourished TB patients	Annual	Annual report	13%	11%	9%	7%	5%	<5%

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

EXECUTIVE SUMMARY

Visit www.nltp.co.ke for the full National Strategic Plan 2019 - 2023

National Tuberculosis, Leprosy and Lung Disease Program,

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