REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL WORKPLACE POLICY ON TUBERCULOSIS DISEASE MANAGEMENT

2022

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

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FOREWORD

That tuberculosis (TB) is a workplace issue is not in doubt. TB remains one of the top 10 causes of death worldwide. Globally, millions of people continue to fall sick from TB each year. In 2020, 10 million people fell ill from TB, and of these, 1.5 million people lost their lives. It is estimated that close to 3 million were not notified to the National TB program largely due to limited access to healthcare services. This disease affects the most productive age groups of the population and has immediate health effects, and direct socio-economic consequences on individuals, families, communities, and society at large. Poor health among working people is a threat to the viability of enterprises and the national stock of human capital. The productivity of the workplace, in particular, is weakened by the loss of skills and experience, absenteeism, disrupted production, and escalating direct costs.

Employer and workers' organizations are key collaborative partners in the fight against TB. Employers can play a vital role in promoting and undertaking TB care and control activities in the workplace and even beyond the workplace into the community. On the other hand, workers and their umbrella organizations can actively participate in TB care and control by working in partnership with employers to develop and implement workplace TB care and control activities. Workers' organizations can play a particularly critical role in advocating for robust workplace TB care and control programs as part of the health package offered by employers.

The development of workplace TB care and control programs would be beneficial to all partners: employers would benefit by having a healthier workforce while workers would gain directly from an easily accessible TB service provided in an environment that is free from stigma and discrimination. Workplace programmes also benefit workers' families, their dependents, and communities. If the business can extend the TB service to the neighboring community, this act of corporate social responsibility and public-private partnerships would be expected to boost the profile of the business/company and eventually could bring dividends by contributing to the business's bottom line.

This policy is aimed at providing an outline of the essential steps that businesses should take when establishing TB care and control programs at the workplace. We hope that all partners involved in workplace health programs will use this guide to make their contribution to the national effort toward ending TB.

Signed by the Cabinet Secretaries:

Nakhumicha S. Wafula
Ministry of Health

Hon. Florence K. Bore
Ministry of Labour and Social Protection

PREFACE

This policy was jointly developed by the Division of National, Tuberculosis Leprosy and Lung Disease-Program (DNTLD-P) of the Ministry of Health in conjunction with the Ministry of Labour, International Labour Organization (ILO), Kenya Federation of Jua Kali Association, Federation of Kenya Employers (FKE), Central Organization of Trade Unions (COTU(K), Kenya Health Federation (KHF), Kenya Private Sector Alliance (KEPSA) with various stakeholders with the primary goal of harnessing the contribution of employers and workers towards the care and control of all forms of Tuberculosis (TB) including drug-resistant TB (DRTB).

Tuberculosis is a communicable disease that is a major cause of ill health and one of the top 10 causes of death worldwide and the leading cause of death from a single infectious agent (ranking above HIV/AIDS). It is caused by Mycobacterium tuberculosis bacillus, which is spread when people who are sick with TB expel bacteria into the air for example, by coughing. Three-quarters of the TB cases and deaths occur in people aged between 15 and 54 years, the most economically productive age group making the workplace a key intervention point for TB. Tuberculosis, therefore, has broader social and economic consequences for individuals, families, and societies at large.

As in other countries, TB in Kenya affects the most economically productive age groups of 15 to 54 years making TB a workplace issue. This disease can affect the productivity of businesses and directly affects the bottom line of these businesses through absenteeism, death, and loss of skills, increase in training costs, and increased costs from the provision of medical care. Additionally, the workplace may provide a suitable environment for the transmission of TB if workplaces or dwelling places of workers are overcrowded and there are inadequate TB screening processes. Some workplace policies may delay TB diagnosis, and encourage workers diagnosed with TB and placed on treatment to default from their treatment, thus promoting TB transmission, the development of DRTB, prolonged morbidity, and even death from TB.

This policy guide represents the first comprehensive approach to workplace TB care and control in Kenya, in support of the DOSH mandate in the labour force.. In the absence of published local experiences, this guide has been developed primarily through a consensus approach and has borrowed heavily from documents developed by WHO and the International Labor Organization (ILO). It is expected that experiences gained by the implementation of this policy coupled with the conduct of appropriate operations research in this field will feed into the evidence base to allow for the refinement of the policy and practice recommendations highlighted in this document.

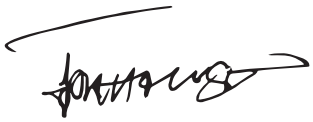
Signed by:

Dr. Josephine Mburu, Ph.D

Principal Secretary
State Department for Public Health and Professional Standards

Mr. Geoffrey E. Kaituko, ACIARB

Principal Secretary
Ministry of Labour and Social Protection



Ms. Jacqueline Mugo

Executive Director
Federation of Kenya Employers (FKE)

Dr. Francis Atwoli

Secretary General
Central Organization of Trade Unions of Kenya (COTU)

ACKNOWLEDGEMENT

TB Workplace policy document involved consultations with key stakeholders through conducting reviews and consultative meetings. It is heavily guided by the World Health Organization recommendations. The Ministry of Health wishes to acknowledge the immense contribution of various organizations and individuals listed below for their efforts in this process. We take note of the support from the office of the Cabinet Secretary, the Principal Secretary, Head of Directorate of Medical Services/ Preventive and Promotive Health, and the Head, Department of National Strategic Public Health Programs. Specifically, the Ministry would like to thank the following organizations: United States Agency for International Development (USAID), World Health Organization (WHO), International Labor Organization (ILO), Centre for Health Solutions (CHS), Respiratory Society of Kenya (RESoK), Federation of Kenyan Employees (FKE) and Central Organization for Trade Union COTU (K) for their technical inputs and support.

We also recognize the stewardship and guidance provided by the Division of National Tuberculosis, Leprosy, and Lung Disease Program led by Dr. Caroline Asin. Special thanks to the TB at Workplace team members particularly Nkirote Mwirigi (DNLTD-P), Rose Wandia (TB ARC II) Jacqueline Limo (DNLTD-P), Rhoda Pola (DNLTD-P), Dr. Simon Wachira (CHS, TB ARC II), Patrick Angala (CHS TB ARC II) Drusilla Nyaboke (DNLTD-P), Dr. Eunice Omesa (WHO), Dr. Hellen Magutu (ILO), Evelyn Kibuchi (StopTB Partnership, Kenya) Dr. SK Macharia (DNLTD-P), Samuel Misoi (TB Advocate), Simeon Ndemo (DNLTD-P), Dr. Michael Macharia (KCCB, Felix Mbetera (DNLTD-P) and Dr. Wilfred Kimani (Ministry of Labour). Specially, we wish to convey our gratitude to the expanded team that worked tirelessly to ensure the successful completion of this process.

Dr. Patrick Amoth, EBS

Ag. Director General for Health

ACRONYMS

DOT	Directly Observed Treatment
DOSHS	Directorate of Occupational Safety & Health Services
DNTLD-P	Division of National Tuberculosis Leprosy and Lung Disease Program
DRTB	Drug-Resistant Tuberculosis
DSTB	Drug-Sensitive Tuberculosis
FBO	Faith-Based Organizations
FDC	Fixed-Dose Combination
FKE	Federation of Kenya Employers
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
KAM	Kenya Association of Manufacturers
KEPSA	Kenya Private Sector Alliance
MDRTB	Multi-drug resistant (MDR) tuberculosis
MDAs	Ministries, Departments and Agencies
MSMEs	Micro, Small and Medium-Sized Enterprise Day
MSEA	Multisectoral Engagement and Approach
OSH	Occupational Safety and Health
SACCOs	Savings and Credit Co-operative Societies
TB	Tuberculosis
WHO	World Health Organization

1 INTRODUCTION

1.1 Background

Tuberculosis (TB) continues to be a major public health concern globally causing up to 1.4 million deaths annually. Kenya is ranked among the 14 high TB and TB/HIV burden countries having notified 72,943 TB cases in 2020 of whom 8% (5,663) were children. An additional 961 DRTB patients were notified. The disease greatly affects men and those between the ages of 15-44 years. (Most productive age- should be justified). Although TB is preventable and curable, it causes suffering among patients and their households, loss of life, and financial catastrophe for those infected and affected by TB. TB is associated with a significant economic impact in many countries and may hamper national development. The disease can therefore cause enormous economic and social disruption by reducing both labor supply and productivity. These economic effects of TB affect not only national but also individuals and households.

Tuberculosis patients often incur large costs related to illness, as well as economic losses related to these as well as for seeking and receiving health care (*Patient Cost Survey, 2017*). Such costs are important access barriers to TB care which can affect health outcomes and increase the risk of transmission of the disease. These costs also present an economic burden that results in financial difficulties and/or pushes households into poverty (or poor households further into poverty). The incidence of TB in the country in 2020 was estimated at 140,000, indicating that at least 48% of incident TB cases were either missed or not notified in the year. Accordingly, the national TB prevalence survey 2016 demonstrated that the country misses identifying nearly half of the people with TB. This translates to a treatment coverage of 52% in 2020, down from 59% in 2019. In 2020, men remained the most affected population contributing to 66% of all notified cases with children accounting for 8%. The public health sector accounts for 78% of all TB cases, with 20% being from the private sector including faith-based organizations (FBOs), and 1- 2% from persons in prisons.

15 - 44 YEARS

Age bracket, especially men, greatly affected by TB.

72,943

cases notified in **2020** of whom **5,663 (8%)** were children. An additional **961** DRTB patients were notified.

The National TB program has made robust efforts to find missing people with TB through the implementation of active case finding especially in facilities with a high number of patients volume facilities across the country, targeted community screening outreaches, contact investigation, and implementation of innovative strategic initiatives including the engagement of the private sector with an overall aim of reducing the national TB case detection gap.

A sizable proportion of Kenya's population (over 16 million or 36%) is classified as belonging to the labor force. While unemployment levels are still very high, many people in the workforce are engaged in some income-generating activities and therefore could be classified as being "gainfully employed". This is the proportion of the Kenyan population that the rest of the population depends on and is also the segment of the population that is most commonly affected by TB, underlining the importance of TB on the socio-economic welfare of families and communities. Since most persons in the labor force spend an average of 8 hours a day at the workplace, TB disease, which is airborne, needs to be prevented and controlled. This is particularly critical for occupations that pose an increased risk of TB exposure, infection, and disease such as the transport sector, education, correctional facilities, textile industry, construction, healthcare, and the informal sectors. In addition, work-related factors may hinder access to TB services and interfere with adherence to treatment once a diagnosis of TB has been made and treatment initiated.

For example, in workplaces where a TB diagnosis could lead to the affected person experiencing stigma and discrimination including the risk of loss of employment, workers may delay seeking care for TB when TB symptoms set in or default from treatment as soon as symptoms improve with anti-TB treatment. The TB Patient Cost Survey (2017) showed that 62.5% of Drug-Resistant TB and 39.1% of Drug-Sensitive TB patients lost jobs due to Tuberculosis. Establishing a workplace TB care and control service that is worker-centered can mitigate all these barriers. This would eventually improve the productivity of the business. However, the savings at the workplace are not the only reason for starting a workplace program. In high TB -incidence environments such as in Kenya, TB is a major contributor to ill health and poverty in the community.

Business success is closely linked to the health and prosperity of the community, which is a source of workers, services, contractors, and customers, a key part of the overall business environment. Additionally, as part of their corporate social responsibility, many businesses have a broad commitment to improving the well-being of their community. A TB control program is a practical way to demonstrate to the workers and local community that businesses care about their well-being. Finally, the macroeconomic impact of TB should be considered in terms not only of how it affects a country's per capita gross national product (GNP) but also how the disease affects the human capital and lifetime earnings of society. There is no doubt that a sick workforce contributes to an unhealthy economy. Poor laborers and farmers stay poor if they are sick. Improving health is a concrete and measurable way of reducing poverty and inequity, at both country and global levels. Investments in health are investments in human potential. In addition, The National Occupational Safety and Health policy captures the prevention of occupational accidents and diseases in general without specifying communicable diseases, especially TB. The regulations don't have an updated focus on communicable diseases and need to narrow it down to TB.

1.2 Purpose of the Policy

The purpose of this document is to provide policy guidance on the management of TB in all its forms at the workplace and address stigma and discrimination related to TB at the workplace

1.3 Rationale

According to WHO, Kenya is one of the 30 high burden TB, TB HIV and DRTB countries in the world. The 2015/2016 Kenya Prevalence Survey found an overall national prevalence of 426/100,000 and demonstrated that Kenya misses approximately 40% of people with TB. DNLTD-P implements interventions within the framework of the National Strategic Plan for TB 2019-2022

According to the Kenya Patient Cost Survey carried out in 2017, **62.5%** of Drug Resistant TB and **39.1%** of Drug Sensitive TB patients lost jobs due to TB.

TB is a global epidemic and therefore a global concern. In Kenya, TB affects more men than women as well as the most economically productive age groups (15-44yrs) and those living in the urban setup. A sizable proportion of Kenya's population (over 16 million or 36%) is classified as belonging to the labor force. While unemployment levels are still very high, many people in the workforce are engaged in some income-generating activities and therefore could be classified as being "gainfully employed". This is the proportion of the Kenyan population that the rest of the population depends on and is also the segment of the population that is most commonly affected by TB, underlining the importance of TB on the socio-economic welfare of families and communities. Because most persons engaged in some form of economic activity or employment will spend an average of 8 hours a day at the workplace, TB disease which is airborne needs to be prevented and controlled. This is particularly critical for occupations that pose an increased risk of TB exposure, infection, and disease such as mining, the textile industry, construction, healthcare, and the informal sectors (for example hawking in crowded streets).

Other work-related factors may hinder access to TB services and interfere with adherence to treatment once a diagnosis of TB has been made and treatment initiated. For example, in workplaces where a TB diagnosis could lead to the affected person experiencing stigma and discrimination including the risk of loss of employment, workers may delay seeking care for TB when TB symptoms set in or default from treatment as soon as symptoms improve with anti-TB treatment.

>16 MILLION

of Kenya's population classified as belonging to the labor force representing **36%**

62.5%

of Drug-Resistant TB patients lost jobs due to TB.

39.1%

of Drug-Sensitive TB patients lost jobs due to TB.

Establishing a workplace TB care and control service that is worker-centered can mitigate all these barriers. This would eventually improve the productivity of the business. However, the savings at the workplace are not the only reason for starting a workplace program. In high TB -incidence environments such as in Kenya, TB is a major contributor to ill health and poverty in the community. Business success is closely linked to the health and prosperity of the community, which is a source of workers, services, contractors, and customers, a key part of the overall business environment. Additionally, as part of their corporate social responsibility, many businesses have a broad commitment to improving the well-being of their community. A TB control program is a practical way to demonstrate to the workers and local community that businesses care about their well-being.

Finally, the macroeconomic impact of TB should be considered in terms not only of how it affects a country's per capita gross national product (GNP), but also how the disease affects the human capital and lifetime earnings of society. There is no doubt that a sick workforce contributes to an unhealthy economy. Because healthy workers are more productive, favorable workplace regulations are necessary and mutually advantageous for both the industry and its workers. Therefore, employers must actively contribute to raising awareness and establishing a workplace policy on TB. This will help with information generation, early diagnosis, treatment links, and patient support.

Policy Goal

The goal of this TB workplace policy is to scale up the implementation of TB prevention and control programmes response in the world of work. This policy document has been developed in line with the 2019- 2023 National Strategic Plan for TB, Leprosy, and Lung Health, which advocates for the establishment of workplace TB services and employment protection policies. The policy's aim is to ensure that workers have access to TB screening, diagnosis, and treatment at while in the workplace, and are protected from stigma and discrimination due to TB in the workplace

Policy Objective

The main objective of this policy is to guide the integration of TB services into existing workplace health programs. Specific objectives include:

1. To enhance the capacity of employers and workers on TB prevention and control at the workplace.
2. To eliminate TB-related stigma and discrimination at the workplace.
3. To improve early TB case finding/detection with linkage to treatment at the workplace.
4. To reduce the incidence of DRTB (Strengthen adherence to TB treatment and improve patient support systems).
5. To reduce the risk of TB transmission at the workplace by instituting appropriate and workplace-specific administrative, environmental and personal protection measures.
6. To strengthen oversight and coordination of TB response at the workplace.

1.4 Target Audience of this Policy

The target audience is all national and county government ministries, departments and agencies, formal and informal institutions, development partners and organizations, in the workplace with regard to TB. All workplaces to include public (MDAs), private sector (formal and informal), Faith-Based Organizations, Civil Society Organizations, MSMEs, Non-State Actors.

1.5 Scope of the Policy

This policy describes the strategies recommended by the Ministry of Health through the National TB Program. It is to be implemented in collaboration with the Ministry of Labour, employers, workers, and other stakeholders.

The scope is aligned with the Kenya National Strategic Plan on Tuberculosis, Leprosy, and Lung Health (2019 – 2023), the End TB Strategy, Sustainable Development Goals (SDGs), and the WHO Consolidated Guidelines on multi-drug resistant (MDR) tuberculosis treatment, 2019, TB Control in the Workplace (WHO 2004), ILO code of Conduct 2000 and the ILO Recommendation 2000, among others.

This scope is therefore guided by the principles of:

a. Meaningful involvement and engagement in response to TB at workplaces.

b. Equality and equity in access to quality health as per the Constitution of Kenya.

c. Diversity in workplaces, stakeholders, and populations.

d. Non-Discrimination and Non-stigmatization.

e. Social Dialogue and Participation of workers in the planning, design, implementation and evaluation of TB Programs.

f. Diversity and Inclusion.

2 LEGAL AND POLICY FRAMEWORK

The workplace policy on TB in Kenya has been anchored on the principles of the law and human rights. It recognizes the various existing policies and international conventions which are majorly designed to approach development issues from a human rights perspective. It is on this recognition that the workplace policy is built on principles emanating from the legal and policy framework enshrined herein below:

2.1 International Legal and Policy Frameworks

2.1.1. The United Nations Human Rights Instruments

The workplace policy was guided by these instruments which emphasize on the proper implementation and realization of all human beings and which include the component of meaningful inclusion, commitment and involvement of states partners in achieving the various objectives outlined in the Instruments. The instruments include:

- Universal Declaration of Human Rights (UDHR) 1948[1];
- International Covenant on Economic and Social Rights (ICESR) 2016[2];
- International Covenant on Civil and Political Rights (ICCPR) 1966[3];
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) 1966[4];
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1988[5];

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[1] United Nations (1948), Universal Declaration of Human Rights

[2] Saul, B., Kinley, D., & Mowbray, J. (2016). The international covenant on economic, social and cultural rights

[3] 1966. "International Covenant on Civil and Political Rights." Treaty Series 999 (December): 171.

[4] United Nations. 1966. "International Convention on the Elimination of All Forms of Racial Discrimination." Treaty Series 660 (March): 195.

[5] United Nations. 1988. "Convention on the Elimination of All Forms of Discrimination against Women." Treaty Series 1249: 13

2.1.2. Global Conventions

- **Moscow Declaration to End TB, 2017[6]:** reaffirm our commitment of state partners to end the TB epidemic by 2030 as envisaged in the Agenda 2030 for Sustainable Development and its Sustainable Development Goals (SDGs) through a Multisector approach among other considerations.
- **ILO Convention 111 on Discrimination (Employment and Occupation) Convention, 1958 (No. 111):** This is a convention under the International Labor Laws that promote the meaningful engagement of employers and employees in upholding the wellbeing of human beings.
- **ILO Convention 155 on Occupational Safety and Health Convention, 1981 (No. 155):** This convention provides for occupational safety, occupational health, and the working environment for workers.

2.1.3. Regional and National Laws and Policies

- **The Constitution of Kenya, 2010:** The Preamble to the Constitution lists equality, participation and inclusion as part of the essential values upon which to base governance. This is given legal force and emphasis by Article 10 of the Constitution, which provides the national values and principles of governance, which include, among others:
    1. Art. 10(2a) the rule of law, democracy and participation of the people; and
    2. Art. 10(2b) human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalized.

- **The Health Act of 2017, Laws of Kenya:** This is an Act of Parliament that makes provision for securing and maintaining health of all the citizens as enshrined under Article 43 of the Constitution.
- **The Intergovernmental Relations Act of 2012, Laws of Kenya:** It's an Act of Parliament to establish a framework for consultation and co-operation between the national and county governments and amongst county governments; to establish mechanisms for the resolution of intergovernmental disputes pursuant to Articles 6 and 189 of the Constitution, and for connected purposes. This Act emphasizes the principle of meaningful involvement of stakeholders on matters pertaining to governance.
- **The Employment Act of 2007:** It's an Act of Parliament to, declare and define the fundamental rights of employees, to provide basic conditions of employment of employees, to regulate employment of children, and to provide for matters connected with the foregoing.

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[6] WHO.2017 Moscow Declaration to End TB. WHO/HTM/TB/2017.11

- **The Occupational Safety and Health Act, 2007:** This is an Act of Parliament to provide for the safety, health and welfare of workers and all persons lawfully present at workplaces, to provide for the establishment of the National Council for Occupational Safety and Health and for connected purposes
- **The Public Finance Management Act of 2012:** This Act contains various provisions on public participation in Kenya that relate to Chapter 12 of the Kenyan Constitution on Public Finance.
- **The County Governments Act No. 17 of 2012:** The provisions on public participation in Kenya contained in this Act affect the county governments. Section 113: Makes public participation in county planning processes compulsory. Section 87**:** Stipulates the principles of public participation. They include timely access to information and reasonable access to planning and policymaking process.
- **The Kenya Health Policy, 2014 - 2030:** It gives directions to ensure significant improvement in overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments. It demonstrates the health sector's commitment, under the government's stewardship, to ensuring that the country attains the highest possible standards of health, in a manner responsive to the needs of the population.
- **The National Strategic Plan for National Tuberculosis (TB) Leprosy and Lung Health 2019 - 2023 (NSP):** The Strategic Plan has dual objectives of sustaining close collaboration with development and implementing partners by enlisting and nurturing new local and international partnerships.

3 BASIC FACTS ON TB

3.1 Introduction

TB is an infectious disease caused by a bacterium called *Mycobacterium tuberculosis* (M.Tuberculosis). TB is majorly a disease that affect the respiratory system but can also affect other body systems/organs. The TB bacteria are spread from an infected person to another person through the air TB affects the lungs mostly but can affect any other part of the body except the hair, nails, and teeth. Transmission occurs when a person with TB disease of the lungs releases the bacteria into the surrounding area when they cough, sneeze, talk, or expel air, dispersing droplets that contain *M. tuberculosis*. When a healthy person inhales the infectious particles into their lungs, they can become infected with Tuberculosis. These droplets, also called droplet nuclei, can remain suspended in the air for long periods. Infection usually requires prolonged sharing of airspace with a person actively spreading TB bacteria into the area. After becoming infected, most people's immune systems can contain the infection but are not able to eliminate it. These people develop latent TB infection. Latent TB infection does not cause symptoms and is not contagious. However, it may progress to active TB disease in 5-10% of infected individuals over time. People with active TB disease show symptoms of TB and can spread the disease. The risk of developing active TB disease is greatest in the first two years after infection, but some risk remains throughout life. Workplace settings such as manufacturing industries, learning institutions as well as health centers/ hospitals have an increased risk of TB transmission. Transmission generally occurs indoors, where droplet nuclei (TB Bacteria) can stay in the air for a long time due to poor ventilation.

TB is preventable, treatable, and curable. Infection prevention and control practices can help reduce the risk of TB transmission. Treatment of persons with latent TB infection can prevent the subsequent development of active TB disease. There is a need therefore for contact tracing of persons that have interacted with a confirmed case of TB to facilitate timely diagnosis and intervention. Other risk factors for progression to active TB disease from latent infection include HIV infection, diabetes mellitus, persons on

15 - 44 YEARS

Age bracket, especially men, greatly affected by TB.

72,943

cases notified in **2020** of whom **5,663 (8%)** were children. An additional **961** DRTB patients were notified.

cancer chemotherapy, malnutrition, persons on immunosuppressant therapy following organ transplants, and those receiving hemodialysis.

3.2 Diagnosis of Tuberculosis

The systematic identification of persons with TB symptoms can reduce transmission and promote timely initiation of treatment.

3.2.1 Common TB Symptoms

- The most common symptom of pulmonary TB is a **cough of any duration**.
- It may be accompanied by one or more of the following:
  - Chest pain;
  - Involuntary weight loss
  - Drenching night sweats
  - Fever particularly with a rise in temperature in the evenings.

- Symptoms of extra-pulmonary TB (outside the lungs) depend on the organ involved. Chest pain, enlarged lymph nodes, and a deformity of the spine are some of the most common signs.

Possible signs and symptoms of TB

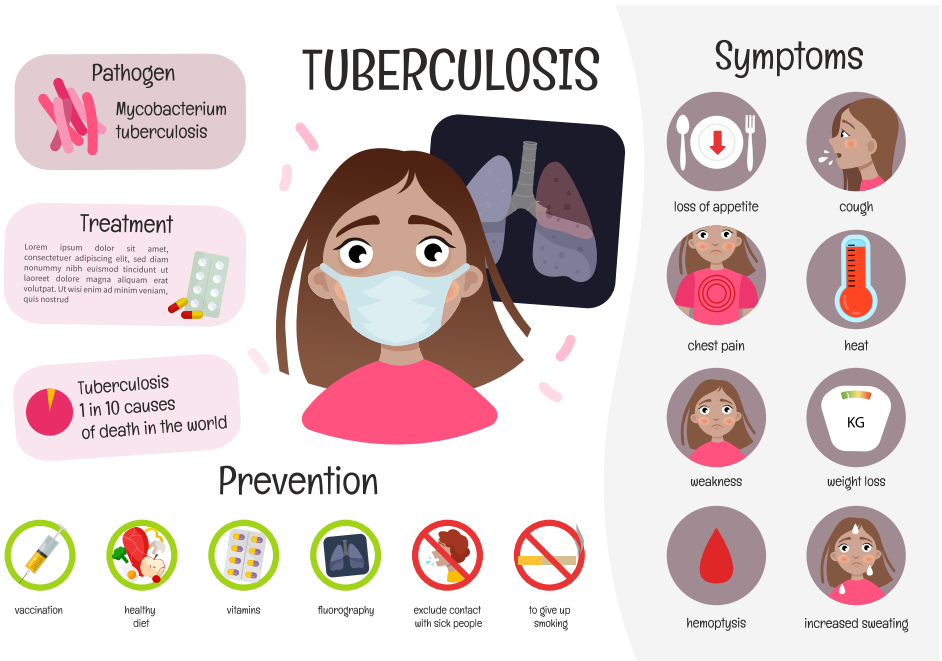

Figure 1: Signs and Symptoms of TB

3.2.2 TB Diagnosis at Workplace

Finding people with TB requires synergistic efforts by all sectors. The priority is to identify all persons with signs and symptoms of TB for further assessment and investigation to rule out active TB disease. Approaches to find the cases include;

1. Passive case finding; persons aware of TB symptoms should have access to health facilities for clinical evaluation and laboratory investigation.
2. Active TB case finding (TB-ACF); Identification of someone presumed to have TB is through TB symptom screening with the help of a healthcare worker. (Workplace settings should undertake regular TB screening to identify undiagnosed persons with TB that present with related symptoms), targeted TB case finding outreaches and contact invitation/tracing for screening are important for identification. Propose collaboration with a healthcare provider for yearly screening or random screening and especially of persons presumed to have TB symptoms and their contacts.
3. Workplace screening should be done twice a year for all personnel. This should include:
    - Detailed history taking.
    - Physical examination.
    - Laboratory testing - Microscopy, molecular test (GeneXpert-recommended test for TB diagnosis)
    - Radiological examination - screening by imaging for presumptive case identification.
4. Linkage: Linkage of identified presumptive TB to a medical practitioner for review and laboratory investigation followed by ensuring that those diagnosed with TB are linked to TB point of care to ensure everyone identified to have TB related symptoms is linked and gets the appropriate TB service, care and support.

3.3 TB Treatment and Adherence to Treatment

Treatment for TB is in two phases: an intensive phase (two or three months) and a continuation phase (four or six months). Treatment of Drug-sensitive TB (DSTB) in Kenya takes 6 months except for severe TB (TB Meningitis and Skeletal) which last 12 months. Treatment of drug-resistant TB (DRTB) takes 9 to 18 months. A workplace in-house clinic is an ideal place for treatment support to occur and to promote treatment adherence. The patient should be advised to invite or refer all contacts for TB screening to the nearest clinic due to possible infection. Ongoing counseling to ensure compliance should be part of patient management. More guidelines should be sought from the nearest public health facility in order to apply the appropriate medical procedures. This will as well help to provide for the appropriate and adequate care and recovery period for the person diagnosed as it may be on a need basis. .

Most patients are no longer infectious after two to four weeks of treatment after which they should be reviewed to confirm they are fit to return to work and continue with treatment. TB patients in whom drug resistance is confirmed should be given sick leave until they have had documented culture conversion of their sputum or are confirmed not to have resistant TB. Adequate sick leave should be available to employees to allow them sufficient time to recover, especially those with drug-resistant TB as they may require hospitalization.

Once the patient returns to work, s/he must be allowed time off work to visit the clinic for follow-up visits. If a TB patient is permanently incapacitated by TB and not able to return to work, then s/he should be dealt with according to the company's policy on medical incapacitation and the labor laws. If a patient is eligible for compensation, the appropriate procedures should be followed.

3.4 TB Prevention at the Workplace

Infection control measures should be adhered to in workplaces as it is essential to prevent transmission of TB. It's based on a three-level hierarchy of controls.

3.4.1 Administrative Controls/ Measures

These are measures designed to reduce exposure to TB bacteria. They include-

- Development of infection control plan.
- Constitute workplace Infection Prevention and Control (IPC) committees with IPC focal person to oversee the implementation of IPC measures.
- Management to consider conducting a TB infection prevention and control assessment.
- Conduct health education and training on TB infection prevention.
- Ensure TB transmission prevention, screening and TB education.
- A robust strategy for treatment support.
- Social policy for non-discrimination against TB.

3.4.2 Environmental Controls/ Measures

- These are measures designed to reduce the concentration of TB bacteria floating in the air. These include;
    - Natural ventilation - Ensuring good ventilation by keeping doors and windows open.
    - Mechanical ventilation - Promoting airflow and exchange through the use of mechanical methods (fans, germicidal irradiation) and/or air exchange systems where natural ventilation is inadequate.

- Filtration.
- Purification - Ultraviolet germicidal irradiation where applicable.

3.4.3 Personal Protection

The use of Personal Protective Equipment (PPEs) reduces exposure to infectious TB droplets in the air. Workplaces should provide and promote the use of the correct personal protective equipment as per the Ministry of Health TB-IPC guidelines and Occupational Safety and Health Policy. The type of PPE depends on point of work; Surgical masks should be provided for infectious TB patients and respirators provided to the healthcare provider.

3.4.4 Sputum Collection

Workplace settings should develop TB plans that include sputum collection at the business or organization premises, including designating areas where persons requested to submit sputum samples, can do so safely. This is best done outdoors but infection transmission prevention measures must be explained carefully and thoroughly to workers so that they understand and appreciate that safety without stigma is the goal.

3.4.5 Promotion of Cough Etiquette and Hygiene

Health education on cough etiquette and hygiene is key at the workplace to prevent active TB transmission. A key component of the infection prevention and control plan. Coughers should cover the mouth and the nose with a flexed elbow, handkerchief, or tissues. Posters that provide illustrations on cough hygiene and etiquette should be prominently displayed, as well as the provision of adequate pedal bins for disposal of used material to minimize environmental contamination

4 POLICY GUIDANCE

4.1 Implementation Approach

4.1.1 Occupational Risk of TB and Impact on Business

TB is a communicable disease and imposes a cost on any business if timely diagnosis and treatment are not initiated. The disease can disrupt daily work operations, reduce worker productivity, and increase direct costs related to the replacement and retraining of workers. One person infected with TB can transmit to 5 or more others within the same environment and this can reduce the workforce in a given workplace. When diagnosed early, started on TB treatment, and supported to complete TB treatment, employees can safely return to work within 2-4 weeks.

4.1.2 Opportunities for Workplace TB Control

Recognizing the impact of epidemics such as TB, COVID-19, and HIV on sectors productivity, profitability, and the community, businesses are increasingly participating in interventions aimed at improving the health of their workforce as part of their corporate social responsibility. The global community has adopted a multi-sectoral approach business can plug in to guide an engagement of other sectors to provide the following;

1. Education and awareness about TB as part of general or occupational employee health education and health promotion activities.
2. Referral of employees with TB symptoms to the nearest health facility for diagnosis and treatment.
3. Support of TB patients during their treatment, including directly observing their treatment. Employers with onsite health clinics can collaborate with the National TB program to offer the option of directly observed treatment (DOT) in the workplace.
4. Advocacy on TB control; Workers' representatives and organizations can also undertake advocacy and awareness-raising, and be a source of volunteers (Workplace TB champion) to support TB patients during their treatment, including DOT in the workplace.
5. Commitment by management to provide sustainable resources for TB control in the workplace.

6. Development and implementation of clear management policies on confidentiality, discrimination, length of time allowed for medical treatment and job modification when necessary; employees should be educated on these policies.
7. Implementation of environmental infection control measures to minimize the risk of transmission of infection in the workplace.
8. Engagement with worker representatives from the planning stages and throughout, to ensure their support and participation.
9. Awareness and educational campaigns to address negative attitudes towards people with TB and increase awareness among the employees about TB.
10. Psychosocial support for employees who have TB, such as alary during treatment or compensation for loss of income, transport to health facilities, food support, or other motivations to continue treatment.
11. Incorporate screening and testing on communicable diseases as part of routine during the hiring process and periodically as may be determined.

The National TB Program's mission is aimed at promoting quality of life by preventing, controlling, and eventually eliminating tuberculosis in Kenya. Successful implementation of this policy will require a multi-sectoral approach by all key stakeholders including:

1. Ministry of Health (The National TB Program).
2. Ministry of Labour.
3. Ministries, Departments, County Governments, and other employers' and workers' representative organizations.
4. The corporate sector (including the non-health private sector)
5. Civil society.
6. Informal sector and Micro, Small and Medium Enterprises (MSMEs).
7. Religious organizations.

The National TB Program is charged with the responsibility of overseeing TB control in Kenya. All workplace TB control initiatives should be undertaken in close collaboration with the National TB Program to guide and facilitate the development of workplace TB care and control action plans. This is particularly critical to ensure that set technical standards and norms for the diagnosis and treatment of TB, including drug-resistant TB are adhered to and also to allow for the provision of TB commodities such as medicines, laboratory reagents and equipment to support workplace TB care activities.

4.2 Guiding Principles in the Implementation of Workplace TB Programs

The implementation process needs to be responsive to the different workplace setups (corporate and informal). Each of these setups needs to have a baseline workplace assessment to determine the state of their engagement with the TB workplace policy. Further to the baseline assessment, a package of entry will be tailored to the situation of the workplace. (The package of entry should include but not be limited to the Terms of reference, roles, and responsibilities of the focal persons).

4.2.1 Senior Management Commitment

To ensure a successful and sustainable workplace TB program, senior managers have an important leadership and advocacy role in promoting and developing workplace health and wellness programs. When managers endorse and approve the policies for preventing and treating TB among their workforce, they are ensuring a productive workforce, by placing a value on their workers' health and integrating it into the company's business culture. Effective TB care and control activities at the workplace can only be realized if there is strong management commitment and a consistent policy applied. TB activities should be entrenched within existing workplace health policies and structures based on The Constitution of Kenya 2010, Occupational Safety and Health Act, 2007, Employment ACT 2007, Work Injury Benefits Act 2007, HIV/AIDS Prevention and Control Act 2006, the National Policy on Occupational Safety and Health (OSH), HIV Workplace Policy, International Labor and Human Rights conventions and recommendations and employers' structures and platforms e.g. FKE, KEPSA, KAM and workers' Unions.

Workplace policy can be institutionalized within existing OSH and IPC committees with a focal point at the managerial level who serves as a liaison between the workers and the management. The focal point should have packaged information to introduce and disseminate the workplace policy. In addition, the role of the focal person needs to be well defined with terms of reference.

4.2.2 Stigma Reduction through TB Awareness Creation

Traditionally TB has been associated with a stigma which makes it more difficult for people with TB to seek diagnosis and treatment. To reduce stigma, all top-level management staff should be sensitized about TB and regular communication about TB should be fostered and mainstreamed in existing policies and structures. Effective health education campaigns should address negative attitudes towards people with TB and related conditions in the workplace. No staff should be denied employment or terminated from employment because they suffer from TB or related conditions. Corporates are encouraged to develop and display posters and TB-related information, education and communication materials aimed at confronting TB stigma and discrimination.

The employer's policies on confidentiality, discrimination, length of time a worker is allowed time off for medical treatment, sick leave, and job modification or redeployment when necessary should be clearly outlined and made easily accessible. These should be clearly explained to employees at the point of recruitment and reiterated as soon as employees are diagnosed with TB.

The focal point persons should be capacitated and enabled to handle any issues that may arise in the workplace and also take on the role of a liaison to escalate any issues to the top managerial level.

4.2.3 TB infection Prevention and Control Measures at the Workplace

Each workplace is strongly advised to have an infection prevention and control plan which should be reviewed annually. The plan should identify high-risk areas for TB transmission, and provide information on TB for its workers. It should also provide infection control recommendations for the workplace, including special standard safety procedures for its high-risk departments. To ensure the plan is implemented, the management should identify a person to monitor the IPC plan. The management should track the implementation of the plan and annually support the Plan's review.

4.2.4 Safety of Workers

All workers should be screened for TB twice annually and when a need arises. These include but are not limited to persons working in health facilities, mining, construction, EPZs and transport industries, prisons, police cells, refugee camps and other congested environments, sports clubs, associations, SACCOs, and welfare groups. In the learning institution setting, teachers, staff, and students should be screened when schools' terms open and close.

IPC plans are an absolute necessity wherever health care is provided. Health care workers should be familiar with TB as an occupational hazard and should take appropriate actions when managing people presumed to have or confirmed with TB. Appropriate support to workers with TB should be accorded as per the existing legislation.

4.2.5 Respect for the Rights of Persons with TB

Maintaining the confidentiality of medical conditions and medical records is crucial to giving employees the confidence to undergo treatment. Lack of confidentiality can lead to discrimination as well as delayed diagnosis and treatment. Confidentiality implies that only those who must know the patient's disease should know. Patients must be aware of the persons who will need to be informed about their disease and consent to disclose this information sought by health care providers. Medical staff should never divulge the medical status of employees without the patient's consent, to any other workers, or to the management who are not directly involved in the provision of health care for that individual. Medical staff should give guidance to the management on whether employees will need time off work and whether there should be any change to their workload and tasks because of their health status. Treatment support including

options for directly observed treatment (DOT) should respect the rights of the worker /patient.

Employees have a right to receive their pay while sick or on treatment and in the case of disability resulting from TB infection at the workplace, they are entitled to compensation as per existing labor laws.

4.2.6 Care and Support of Staff/workers with TB

Workplaces should provide access to appropriate health services for TB patients until they complete their treatment. Additionally, welfare benefits may be accorded such as subsidized treatment services, psychosocial support, free or subsidized transport to health facilities, and nutritional support. Where applicable, TB DOTs services may be offered by the workplace health services officers through collaboration with the relevant Sub-County TB coordinator. Importantly, to motivate the patient to continue treatment, social support should be adapted to the delivery and duration of the treatment.

4.2.7 Adjusting of Tasks According to the worker/patient's Health Status

For at least the first 2–4 weeks of TB treatment or the first 3-6 months of DRTB treatment, the management should ensure that a patient should be on sick leave until there is confirmed sputum conversion, with appropriate treatment support including DOT arranged for the convenience of the patient. Once the patient's sputum is negative for TB bacilli, he/ she may resume work, with an adjusted workload modified based on the fitness level of the patient. For example, it may be possible for an employee who is normally engaged in heavy labor to do lighter duties until they are fit to assume their normal duties.

4.3 Implementation Guidance

The Stepwise approach for developing and implementing a workplace TB Care and Control Action Plan

This policy recommends the adoption of a stepwise approach in the development and implementation of a TB control workplace program. The key steps should include:

4.3.1 Step 1: Situation Analysis

This should be done primarily by the National TB Program or agencies acting on behalf of the National TB Program. The primary purpose is to identify relevant players in particular geographical areas such as the county, regional or national level. While all companies, businesses, and organizations can be engaged to participate in the full range of TB service provision capacity constraints in the DNLTD-P and its technical partners

may constrain the engagement of all. Criteria that may help to prioritize entities to be engaged may include the number of employees of the organization to be engaged, the nature of work done by the organization and its risk for TB transmission, disease, and treatment-related challenges, and the willingness of the company management to be engaged and to play roles that go beyond providing services to employees.

The steps to be followed include:

4.3.1.1 Mapping of relevant organizations

- List all Ministries, Departments and Agencies (MDAs)
- Make a list or procure a list from business associations, employers' organizations, workers' organizations, or the department of labor on the companies in the county, region, or country.
- List all informal sector umbrella bodies and religious organizations.
- Analyze the list to identify occupational sectors which have a high prevalence of TB or HIV such as mines, construction, garment factories, etc.
- Classify corporates based on size and capacity to assess what potential contribution they can make.
- Identify input required to optimize their contribution.

4.3.1.2 Review of relevant labor laws and regulations

Ensure familiarity with relevant labor laws and regulations that could help or hinder the business sector engagement course. These laws include the Constitution of Kenya 2010, the Labor Relations Act 2007, the Employment Act 2007, Work Injury Benefits Act 2007 (WIBA), the disability act and the HIV and AIDS prevention and Control Act 2006, Occupational Safety and Health Act 2007, The Public Health Act among others.

The engagement of corporations should be guided by these regulations.

4.3.2 Step 2. Development of a Comprehensive Workplace TB Action Plan

Jointly develop a comprehensive plan with relevant stakeholders to foster a true partnership between the National TB Program or agencies acting on behalf of the DNLTD-P and identified or prioritized stakeholders.

4.3.2.1 Stakeholder identification and engagement

The main stakeholders that may need to be engaged in the development of the comprehensive plan to engage businesses at the county, regional, or national-level include:

- Ministry of Health and the relevant disease control programs (the National TB Program, NASCOP, NCD).

- Ministry of Labour and Social Protection.
- Individual employers (corporate organizations).
- Umbrella organizations of individual employers such as Kenya Association of Manufacturers, Federation of Kenya Employers, Kenya Private Sector Alliance, and others.
- Central Organization of Trade Unions (COTU) and other workers unions.
- The International Labor Organization.
- Health insurance organizations.
- Organizations engaged with the private sector to promote specific health agendas such as HIV and TB care e.g. Global Business Coalition on HIV, TB, and Malaria (GBC).
- County Government.
- World Health Organization.
- Civil Society.
- Religious organizations.

Each of these organizations will be bringing specific competencies and skills that appropriately used could assist with the development of a robust plan that is likely to succeed. The engagement of a wide array of stakeholders also allows these key players to buy into the plan and to foster ownership which is likely to help with sustaining the plan.

4.3.2.2 Formulation of a Workplace Policy

The development of TB, DRTB, and TB/HIV workplace policies is necessary to provide the framework for direct action at the workplace and to demonstrate the support and commitment of management. The development of workplace policies should be participatory and include the active involvement of senior management and representatives of workers to enhance trust, transparency, accountability, ownership, commitment as well as the sustainability of the workplace program. The ILO supports workplaces to develop workplace programs based on the following key principles of the ILO Code of Practice:

- Recognition of HIV and TB as workplace issues
- Bipartite approach (working with management and workers representatives)
- Gender equality
- Protection of the rights of workers
- Non-discrimination
- Confidentiality
- Continuation of employment

- Prevention
- Treatment, care, and support.

The purpose of a policy is to ensure a consistent and equitable approach to the implementation of TB, DRTB and TB/HIV workplace programs among employees, their families as well as the communities in which the business is situated.

4.3.2.3 Outline Activities, Roles, and Responsibilities

The workplace TB action plan should clarify the process, and roles and responsibilities of partners and staff to ensure the smooth functioning of the workplace program. In addition, the plan should clearly articulate the objectives of the program, the tasks which will be undertaken and by whom, the use of incentives and enablers e.g. recognition, inclusion of TB in performance contracts, the training that will be provided (by whom, who will be trained, what they will be trained on, for how long and how training will be evaluated) and advocacy and communication interventions that will ensure that the program is adequately resourced, accepted and used, and how the programs will be monitored and evaluated. It is desirable to define as early as possible, the areas that may require some form of operations or implementation research to refine program practices.

For effective and sustainable TB control programming at the workplace, there is a need to ensure collaboration among management, employees, the government, and other key stakeholders. To successfully manage the workplace TB control action plan and its implementation, the following should be considered.

At Inception:

1. Designate a senior management representative and workers' representative, in addition to the medical personnel, to be responsible for the proper functioning of the workplace TB control program and to play an oversight role.
2. Ensure that the program is developed in conjunction with workers' representative(s)
3. Ensure that the TB workplace policy program is linked to the National TB Program and the County Health Management for appropriate technical and logistical support where necessary.
4. Ensure workplace TB control activities are aligned to the DNLTD-P objectives and the management is committed to their long-term implementation.
5. Ensure that the workforce understands the importance of the TB workplace policy and its role in implementing it.

During the program implementation:

1. The management together with the oversight committee should ensure consistency with appropriate national laws and policies.

2. The workplace policy should ensure the support and protection of the TB-infected workers, gives guidance to managers, supervisors, and OSH recommendations.
3. The management should provide the appropriate support and care for the TB-infected workforce, to ensure confidence among infected workers, who in turn can play the role of TB champions at the workplace and assist in planning for control of the spread of TB and its impact in the workplace.

4.3.2.4 Defining the task mix

A key aspect in planning for a workplace initiative is to map the roles and responsibilities of various collaborating partners including the DNLTD-P and to allocate tasks appropriately based on those roles and the capacities available in partner organizations. Collaboration agreements may be entered between the companies and businesses and the technical partners of the National TB Program or the National TB Program itself to foster accountability. The table below lists some of the main tasks that can be undertaken and indicates how these can be distributed. This task mix is indicative and needs to be adapted to the specific business context.

Indicative Task Mix for a TB workplace program

Roles and Responsibilities

- Development of a TB Workplace policy
- Undertaking TB awareness-raising and education programs for workers
- Undertaking TB awareness-raising and education programs for the community
- Establishing referral mechanisms to public/private health facilities
- Undertaking passive TB screening
- Undertaking active TB screening
- Sensitization of treatment supporters in the workplace to support workers with TB in the workplace
- Support the delivery of TB medication to the workplace as part of TB differentiated service delivery
- Diagnosis of TB through onsite outreach clinics
- Support of onsite TB DOTS in workplaces with workplace clinics to support workers
- Provision of TB preventive therapy for workers and their families in workplaces with workplace clinics to support workers
- Opening workplace health facilities to the community in support of TB service delivery.

4.3.2.5 Incentives and Enablers

A range of factors affects the ability and motivation of companies of all types to engage in TB control efforts. Incentives and enablers, if well designed, can overcome some of the motivational barriers. They are useful not only to attract companies and ensure their continued involvement but also to enhance their performance. Companies being business-minded are expectedly profit-driven. Incentives from national programs especially the provision of anti-TB medicines, training of health workers by the DNLTD-P, and TB awareness creation in workplaces are motivators for companies to engage in workplace programs, as these incentives provide benefits to the company with little or no additional investment. The obvious incentives and enablers that may be used by DNLTD-P and its technical partners include the provision of laboratory equipment and reagents, drugs, training opportunities, recognition awards for well performing companies and experience sharing forums. Other incentive and enabler schemes may emerge as workplace TB care and control program are scaled up and appropriate implementation or operations research is conducted to define the most effective measures.

4.3.2.6 Training for a Workplace TB Care and Control Program

An essential component of the TB workplace program is the training strategy and plan. Training should be focused on providing basic knowledge and skills for trainees to undertake specific tasks (task-based training). There may be a need to develop appropriate training materials or to adopt and adapt existing national and international training materials. All training should be conducted in collaboration with the DNLTD-P through its national and county officers.

4.3.2.7 Advocacy and Communication

The action plan for the workplace TB care and control program should include an advocacy and communication component that outlines how the interest of businesses, government, and other players will be enhanced and sustained and how resources for the program will be mobilized. Thus the target of the advocacy and communication interventions will include government, company managers, managers of workers' organizations, and others. There may be a need to continue advocacy efforts targeting specific companies that may have policies that are injurious to TB care and control-related for example to confidentiality, discrimination, and length of time one is allowed off work for medical treatment.

5 MONITORING AND EVALUATION

5.1 Introduction

Data forms part of the general health information system, which aims to provide the basis for programmatic and policy development.

County Governments and or the technical/implementing partners working collaboratively with the DNLTD-P will enforce, continuously monitor and evaluate the implementation of the workplace policy.

Data capture at all workplaces will be on mainstream TB recording and reporting tools for standardization and onward data relay. Identified persons with TB shall be notified to the DNLTD-P as recommended by WHO by the respective Sub-county and County TB coordinators, they are also responsible for follow-ups of laboratory investigations being done at the National reference laboratories

Institution	M&E Roles and Responsibilities
Division of National Leprosy, Tuberculosis, and Lung Disease-Program (DNLTLD-P)	• Ensure effective coordination of the overall TB workplace policy M&E at the national and county levels. • Develop the overall operational guidelines for the TB workplace policy M&E framework. • Ensure effective rollout of TB workplace policy M&E framework to counties and all sectors. • Develop, in collaboration with counties, formal and informal public/private sector employers reporting systems, including the tools and procedures. • Ensure effective TB workplace policy data management • Build the capacity of counties in M&E to enable them to operationalize the workplace policy M&E framework. • Lead the national workplace policy monitoring committee and support counties to establish and operationalize the county workplace policy monitoring committee. • Provide technical support to counties in data collection, reporting, and analysis for TB workplace policy M&E system. • Provide technical support to counties to conduct periodic data audits, develop data quality improvement plans, and monitor their implementation.

Institution	M&E Roles and Responsibilities
County	• Overall coordination of the implementation of TB Workplace policy M&E framework at the county level. • Establish and maintain the formal and informal public/private sectors TB workplace policy implementers' database at the county level. • Ensure effective establishment and implementation of the formal and informal public/private sector TB workplace policy reporting systems. • Receive and review data from all sectors and implementers reporting at the county level. • Develop county TB workplace policy reports. • Establish and operationalize the county TB workplace policy M&E committee. • Provide feedback on TB workplace policy data received from formal and informal public/private sectors at the county level

Technical Coordination Mechanisms

The M&E technical coordination structures will include the TB workplace policy monitoring committee and TB ICC at the national and county levels. The roles of these structures are outlined below.

National TB Workplace Policy Monitoring Committee

The national TB workplace policy monitoring committee will play the following technical roles:

- Advice on the role out of the TB workplace policy M&E framework.
- Review M&E data to assess the TB workplace implementation progress, identify bottlenecks, and make recommendations on possible solutions.
- Review strategic information to be disseminated to the TB ICC, counties, and other stakeholders. Make recommendations on adjustments in the implementation of the TB workplace policy from time to time informed by evidence.
- Establish linkage to the county-level TB workplace policy monitoring committee to:
    - Build the M&E capacity at the county.
    - Support the operationalization of the TB workplace policy M&E framework by guiding the development of county M&E plans.
    - Support the county and sub-committees in data analysis.

Members of this committee will be M&E experts drawn from the National TB program and stakeholders from across all sectors and partners. The National TB Program will coordinate and provide secretarial support to this committee

County Monitoring Committee

The county TB workplace policy M&E committee will largely play roles similar to those of the national level M&E committee but at the county level. The roles include:

- Review and analyze data received at the county level.
- Advise the county TB Inter-Agency Coordination Committee (TB-ICC) and the county health executive committee (CEC) on the improvement of TB workplace policy implementation at the county level.
- Support the overall operationalization of the TB workplace policy M&E framework at the county level
- Maintain linkage with the TB Workplace Policy M&E committee at the national level.

This committee will be convened by the county TB coordinator. Members of the committee will be persons with M&E expertise drawn from across relevant sectors and partners.

TB ICC at National and County Levels

The TB ICC at the national level will continue while the counties are encouraged to form their TB ICC at their level to provide a forum for stakeholders and partners to periodically review the progress in the implementation of the TB workplace policy within a multi-sectoral context. These committees will be partnership forums whose roles will include:

- Reviewing overall progress in implementation of TB workplace policy.
- Identifying success and challenges in the implementation of the TB workplace policy.
- Receiving and reviewing the monitoring reports for the counties (for county ICCs) and countrywide (for national ICCs).
- Building consensus on emerging issues and adjustments that need to be made to the TB workplace policy based on evidence promoting mutual accountability of all stakeholders.

Process indicators

Some indicators of the process are:

1. The number of workplaces mapped.
2. The number of employers and employees sensitized about TB.
3. The number of workplaces with TB workplace policy.
4. The number of workplaces with policies on medical confidentiality that includes TB.
5. The number of workplaces with TB infection prevention and control (TB IPC) work plans.
6. The number of workplaces with reviewed TB IPC work plans.
7. The number of workplaces with TB focal/point persons
8. The number of TB messages developed and disseminated.
9. The number of workers screened for TB.
10. The number of workers identified as presumptive TB cases.
11. The number of workers investigated for TB.
12. The number of workers diagnosed with TB, linked to TB care and initiated TB treatment.
13. The number of workers who completed treatment.
14. The number of contacts identified, screened for TB, investigated for TB, diagnosed with TB and initiated on TB treatment, and initiated on TB preventive therapy.

Impact indicators

Some indicators of impact are:

1. Reduction in TB incidence.
2. Increased levels of knowledge on TB.
3. Reduced number of deaths and lost to follow-up from TB-related causes.
4. Reduced number of person-hours lost through TB-related absenteeism.
5. Reduced impact of TB on productivity and profitability.
6. Reduced catastrophic costs related to TB care.

5.2 Recording and Reporting

Systematic and continuous recording and reporting of program data are vital for The Workplace TB policy which shall be hinged on the National TB Program's M&E framework as stipulated in the National Tuberculosis Strategic Plan 2019-2023 (Annex the document). Further, specific indicators for the workplace are highlighted in the Framework below.

5.3 Monitoring and Evaluation Framework

This framework is designed in a manner that measures the extent to which the objectives are achieved by linking the results/outcomes to the planned activities. As with the other M&E plans, this framework is dynamic in nature involving a continuous process of improvement and revision and help partners achieve results.

Monitoring and Evaluation Framework for TB Workplace Policy				
1 Advocacy, Communication and Community Engagement				
	Indicator	**Indicator Definition**	**Target Group**	**Frequency**
1.1	Map the targeted workplaces based on a documented risk	Number of targeted workplaces mapped	Formal and informal workplaces both in the public and private sectors	Annually
1.2	Number of TB messages developed per targeted workplace	Number of TB messages developed	Workers and employers in formal and informal workplaces both in the public and private sectors	Annually
1.3	Number of sensitization meetings held	Number of sensitization meetings held	Workers and employers in formal and informal workplaces both in the public and private sectors	Quarterly
1.4	The proportion of managers sensitized about TB	Numerator: Number of managers sensitized Denominator: Total number of managers in the mapped workplaces	Managers in formal and informal workplaces	Quarterly
1.5	The proportion of workers sensitized about TB	Numerator: Number of workers sensitized Denominator: Total number of workers in the mapped workplaces	Workers in formal and informal workplaces	Quarterly

	Indicator	Indicator Definition	Target Group	Frequency
2. Care Cascade				
2.1	The proportion of workers screened for TB	Numerator: Number of workers screened Denominator: Total number of workers per organization	Workers in formal and informal workplaces	Quarterly
2.2	The proportion of workers who are presumptive TB cases	Numerator: Number of workers with symptoms of TB Denominator: Number of workers screened	Workers screened for TB in formal and informal workplaces	Quarterly
2.3	The proportion of workers who are presumptive TB cases investigated for TB disease	Numerator: Number of workers investigated for TB disease Denominator: Number of workers who are presumptive TB cases	Workers identified as presumptive TB cases in formal and informal workplaces	Quarterly
2.4	The proportion of workers investigated who are confirmed to have TB	Numerator: Number of workers who are confirmed to have TB Denominator: Number of workers who are presumptive TB cases who were investigated for TB disease	Workers identified as presumptive TB cases that were investigated in formal and informal workplaces	Quarterly
2.5	The proportion of workers with TB linked for treatment	Numerator: Number of workers who tested TB positive who linked and initiated TB treatment Denominator: Number of workers who are confirmed to have TB	Workers diagnosed with TB in formal and informal workplaces	Quarterly
2.6	The proportion of workers with TB linked for treatment who completed treatment	Numerator: Number of workers who completed TB treatment and assigned an outcome Denominator: Number of workers who tested TB positive who linked and initiated TB treatment	Workers diagnosed with TB linked and initiated TB treatment in formal and informal workplaces	Quarterly
2.7	The proportion of workers who develop complications secondary to TB disease	Numerator: Number of workers who develop complications secondary to TB disease Denominator: Number of workers who initiated TB treatment	Workers on TB treatment in formal and informal workplaces	Quarterly

	Indicator	Indicator Definition	Target Group	Frequency
2.8	Number of workers identified as TB contacts	Number of workers identified as TB contacts	contacts (who are Workers) of workers with bacteriologically confirmed TB in formal and informal workplaces	Quarterly
2.9	The proportion of workers who are eligible for TPT	Numerator: Number of workers eligible for TPT Denominator: Number of workers identified as TB contacts	Workers contacts of workers with bacteriologically confirmed TB identified as eligible for TPT in formal and informal workplaces	Quarterly
2.1	The proportion of workers who are initiated on TPT	Numerator: Number of eligible workers initiated on TPT Denominator: Number of workers eligible for TPT	Workers eligible for TPT in formal and informal workplaces	Quarterly
2.11	The proportion of workers who completed TB preventive therapy (TPT)	Numerator: Number of workers completing TPT Denominator: Number of workers initiated on TPT	Workers initiated on TPT in formal and informal workplaces	Quarterly
3. Creating and Enabling Environment				
3.1	Availability of clear management policies on confidentiality of workers medical conditions (including TB)	Availability of policy on confidentiality of medical conditions including TB	Workplaces with confidentiality policies	Annually
3.2	The proportion of workplaces with policies on length of time allowed for TB medical treatment and job modification	Numerator: Number of workplaces with policies Denominator: Total number of workplaces mapped	Workplaces mapped	Annually
3.3	The proportion of workers who have been sensitized on the policies on confidentiality, length of time allowed for treatment, and job modification	Numerator: Number of workers sensitized Denominator: Total number of workers in each of the mapped workplace	Workers eligible in formal and informal workplaces	Annually

	Indicator	Indicator Definition	Target Group	Frequency
4. Infection Prevention and Control				
4.1	The proportion of workplaces that have an infection prevention control (IPC) work plan	Numerator: Number of workplaces with an IPC work plan Denominator: Total number of workplaces mapped	Workers eligible in formal and informal workplaces	Annually
4.2	The proportion of workplaces that have an infection prevention control (IPC) focal person	Numerator: Number of workplaces with an infection prevention control (IPC) focal person Denominator: Total number of workplaces mapped	Workers eligible in formal and informal workplaces	Quarterly
4.3	The proportion of workers who have been sensitized on the IPC work plan	Numerator: Number of workers sensitized on IPC plan Denominator: Total number of workers in each of the mapped workplace	Workers eligible in formal and informal workplaces	Annually
4.4	The proportion of workplaces with their IPC work plans reviewed annually	Numerator: Number of workplaces with an IPC Work plan reviewed annually Denominator: Total number of workplaces mapped	Workers eligible in formal and informal workplaces	Annually

Policy Review

This workplace policy will be reviewed every 5 years in line with the National TB Strategic Plan

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