REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM



2025 ANNUAL REPORT

DIVISION OF TUBERCULOSIS AND OTHER LUNG DISEASES

Table of Contents

Chapter 1: Epidemiology of Tuberculosis, Leprosy and Lung Diseases in Kenya in 2025 1

1.1 Introduction 2
1.2 TB case notification trends 3
1.3 DRTB case notification 5
1.4 Age and sex distribution 7
1.5 Childhood tuberculosis 8
1.6 Contribution by Sector on TB Notification 8
1.7 Nutritional status and food support among TB patients 10
1.8 TB/HIV 11
1.9 TB prevention 12
1.10 TPT among Household Contacts 13
1.11 TB and Co-morbidities 14

Chapter 2: Integrated Strategies for Finding Missing People with TB and other Lung Conditions 19

2.1 Active Case Finding and Screening Strategies 20
2.2 KIC TB Mainstreaming Intervention 27
2.3 Public Private Mix (PPM) 28
2.4 Treatment Adherence and treatment Interrupters Tracing 32

Chapter 3: Tuberculosis and Comorbidities 33

3.1 TB/HIV 34
3.2 Other Comorbidities 37
3.3 TB Prevention 38
3.4 Planning, Policy and Guidelines Development 40

Chapter 4: Social Support and Nutrition 42

4.1 Social Support for patients with DR-TB, January-November 2025 43
4.2 Social Health Insurance Fund Support for DRTB patients 44
4.3 Nutrition in Tuberculosis, Leprosy and Lung Disease 45
4.4 Capacity Building and Mentorship 46

Chapter 5: Supply Chain Management, ... 48
Pharmacovigilance and ADSM 49

5.1 Governance and Coordination 49
5.2 TB Supply Chain Management 49
5.3 Product Quality and Patient Safety 53

5.4 Capacity Building Activities to Improve TB Commodity Management and Patient Safety 55
5.5 Risks and Mitigation Actions for 2026 56
Chapter 6: Prevention, Health Promotion and Community Engagement 57
6.1 Community Engagement and Institutional Approaches in TB control 58
6.2 Communication, Advocacy and Public Engagement 60
Chapter 7: Lung Health 67
7.1 Integrated Lung Health 68
7.2 Rationale and Scope 68
7.3 Key Achievements (April-Dec 2025) 70
7.4 Priorities for 2026/2027 74
7.5 Gaps and Bottlenecks 74
Chapter 8: Monitoring, Evaluation and Research 75
8.1 Annual National Strategic Plan Review 76
8.2 Revamping Research Activities 77
8.3 Strengthening Digital TB Case Management through TIBU Lite User Engagement and System Enhancements (2025) 79
8.3.1. Scale-up of TIBU-Lite point of care implementation 80
8.4 Strengthening Data Quality and Use for Decision-Making 85
8.5. Annual Joint Workplan 88
8.6 M&E Recording and Reporting Tools 88
Chapter 9: Finance, Administration and Human Resources 90
9.1 Funding Summary and Performance 91
9.2 Financial Controls, Audits and Compliance 92
9.3 Human-Resource Establishment and Staffing Gaps 93
9.4 Capacity Development and Staff Welfare 94
9.5 Key Operational Risks and Priorities for 2026 96

List of Tables

Table 2.1: Facility Active Case Finding Cascade 2022-2025 22
Table 2.2: TB cascade of care for different populations in 2025 26
Table 3.1: Overall status of progress 38
Table 4.1: Summary of Nutritional Assessment and Support (2025) 46
Table 4.2: Challenges and priority areas of nutrition 47
Table 5.1: Supply plan summary for first line medicines tracer commodities 50
Table 5.2: Order fill rates for selected TB tracer commodities 50
Table 5.3: KEMSA turnaround times for first- and second-line TB medicines 51
Table 5.4: KHIS reporting rate and timeliness for TB commodity reports 52
Table 5.5: Data quality performance based on opening and closing balance alignment 52
Table 5.6: Adverse event reporting rates in TIBU and PvERS 53
Table 5.7: Most common adverse events by DRTB regimen and reporting system 54
Table 5.8: Top reported adverse reactions by reporting system 54
Table 5.9: Capacity building activities for TB commodity management and patient safety 55
Table 5.10: Supply chain risks and mitigation actions for 2026 56
Table 5.11: Pharmacovigilance challenges and mitigation actions for 2026 56
Table 6.1. Prisons TB screening outreach cascade 59
Table 6.2: News/ feature stories on TB 61
Table 6.5 Country delegation 66
Table 8.1: High-level 2025 data quality findings 85
Table 8.2: Printed M&E Recording and Reporting Tools 89
Table 9.1: Detailed breakdown of the capacity building data 95

List of Figures

Figure 1.1: Summary of TB incidence vs case notification in Kenya, 2020–2025 2
Figure 1.2: TB case finding trend in Kenya, 2020–2025 3
Figure 1.3: Ranking of counties notifying DSTB and DRTB 4
Figure 1.4: TB case notification by type of diagnosis and patient category 5
Figure 1.5: Trend of adult and childhood drug-resistant tuberculosis case notification, Kenya, 2020–2025. 6
Figure 1.6: Drug-resistant TB cases notified by resistance pattern 7
Figure 1.7: Age-Sex distribution of TB in Kenya, 2025 8
Figure 1.8: Case notification by sector 9
Figure 1.9: Case notification by sector 11
Figure 1.10: TB-HIV co-infection key statistics 12
Figure 1.11: TB preventive therapy initiation among different risk groups, 2025 12
Figure 1.12: TPT among PLHIV, 2025 13
Figure 1.13: TPT among household contacts, 2025 14
Figure 1.14: TB and co-morbid conditions, 2025 15
Figure 1.15: Summary of TB treatment outcomes, 2025 16
Figure 1.16: Summary of Leprosy data in Kenya, 2025 17
Figure 1.17: Summary of Lung health data reporting, 2025 18
Figure 2.1: Performance of CAD in sites using Qure qXR for TB and lung health screening 24
Figure 2.2: TB investigation outcomes 26
Figure 2.3: Spirometry test cascade 27
Figure 2.4: The figure shows trends in total notifications and the private sector's contribution over four years (2022–2025). 29
Figure 4.1: Summary of DOT workers and patient supported quartely 43
Figure 5.1: Comparison of the distribution of first line medicines between 2024 and 2025 51
Figure 6.1 TB Bill Board in Busia Town 64
Figure 7.1: Integrated TB and Lung Health guidelines, SOPS, Job aids, 2025 70
Figure 8.1 Number of CHPs trained on Tibu-Lite by county 82
Figure 9.1 Funding Sources 91
Figure 9.2 Funding received per intervention 92
Figure 9.3: Overall staffing status 93
Figure 9.4: Positions filled vs vacant 94

List of Abbreviations

ADSM	–	Active TB Drug Safety Monitoring and Management
AEs	–	Adverse Events
AHD	–	Advanced HIV Disease
AI	–	Artificial Intelligence
API	–	Application Programming Interface
AMREF	–	Africa Medical and Research Foundation
ART	–	Anti-retroviral Therapy
CHAI	–	Clinton Health Access Initiative
CHMT	–	County Health Management Team
CTLC	–	County TB and Leprosy Coordinators
CHA	–	Community Health Actors
CHEW	–	Community Health Extension Workers
CHO	–	Community Heath Officers
CHS	–	Centre for Health Solutions - Kenya
CHP	–	Community Health Promoters
CME	–	Continuous Medical Education
CNR	–	Case Notification Rate
CPT	–	Cotrimoxazole Preventive Therapy
CoE	–	Committee of Experts
COPD	–	Chronic Obstructive Pulmonary Disease
CPF	–	Counterpart Funding
CDR	–	Common Respiratory Disease
DAC	–	Donation Authorization Certificate
DIP	–	Donation Import Permit
DOT	–	Directly Observed Therapy
DQA	–	Data Quality Assessment
DQI	–	Data Quality Improvement
DR-TB	–	Drug Resistant TB
DSD	–	Differentiated Service Delivery
DSTB	–	Drug Susceptible TB
EPCON	–	Epidemic Control
ERP	–	Enterprise Resource Planning
FBO	–	Faith Based Organization
FY	–	Financial Year
GF	–	Global Fund
HCWs	–	Health Care Workers
iPACT	–	Integrated Program on Asthma, COPD and Tuberculosis
IPC	–	Infection Prevention Control
KAP	–	Knowledge Attitude and Practice
KELIN	–	Kenya Legal and Ethical Issues Network

KEMSA	–	Kenya Medical Supplies Authority
KHIS	–	Kenya Health Information System
K-TAP	–	Kenya – TB Acceleration Plan
LMIS	–	Laboratory Information Management system
LTFU	–	Loss to Follow Up
M&E	–	Monitoring and Evaluation
MAM	–	Moderate Acute Malnutrition
MoU	–	Memorandum of Understanding
MWRD	–	Molecular WHO Recommended Diagnostics
NASCOP	–	National AIDs and STI Control Program
NHP	–	Nutrition Health Products
NOMT	–	National Order Allocation and Management
NSP	–	National Strategic Plan
NTP	–	National TB Program
PMS	–	Patient Management System
PPB	–	Pharmacy and Poisons Board
PPM	–	Public Private Mix
PTLD	–	Post TB Lung Disease
PvERS	–	Pharmacovigilance Events Reporting System
QoC	–	Quality of Care
ReSOK	–	Respiratory Society of Kenya
RHZ	–	Isoniazid
RRI	–	Rapid Results Initiative
RTWGs	–	Regional Technical Working Groups
SAM	–	Severe Acute Malnutrition
SCHMT	–	Sub County Health Management Team
SCTLC	–	Sub County TB and Leprosy Coordinator
SHA	–	Social Health Authority
SHIF	–	Social Health Insurance Fund
SOP	–	Scope of Procedure
STI	–	Sexually Transmitted Infections
TB	–	Tuberculosis
TB/HIV	–	Tuberculosis/ Human Immunodeficiency Virus
TBI	–	Tuberculosis Infection
TWGs	–	Technical Working Groups
TSR	–	Treatment Success Rate
UNHLM	–	United Nations High Level Meeting
US DoS	–	United States Department of State
WHO	–	World Health Organization

EXECUTIVE SUMMARY

The 2025 Annual Report consolidates progress made by the Division of National Tuberculosis, Leprosy and Lung Disease Program in tuberculosis, leprosy and lung health service delivery, surveillance, prevention, diagnostics, patient support, supply chain management, monitoring and evaluation, research, resource mobilization, finance, administration and human resources.

In 2025, Kenya notified 91,715 TB cases, comprising 90,900 drug-susceptible TB cases and 815 drug-resistant TB cases. The estimated TB incidence was 207 per 100,000 population, equivalent to approximately 110,395 incident cases nationally. Approximately 83% of estimated people who developed TB were diagnosed and notified, leaving an estimated 17% undiagnosed or unreported.

Case finding interventions expanded through active case finding, facility-based screening, community referrals, prison outreach, digital chest X-ray and AI-supported interpretation. Continued gaps remain in the investigation of presumptive TB cases and linkage from diagnosis to treatment initiation.

The diagnostic network continued to provide access to molecular WHO-recommended rapid diagnostics, microscopy, culture, line probe assay and digital chest X-ray. By 2025, molecular diagnostic coverage had expanded to 307 GeneXpert and Truenat sites, with priority placed on optimizing utilization, strengthening specimen referral and expanding near point-of-care testing.

Patient support, nutrition and rights-based care remained central to the program. Between January and November 2025, 1,373 eligible DR-TB patients and 1,126 DOT workers received cash-transfer support. Nutrition assessment showed a high burden of undernutrition among TB patients, including 47.1% of notified DSTB cases and 51% of DRTB cases.

Supply chain management, pharmacovigilance and active drug safety monitoring supported commodity availability and patient safety. Annual quantification and mid-year reviews informed supply plans through 2027/28. Reporting rates exceeded the national target, although timeliness and data quality gaps persisted.

Integrated lung health implementation marked an important shift from a disease-specific TB platform to a broader respiratory health model targeting TB, post-TB lung disease, asthma, COPD, cystic fibrosis, occupational lung disease and lung cancer.

Monitoring, evaluation and research activities focused on implementation review, data use, digital surveillance, research dissemination and operational research. The Annual NSP Review highlighted progress in treatment outcomes and TB/HIV integration while identifying persistent challenges in financing, diagnostics, human resources, lung health integration and leprosy early detection.

Financing remained a critical constraint. For FY 2024/25, the TB NSP resource requirement was Kshs 17.748 billion, while reported financing was Kshs 4.412 billion, representing 25% of the required resources and a 75% funding gap. Human resource capacity also remained constrained, with 51 supported staff against an establishment of 70 positions.

ACKNOWLEDGEMENT



The Division of National Tuberculosis, Leprosy and Lung Disease Program acknowledges the Ministry of Health leadership, county governments, healthcare workers, community health structures, implementing partners, civil society organizations, professional bodies, academic and research institutions, development partners and affected communities for their contribution to the 2025 program achievements.

Special appreciation goes to all thematic leads and contributors who prepared the individual write-ups and data summaries used in this compilation. Their technical inputs, programmatic experience and commitment to improving TB, leprosy and lung health outcomes have made this annual report possible.

The Division further appreciates the continued support from the Government of Kenya, the Global Fund, United States Government mechanisms and other partners whose investments supported implementation of priority interventions during the reporting period.

Dr Abdullahi Omar
Ag. Head of Program
Division of Tuberculosis and Other Lung Diseases

CHAPTER 1

EPIDEMIOLOGY OF TUBERCULOSIS, LEPROSY AND LUNG DISEASES IN KENYA IN 2025



1.1 Introduction

This chapter provides a summary of the epidemiology of tuberculosis, Leprosy and Lung diseases in 2025 as per National data.

a. Tuberculosis Disease burden

Kenya is high burden for TB and HIV and is among 30 TB high burden countries that contributes up to 90% of the global burden. The estimated TB incidence in 2025 was 207 TB cases per 100,000 population, equivalent to approximately 110,395 incident TB cases nationally. In that year, Kenya notified 91,715 TB cases, comprising 90,900 DSTB and 815 DRTB cases. This means that approximately 83% of the estimated people who developed TB in Kenya in 2025 were diagnosed and notified, leaving an estimated 17% (approximately 18,660 people) either undiagnosed or unreported.

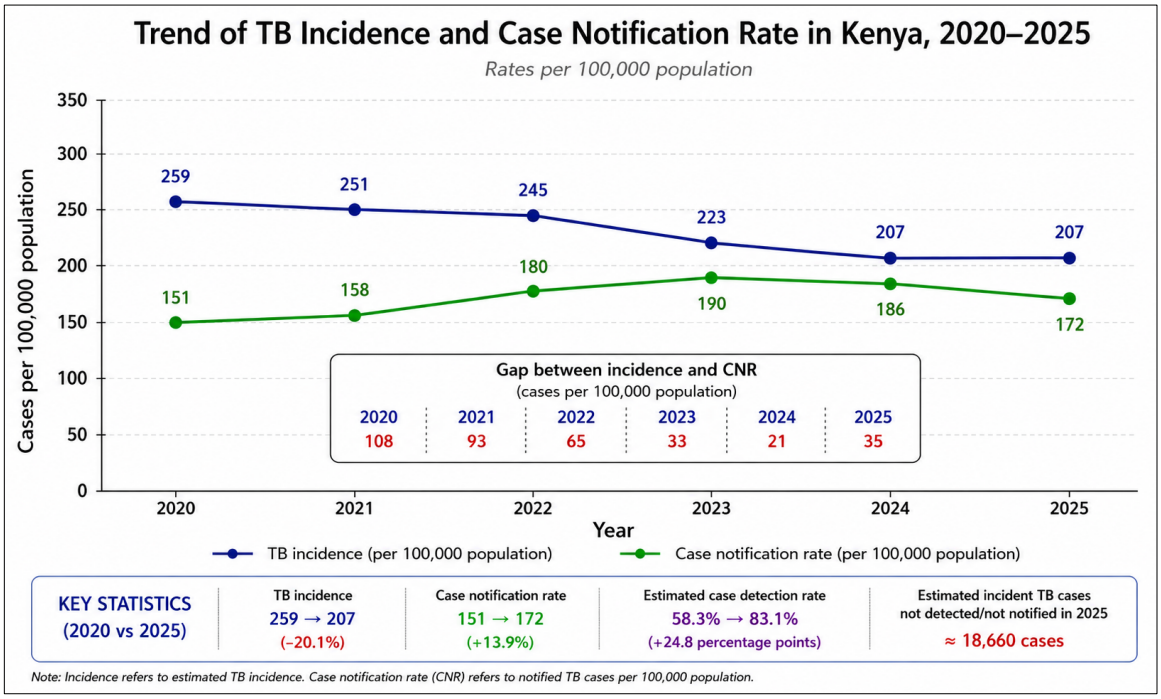

Figure 1.1: Summary of TB incidence vs case notification in Kenya, 2020–2025

1.2 TB case notification trends

DSTB continued to account for more than 99% of all notified cases (90,900) while DRTB contributed less than 1%. There was a reduction in DSTB case notification in 2025 while DRTB case notification increased slightly from 759 in 2024 to 815 in 2025, suggesting improvements in DRTB case detection in comparison with the WHO estimate.

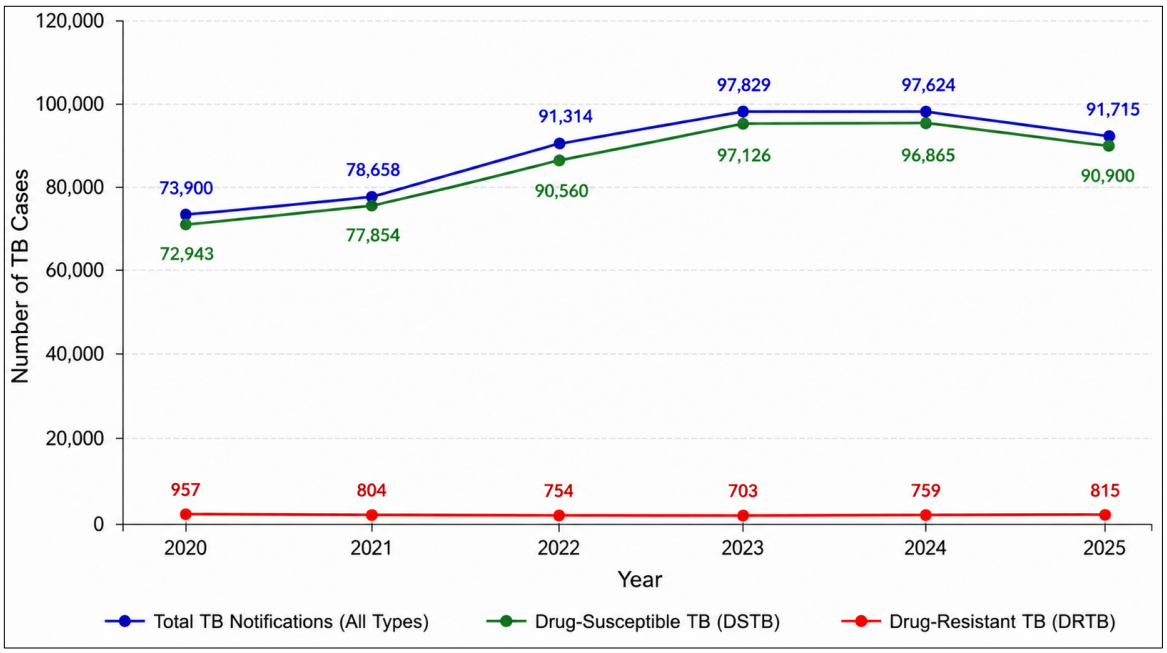

Figure 1.2: TB case finding trend in Kenya, 2020–2025

Case notification rates (CNR) varied considerably across Kenya's 47 counties in 2025, reflecting differences in TB burden, population characteristics, health-seeking behavior, access to diagnostic services, and program performance.

1.2.1 Ranking of counties notifying DSTB and DRTB

TB case notification rate (CNR)by county, Kenya 2025 per 100,000 population (DSTB + DRTB)

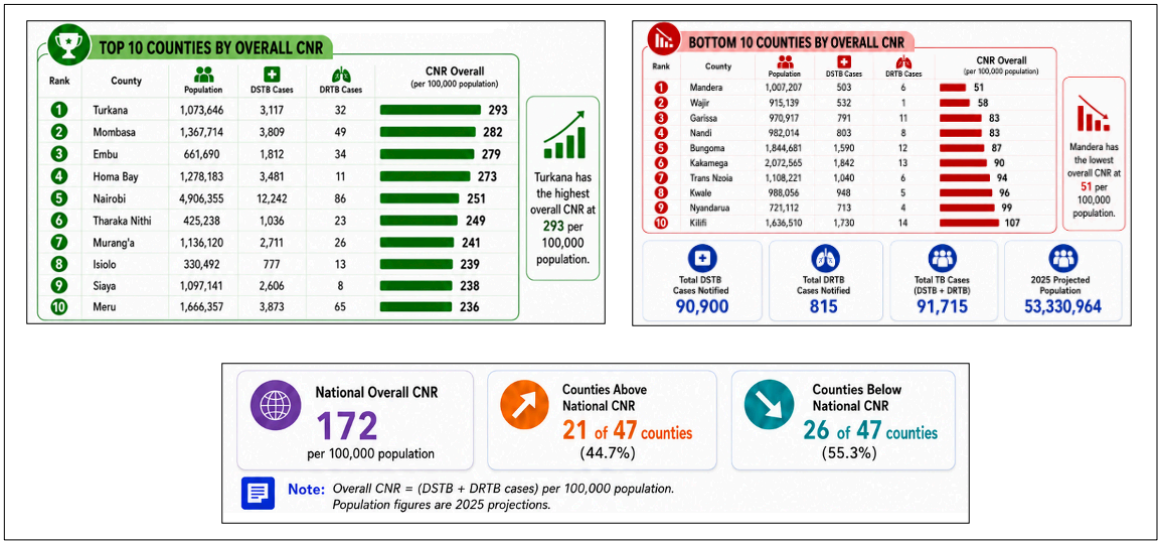

Figure 1.3: Ranking of counties notifying DSTB and DRTB

1.2.2 TB case notification trends by Type, Patient category and Diagnosis

Pulmonary TB remains the main driver of the TB burden. Out of the 77,058 Pulmonary TB cases, 49,916 cases were bacteriologically confirmed, giving a confirmation rate of 64.8%. This suggests relatively good diagnostic confirmation among pulmonary cases, which is important because pulmonary TB is the most infectious form and has the greatest implication for community transmission.

Extra Pulmonary TB shows a different diagnostic pattern. Out of 13,842 EP TB cases, only 4,331 cases were bacteriologically confirmed, representing 31.3%, while 9,511 (68.7%) cases were clinically diagnosed. This indicates that EP TB is still largely diagnosed clinically.

New patients dominate the TB notifications. There were 82,584 new cases, representing 90.9% of all TB cases, while 8,316 previously treated cases accounted for 9.1%. This shows that the TB burden is largely driven by new incident cases.

Tuberculosis cases by type, patient category and diagnosis, an overview of bacteriologically confirmed vs clinically diagnosed.

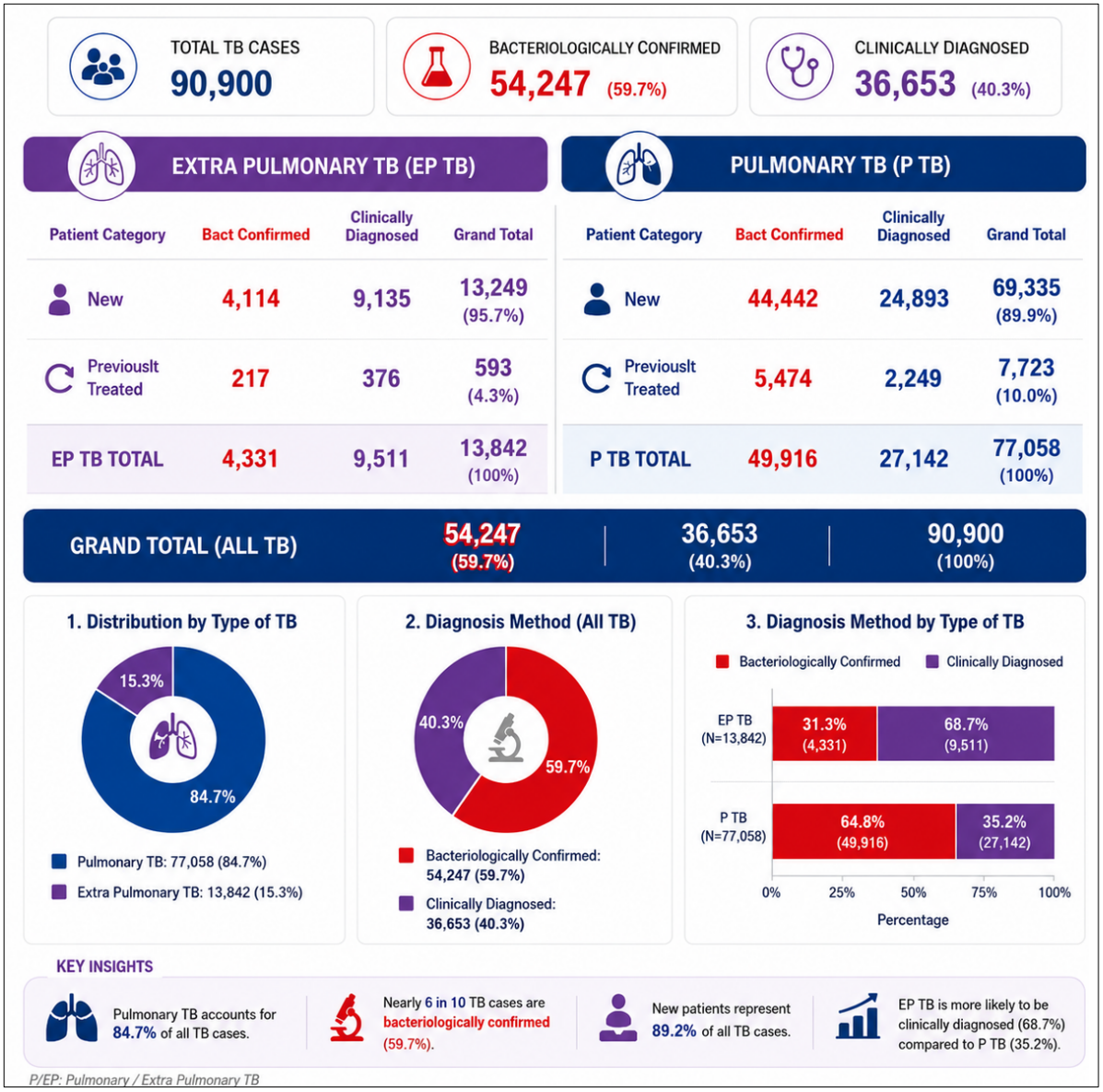

Figure 1.4: TB case notification by type of diagnosis and patient category

1.3 DRTB case notification

In 2025, Kenya notified 815 drug-resistant TB (DRTB) cases, comprising 779 adults (95.6%) and 36 children (4.4%).

Adult DRTB case notification increased for the second consecutive year, rising from 723 cases in 2024 to 779 cases in 2025, following a decline in 2020 and 2023.

In contrast, paediatric DRTB notification remained low throughout the six-year period; the 36 cases reported in 2025 marked the highest number recorded in six-year period. Despite this progress, the small proportion of children diagnosed with DRTB continues to indicate substantial under-detection.

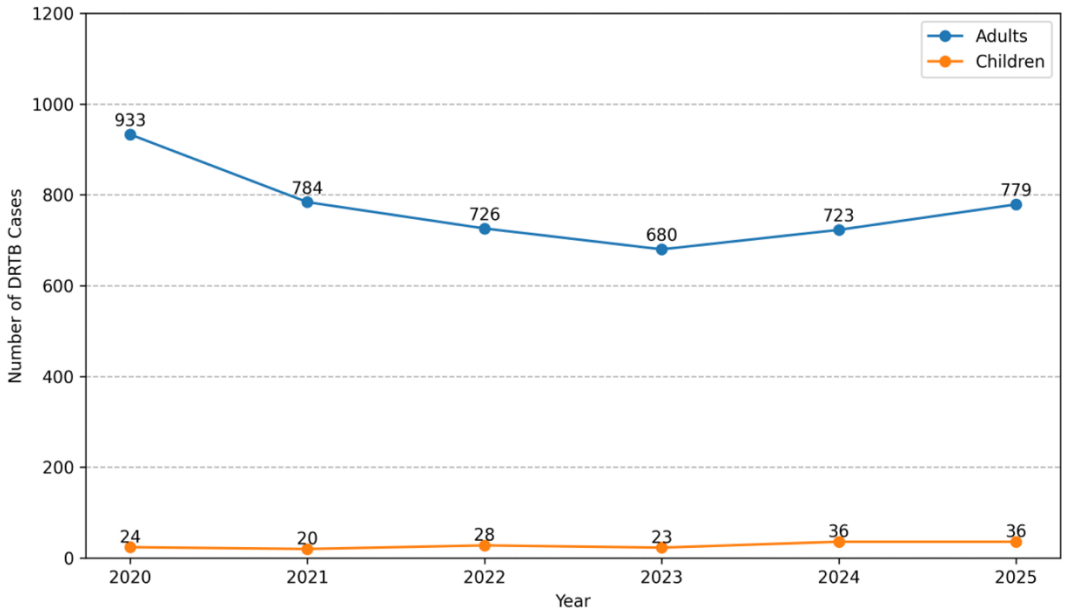

Figure 1.5: Trend of adult and childhood drug-resistant tuberculosis case notification, Kenya, 2020–2025.

In 2025, MDR/RR-TB remained the dominant form of drug-resistant tuberculosis in Kenya, accounting for 449 (55.1%) of the 815 notified DRTB cases. Although this represented a slight decline from 456 cases in 2024, MDR/RR-TB notification remained substantially higher than the 2022 low of 327 cases, indicating a rebound in case detection over the past three years (2023 – 2025) while maintaining MDR/RR-TB as the dominant resistance pattern.

Isoniazid mono-resistant TB was the second most common resistance pattern, with 345 cases (42.3%) reported in 2025. Following a peak of 413 cases in 2022, notification declined to 292 cases in 2024 before increasing again in 2025.

Pre-extensively drug-resistant TB (Pre-XDR-TB) remained uncommon but increased to 14 cases in 2025, the highest number reported over the five-year period, compared with 8 cases in 2024.

Poly-drug resistant TB (PDR-TB) remained rare, with 5 cases reported in 2025, compared with 2 cases in 2024 and between 1 and 3 cases annually during 2021 to 2023. While the

absolute numbers remain low, the increase observed in 2025 underscores the importance of maintaining robust DRTB surveillance.

Extensively drug-resistant TB (XDR-TB) continued to account for the smallest proportion of DRTB, with 2 cases reported in 2025 compared with 1 case in 2024 and no cases reported between 2021 and 2023. Although the numbers are very small, the emergence of XDR-TB over the past two years is epidemiologically significant because these patients require highly specialized management and represent a risk for ongoing transmission of the most resistant TB strains.

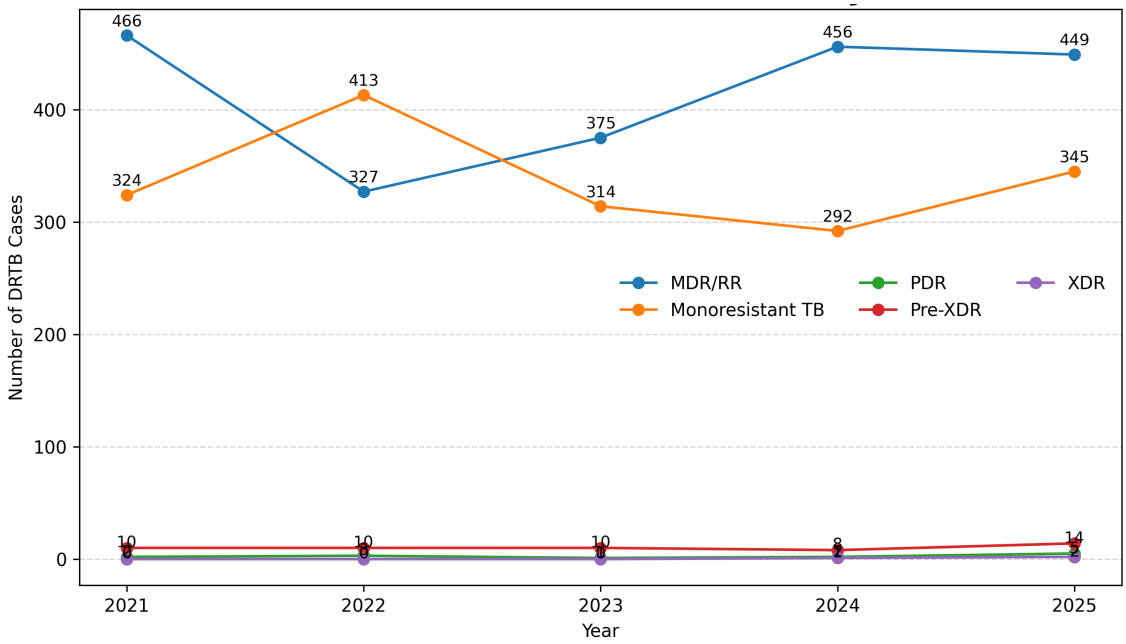

Figure 1.6: Drug-resistant TB cases notified by resistance pattern

1.4 Age and sex distribution

TB affected all age groups in 2025; however, the highest burden occurred among adults aged 25–44 years. Males accounted for most notified cases across all adult age groups, while childhood TB remained an important contributor to the national burden. The predominance among economically productive age groups highlights the continued impact of TB on households and the national economy.

2025 Kenya TB age-sex distribution and population comparison. TB notified cases by sex alongside KNBS population distribution vs share of TB notifications.

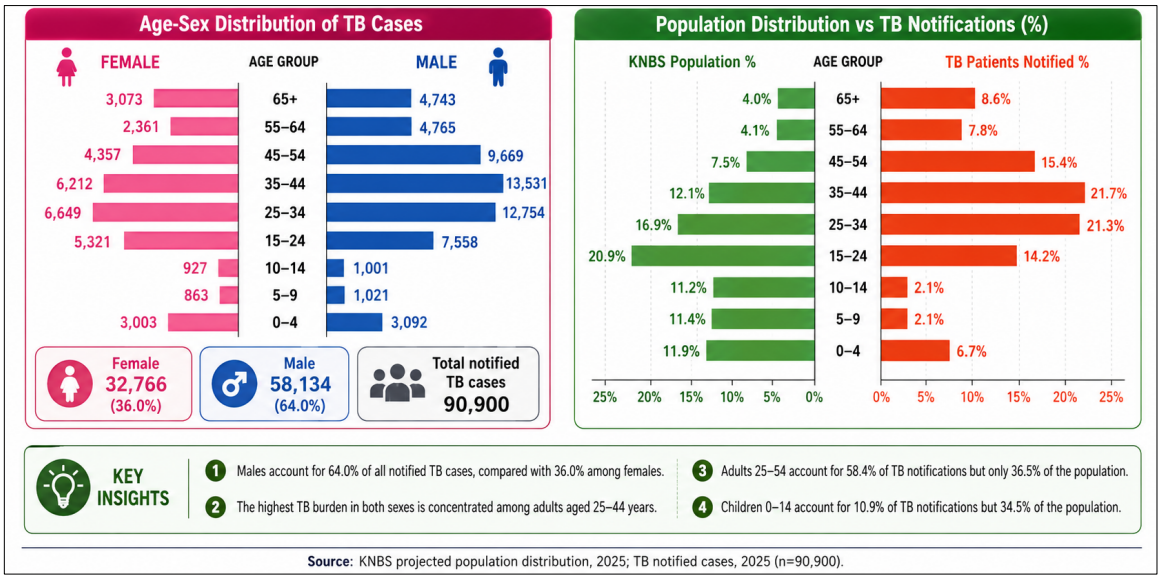

Figure 1.7: Age-Sex distribution of TB in Kenya, 2025

1.5 Childhood tuberculosis

Childhood TB notification increased from 5,662 cases in 2020 to 12,829 in 2023 with a decline to 12365 in 2024 and 10,986 cases in 2025. Continued expansion of child-friendly specimen collection, molecular diagnostics, and systematic contact investigation will be essential for improving childhood TB detection and treatment success.

1.6 Contribution by Sector on TB Notification

In 2025, the public sector remained the dominant contributor to TB notification, increasing slightly to 78% from 76% in 2024. This confirms that most TB cases continue to be diagnosed, treated, and reported through public health facilities.

The private sector contribution declined slightly from 15% in 2024 to 14% in 2025. Although the drop is small, it suggests the need to sustain private-sector engagement,

reporting, and linkage mechanisms so that TB cases diagnosed outside the public sector are consistently notified.

The other faith-based sector contribution also reduced slightly, from 7% in 2024 to 6% in 2025. Faith-based facilities remain important partners, especially in areas where they provide substantial health services.

The prisons sector remained stable at 1% in both 2024 and 2025. Although its overall contribution is small, prisons remain a high-risk setting for TB transmission and should continue receiving targeted screening.

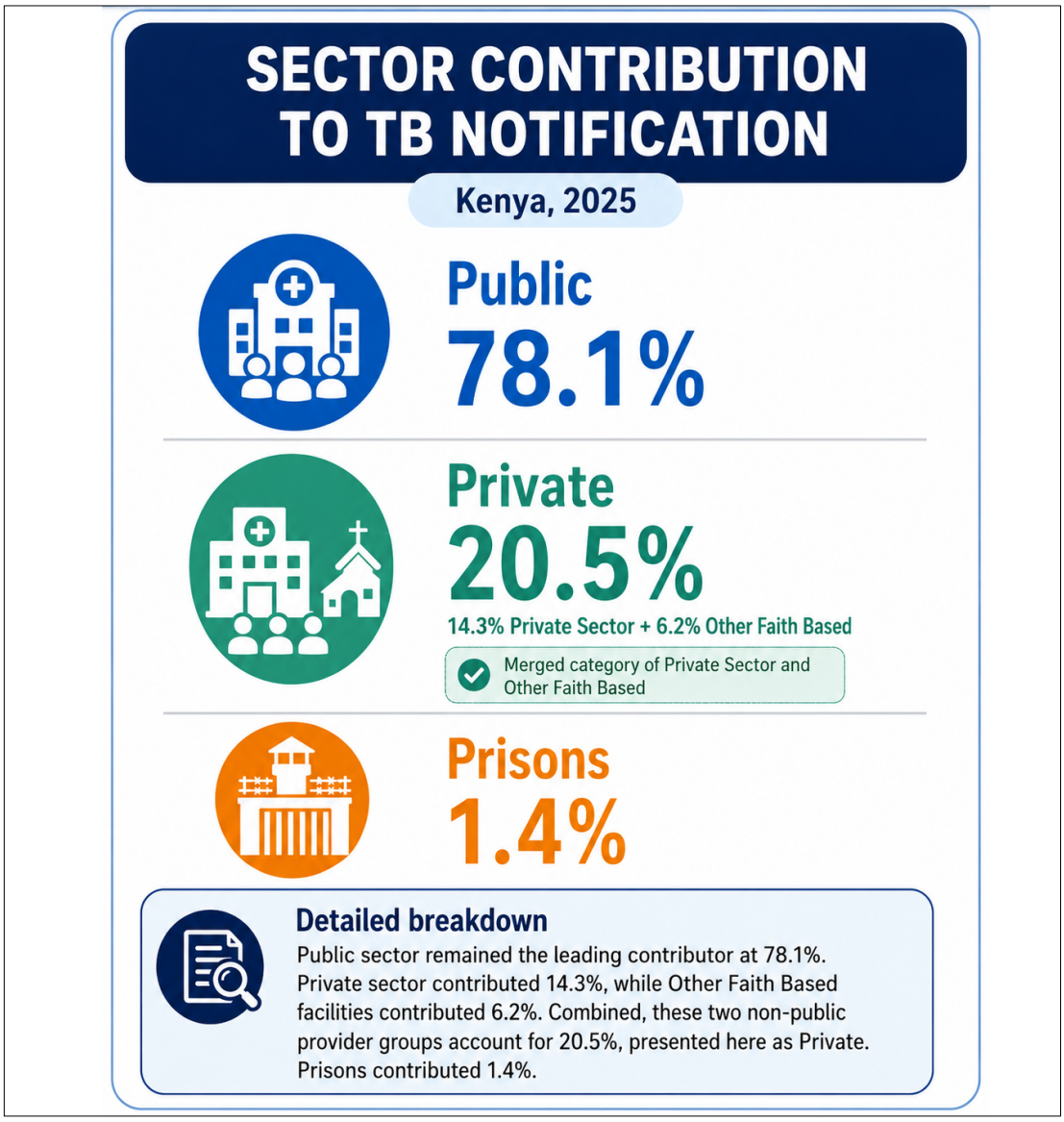

Figure 1.8: Case notification by sector

1.7 Nutritional status and food support among TB patients

The graphic shows that nutritional vulnerability among TB patients is substantial, but food support coverage remains very low.

Out of 90,900 TB patients, 42,836 patients, representing 47.1%, had either Severe Malnutrition or Moderate Malnutrition and were therefore eligible for food support through RUTF or FBF. However, only 5,545 eligible patients received support, giving an overall eligible support coverage of 12.9%. This means 37,291 eligible patients, or 87.1%, did not receive food support.

Among the eligible groups, Severe Malnutrition had the highest support coverage. Overall, 2,966 of 17,196 severely malnourished patients received food support, translating to 17.2% coverage. For Moderate Malnutrition, 2,579 of 25,640 patients received support, giving 10.1% coverage. Although moderate malnutrition had the largest number of eligible patients, its coverage was lower than that of severe malnutrition.

When comparing adults and pediatrics, pediatrics had better food support coverage than adults. Among adults, 38,578 patients were eligible, but only 4,845 received support, giving 12.6% coverage. Among pediatrics, 4,258 were eligible, and 700 received support, giving 16.4% coverage. This suggests that pediatric patients were relatively better prioritized, although coverage was still low.

The graphic also shows that some food support was given to patients outside the eligible nutrition categories. A total of 797 patients with Normal, Overweight, or Obese nutritional status received support, despite not being classified as eligible based on the stated criteria. This may point to either special clinical considerations, documentation issues, or targeting gaps that need review.

Food support coverage by nutritional status, TB patients, 2025. Support refers to RUTF or FBF. All patients with severe malnutrition and moderate malnutrition were eligible for food support.

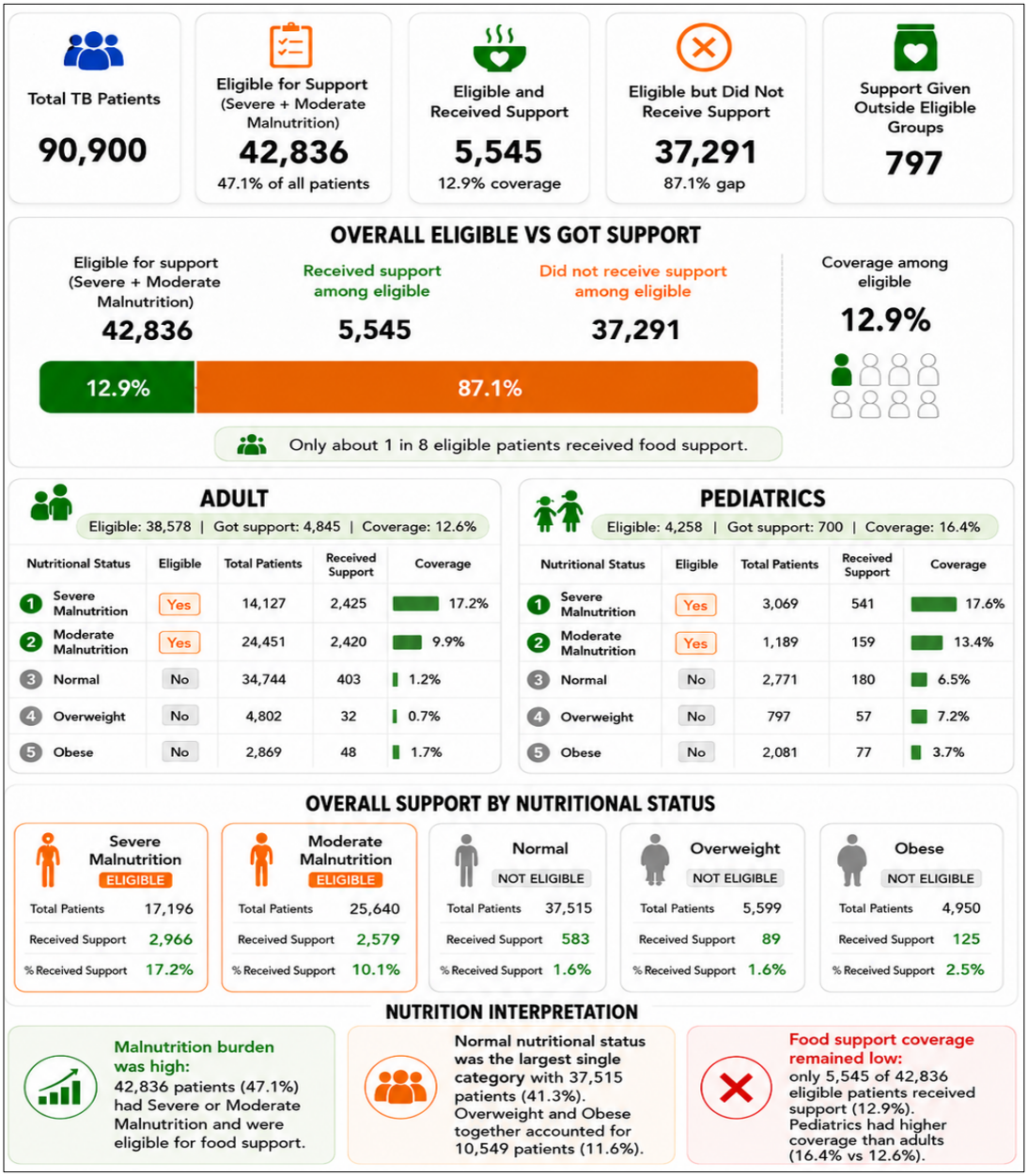

Figure 1.9: Case notification by sector

1.8 TB/HIV

HIV testing among TB patients remained consistently high throughout the six-year period, ranging from 97% to 99%, reaching 99% in 2025. TB/HIV co-infection remained relatively stable at approximately one quarter of all notified TB patients, decreasing slightly to 25% in 2025. ART uptake among co-infected patients remained high at 96%, reflecting

sustained integration of TB and HIV services. Despite these achievements, TB/HIV co-infection continues to contribute substantially to TB morbidity and mortality.

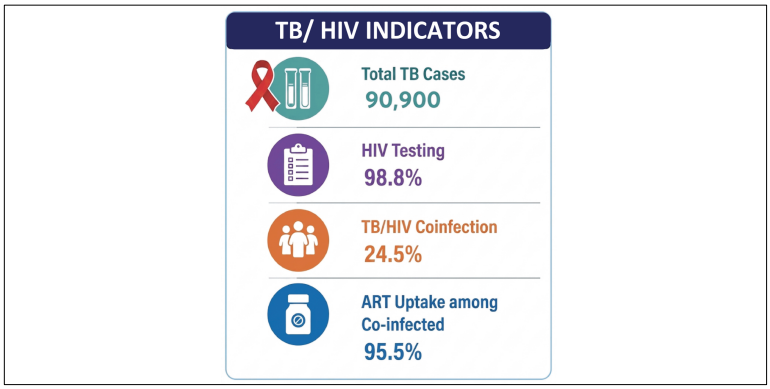

Figure 1.10: TB-HIV co-infection key statistics

1.9 TB prevention

The National TB Program prioritizes populations at increased risk of TB for TB prevention interventions. They include health workers, people in prisons and correctional facilities, people living with HIV, household contacts, miners, refugees, and other congregate settings. A summary of TB prevention performance is illustrated below:

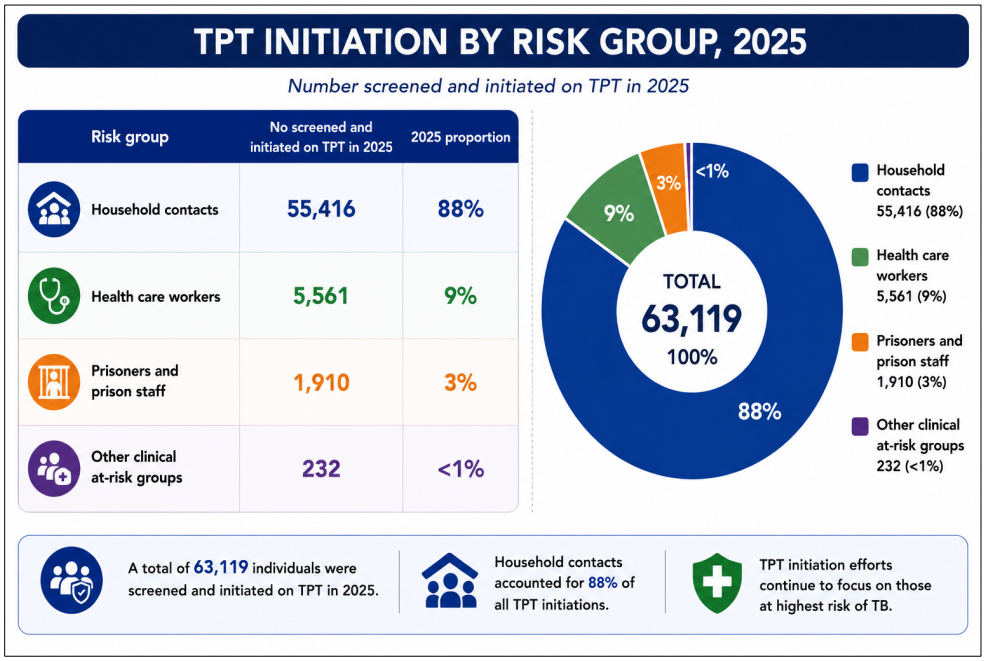

Figure 1.11: TB preventive therapy initiation among different risk groups, 2025

TPT among People Living with HIV (PLHIV)

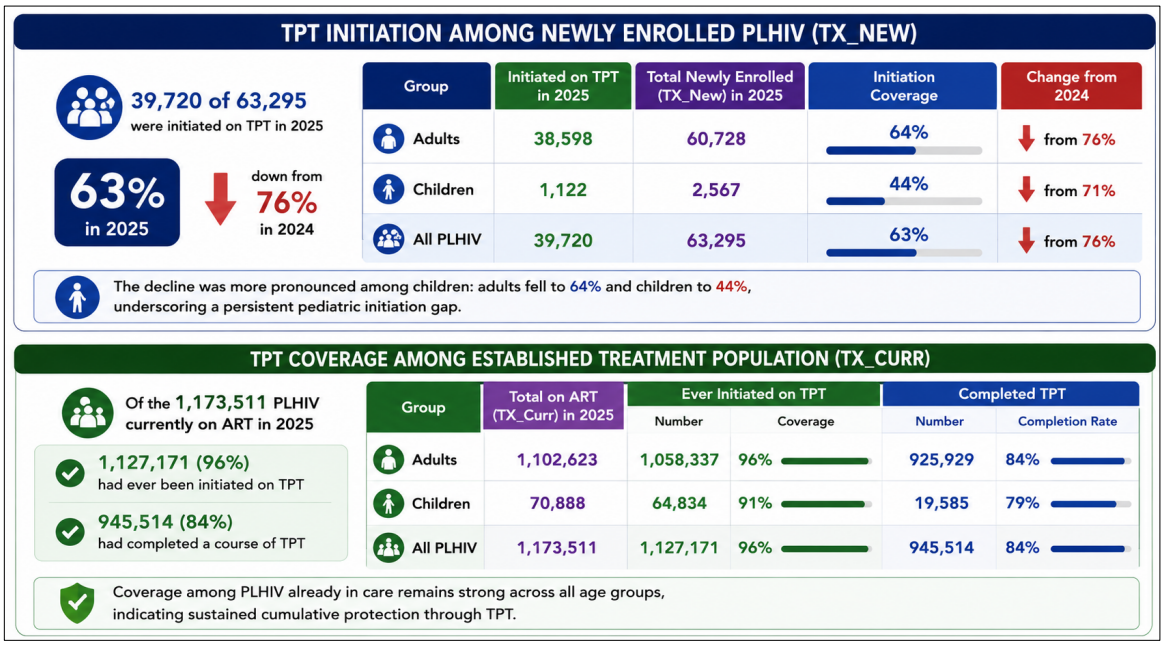

Figure 1.12: TPT among PLHIV, 2025

1.10 TPT among Household Contacts

Household contact investigation remains the cornerstone of TB prevention. In 2025, 78,709 household contacts were listed, representing a contact listing coverage of 52%. Of these, 68,189 (86.6%) were screened for TB disease. A total of 66,095 contacts were eligible for TB preventive treatment (TPT), and 55,416 were initiated on treatment, corresponding to an initiation rate of 84%. These findings demonstrate strong progression through the prevention cascade once contacts are identified, while highlighting the need to improve initial contact listing coverage.

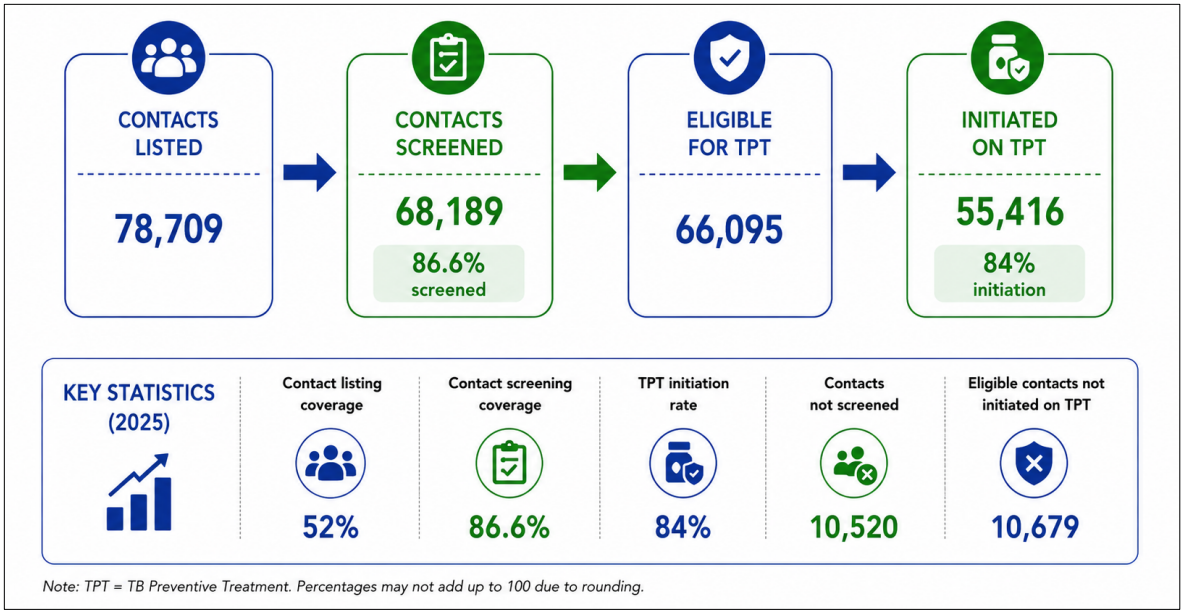

Figure 1.13: TPT among household contacts, 2025

1.11 TB and Co-morbidities

Alcoholism is the most commonly reported comorbidity, with 16,346 cases, representing 8.28% of all records and 66.30% of clients who had at least one comorbidity. This means that among clients with any recorded comorbidity, about 2 out of every 3 had alcoholism.

Smoking is the second most common, with 8,315 cases, accounting for 33.73% among those with comorbidities. The strong presence of both alcoholism and smoking suggests that substance-use-related conditions dominate the comorbidity profile.

Drug and Substance Abuse ranks third, further reinforcing the pattern that behavioral and substance-use risks are the leading comorbidities in this dataset.

Diabetes and hypertension also appear among the top five, with Diabetes at 9.18% and Hypertension at 8.31% among those with any comorbidity. These are important chronic conditions because they can complicate TB management, affect treatment response, and require integrated clinical follow-up.

Comorbidities profile among clients. Alcoholism is the leading reporting comorbidity, followed by smoking and drug and substance abuse.

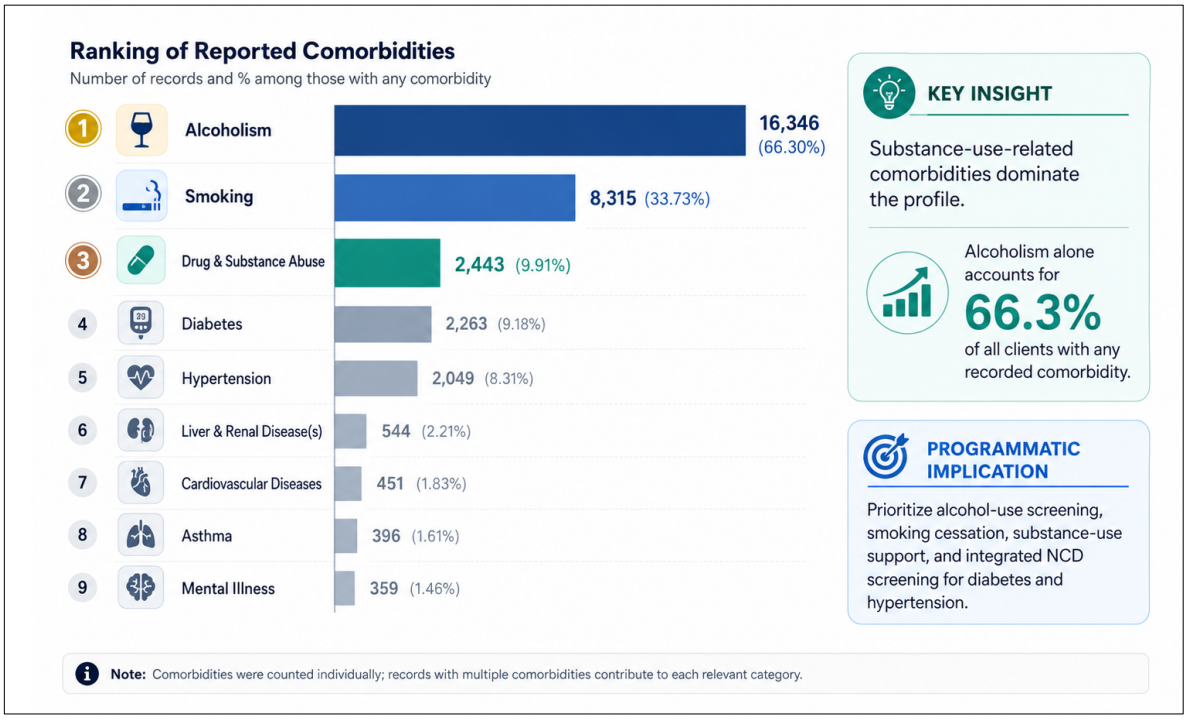

Figure 1.14: TB and co-morbid conditions, 2025

1.12 TB Treatment Outcomes

Nationally, TB treatment outcomes remained favorable across all patient groups in the 2024 cohort. Treatment success was highest among children (94.4%), followed by DSTB patients (89.1%), DRTB patients (86.9%), and people living with HIV (85.7%). Mortality was highest among PLHIV (9.2%) and DRTB patients (7.4%), while loss to follow-up and treatment failure remained low across all cohorts. These findings demonstrate sustained program performance while highlighting the need to further reduce mortality among TB patients living with HIV and those with drug-resistant TB.

TB treatment outcomes 2024 cohort; trends by patient group. Percentage of patients with known treatment outcomes.

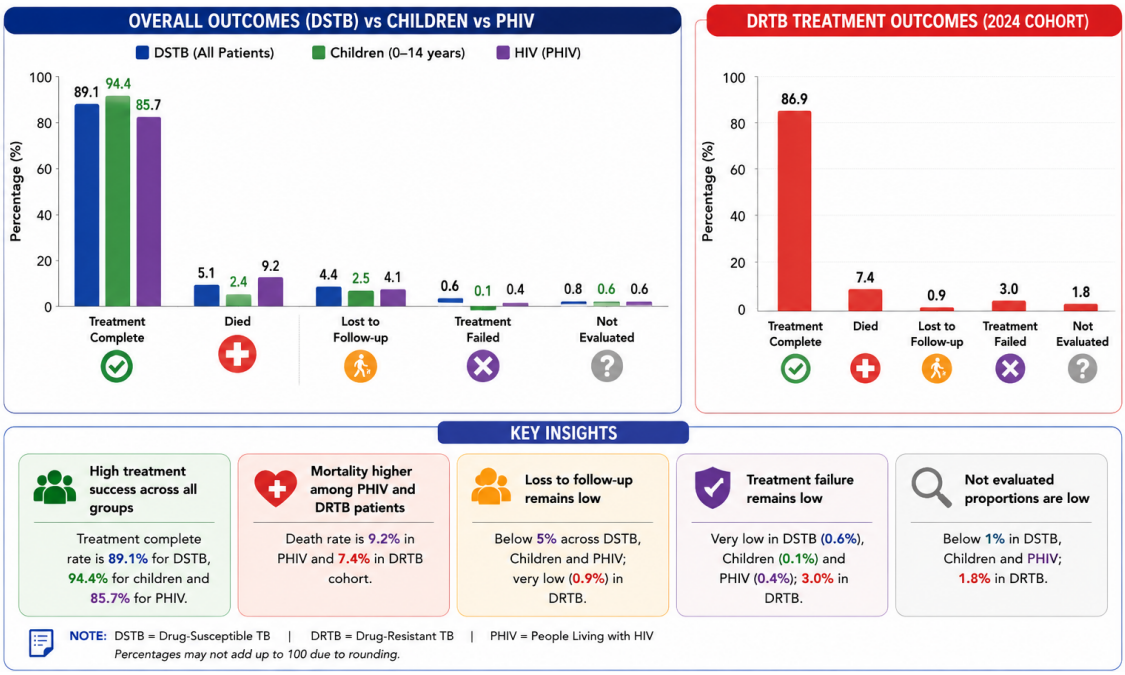

Figure 1.15: Summary of TB treatment outcomes, 2025

b. Leprosy

Kenya reported 70 leprosy cases in 2025 representing a substantial reduction from the previous year. 80% of the cases were multibacillary (MB) leprosy, while only 20% were paucibacillary (PB). This is a key programmatic concern because MB disease is associated with higher bacterial load and may indicate that many patients are being diagnosed late. A high MB proportion also means there is continued potential for transmission if cases are not detected and treated early.

Adults accounted for 96% of cases in 2025, confirming that leprosy continues to be reported mainly among adults. Children accounted for 4%, which is relatively low, but still important. Any child leprosy case is a warning sign because it may reflect recent transmission within households or communities. This reinforces the need for contact screening around confirmed cases.

c. About 60% of patients had disability grade 1 or 2, meaning that more than half of the cases were already presenting with impairment at diagnosis. This strongly suggests late case detection and missed opportunities for earlier identification and treatment.

Leprosy surveillance narrative.

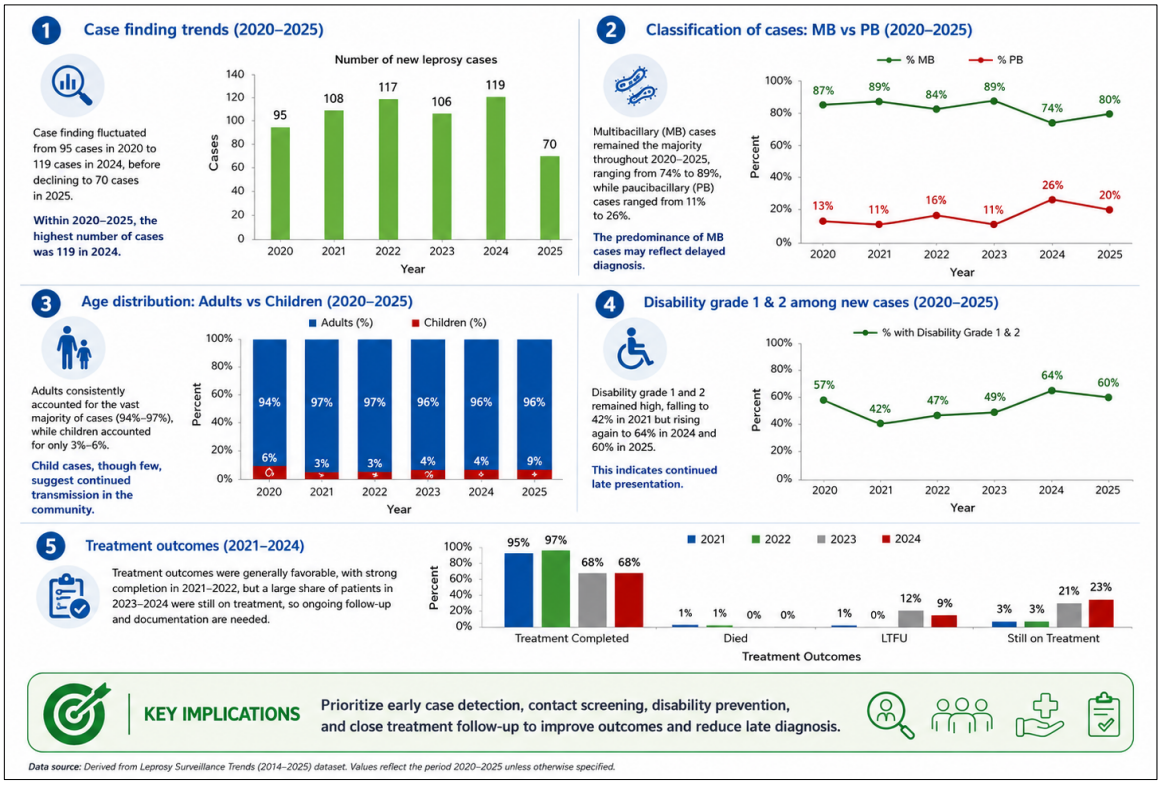

Figure 1.16: Summary of Leprosy data in Kenya, 2025

c. Lung Health

The Lung Health Register was added to the national surveillance system in mid-2025, with user training only covering 4 Counties in the reporting period. As such, the country has reported data from the 4 counties over a few months in 2025. In total, 3,358 patients were reported, with 3,144 adults, representing 93.6% of all patients. Children aged 0–14 years account for only 197 patients, or 5.9%, while 17 records had missing age information.

By age distribution, the highest number of patients were in the 35–44 years age band with 701 patients, followed by 45–54 years with 643 patients. This shows that the main burden is concentrated among middle-aged adults, especially those aged 35–54 years.

Most patients were registered as new patients, accounting for 2,720 patients, or 81.0%. Continuing patients were 638, representing 19.0%. This suggests that the register is mainly capturing new lung health presentations rather than follow-up cases.

Lung health register analysis

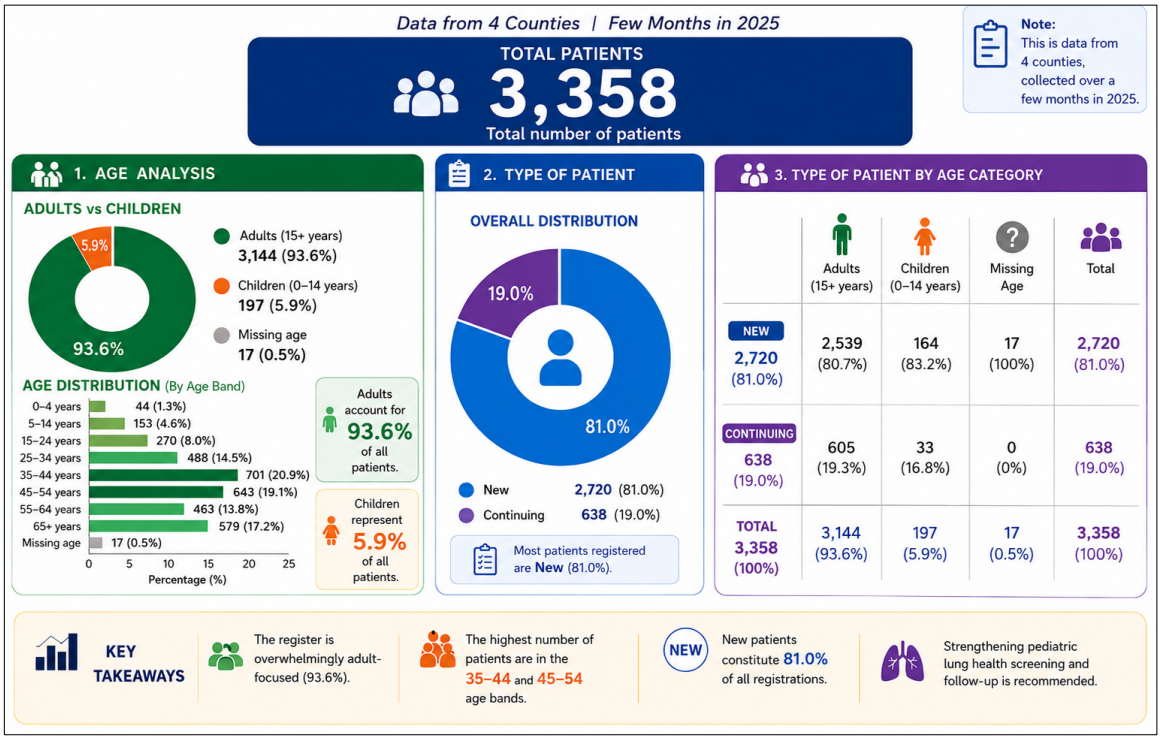

Figure 1.17: Summary of Lung health data reporting, 2025

CHAPTER 2

INTEGRATED STRATEGIES FOR FINDING MISSING PEOPLE WITH TB AND OTHER LUNG CONDITIONS



2.1 Active Case Finding and Screening Strategies

2.1.1 Background information

Active case finding (ACF) for tuberculosis (TB) involves the proactive and systematic identification of individuals with suspected active TB (Presumptive TB) in a predetermined target population. This is achieved through integrated approaches that include symptom screening, comprehensive history taking, physical examination, and appropriate use of radiological and laboratory diagnostic investigations to confirm TB disease. Active case finding is engraved in the National Strategic Plan (NSP) 2023/24–2027/28 where there is continued commitment to deliver patient-centered, high-quality care through evidence-based prioritization and resource allocation across the TB care cascade.

Institutionalization of community-based TB ACF within community health structures was strengthened through capacity building and active engagement of Community Health Promoters (CHPs) and other actors to conduct TB awareness creation, symptom screening, referral and follow up of individuals to facilities for diagnosis and treatment.

At the Health facility ACF ensures universal TB and lung health screening for all individuals presenting at any service delivery point (SDP), ensuring early identification and timely linkage to diagnosis and treatment in both Public and Private facilities.

Recent programmatic developments have strengthened screening strategies by expanding the scope beyond TB to include other lung conditions, promoting a more integrated lung health approach. This includes the scale up of AI-enabled digital chest X-ray (DCXR) technologies, use of C-Reactive Protein and spirometry. These additions, collectively have higher sensitivity in detecting abnormalities suggestive of TB and other respiratory diseases, particularly among populations where symptom-based screening may be less sensitive, such as children and people living with HIV (PLHIV). These innovations are now embedded within the national screening and diagnostic algorithms, enabling early detection, improved triaging, and optimized use of confirmatory tests. The integration of AI-assisted imaging into routine screening not only enhances case detection but also supports overburdened health systems by improving efficiency and standardization in radiological interpretation.

2.1.2 Interventions Implemented to Strengthen Facility ACF

Capacity Building to the Counties

In 2025, the National TB Programme strengthened ACF implementation through integrated training, sensitization, supportive supervision and Technical Assistance focusing on TB and lung health.

Training and Sensitization of Health Care Workers

Integrated training and sensitization on TB and lung health was carried out to enhance HCWs' knowledge and skills on systematic screening. The training and sensitizations covered identification of people with presumptive TB, use of digital chest X-ray with AI-supported CAD, linkage to diagnosis, and management of other respiratory conditions within integrated service delivery models. The training covered 16 counties and a total of 384 HCWs were trained. To ensure ongoing capacity building for HCWs at facility level and 300 Subcounty TB Coordinators were capacity built.

Technical Assistance to Counties

Routine support supervision and mentorship was conducted by the TB coordinators in all the Counties.

National

Technical Assistance (TA) missions were conducted in 42 counties where ACF was assessed as one of the key thematic areas. The missions focused on reviewing implementation of screening practices, documentation and reporting, linkage of presumptive cases to diagnostic services, utilization of screening tools, and integration of TB and lung health services. The TA missions provided an opportunity to identify gaps, offer on-site mentorship, and strengthen the quality and effectiveness of ACF interventions at facility and community levels.

Table 2.1: Facility Active Case Finding Cascade 2022-2025

Indicator	2022		2023		2024		2025	
	n	%	n	%	n	%	n	%
Total Facilities Workload	73,221,107	N/A		N/A	114,513,141		102,940,046	
Respiratory conditions	21,622,286	N/A	24,237,343	N/A	19,996,995	N/A	18,471,032	
Screened for TB	25,253,561	34	32,071,871	32	35,961,338		37,941,918	
Presumptive TB cases identified	812,882	3.2	841,501	3	1,171,802	3.3	945,876	2.5
Presumptive TB cases investigated	502,970	62	509,419	61	587,395	50	566,315	60
Total presumptive cases diagnosed with TB	41,733	8	50,936	10	73,014	12	79,521	14
Presumptive cases clinically diagnosed to have TB	13,331	32	17,182	34	18,642	26	21,005	26
Presumptive cases bacteriologically confirmed to have TB	28,402	68	33,754	66	54,372	74	58,516	74
Confirmed TB cases started on treatment	39,738	95	47,366	93	52,235	72	56,935	76
Presumptive cases referred by CHPs	22,952		27,100		37,726		52,412	

(Data source TIBU and KHIS)

In 2025, the total facility workload was 102,940,046, the respiratory cases were 18,471,032. A total of 37,941,918 (36.9% of the workload) were screened for TB and among them 945,876 (2.5.%) were presumptive (Had TB symptoms) and among them 566,315 (60%) were investigated. From this, a total of 79,521.00 (21,005 clinically diagnosed and 58,516 bacteriologically confirmed) were diagnosed with TB and 56,935 (76%) initiated treatment.

Compared to the previous year, this demonstrates progressive expansion in TB screening and case detection efforts, with notable improvements in identification and confirmation of TB cases over the years as shown in the table above.

This notwithstanding, a myriad of gaps persist as per above data including, suboptimal coverage of screening, low investigation of presumptive TB cases, linkage to treatment and optimization of community-based referrals, underscoring the need for strengthened

diagnostic pathways, patient tracking systems, and targeted interventions to improve the efficiency of the ACF cascade.

Community contribution to case finding improved substantially over the period, with presumptive TB cases referred by Community Health Promoters (CHPs) more than doubling from 22,952 in 2022 to 52,412 in 2025. This reflects increasing community engagement and expanded reach of community-based TB screening interventions.

Use of Artificial Intelligence (AI) Enabled Digital Chest X-ray for TB and other lung Conditions Screening and Diagnosis

In 2025, the country expanded the use of AI enabled digital X-ray with computer-aided detection (CAD) for TB and other lung conditions screening amongst individuals aged 15 years and above, in line with WHO recommendations. CAD uses artificial intelligence (AI) to analyse digital chest X-ray images in real time for radiological chest abnormalities helping with faster diagnosis, prompt initiation to treatment and referral for further evaluation and management. Currently, there are 2 CAD software products in use in the country for TB screening, CAD4TB and Qure qXR.

During the year, a total of 80 AI-enabled ultra-portable digital X-ray units were procured, bringing the cumulative number of AI-enabled CXR solutions deployed nationally to 150. By the end of 2025, the technology was available in all 47 counties, with plans to deploy additional units in subsequent years to strengthen coverage in underserved and high-burden areas.

To support effective rollout and adoption, the Program conducted a series of training workshops targeting all 300 Sub-County TB and Leprosy Coordinators (SCTLCs), who served as sub-county trainers of trainers (TOTs) ensuring the successful rollout and optimal use of the AI-enabled digital X-ray technology in TB screening and diagnosis. Additionally, capacity building was conducted for 235 HCWs including radiologists, radiographers and clinicians drawn from all the 47 counties. The figure below shows the performance of CAD in sites using Qure qXR for TB and lung health screening.

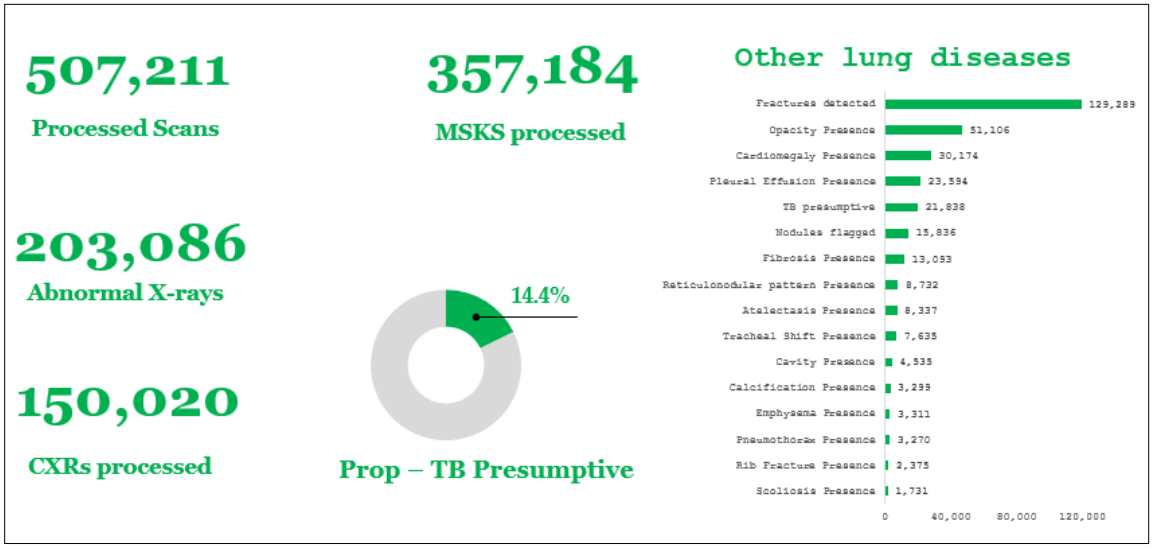

Figure 2.1: Performance of CAD in sites using Qure qXR for TB and lung health screening

In 2025, across the 8 sites using CAD4TB (Mutomo, Rhodes, Mutuati, Madiany, Pandpieri, Jomvu, Kalobeyei, and Mathare North), 43,158 individuals were screened using CXR-CAD. Of these, 3,439 (8.0%) returned a positive screening outcome with CAD score above 60, triggering further investigation. A total of 9,104 individuals were investigated, yielding 1,154 bacteriologically confirmed cases and 673 clinically diagnosed cases; a combined 1,827 TB cases detected.

Rhodes and Mathare North were the highest-volume sites, screening 8,983 and 6,070 individuals respectively. Kalobeyei consistently had high CAD60+ positivity rates across all quarters. Mutuati and Jomvu had more modest screening volumes.

MWRD (molecular/rapid diagnostic) utilization remained high across the year, typically above 95% in most quarters and sites, reflecting strong adherence to the guidelines.

Among those who screened positive for tuberculosis on CAD analysis, bacteriological confirmation rates ranged between 30 and 37%, yields significantly higher than those achieved by symptom screening alone (~ 5%), reducing the number of confirmatory tests needed per case detected.

Other sites

Contact Management

The NTP in collaboration with implementing partners, implemented a comprehensive contact management strategy across all the 47 counties. It involved line listing of contacts, TB screening, Laboratory testing for those with symptoms, initiation of TB treatment and TB Preventive Therapy (TPT). This was carried out through two processes; Contact invitation and contact tracing.

Contact invitation was carried out by the HCWs who invited all the contacts to the health facilities where health education, TB screening and linkage to subsequent care was provided.

Contact tracing was carried out by Community Health Promoters (CHPs) who visited the households of bacteriologically confirmed TB patients as well as households with children under five years diagnosed with any form of TB. During these visits, CHPs provided health education before systematically screening all the household members. All contacts were promptly referred to the health facility for further evaluation for TB and TPT initiation to reduce their risk of developing active disease.

In 2025, a total of 50,516 bacteriologically confirmed TB patients were notified and among them 22,376 had their contact line listed in the contact management. From these index patients 78,709 contacts were listed and 68,189 screened for TB with 2,018 being diagnosed for TB and 55,416 started on TB Preventive therapy (TPT)

Targeted TB Screening Outreaches

NTLD-P and implementing partners conducted targeted TB screening outreaches in different counties for early TB detection among populations at high risk of TB. Screening was done through a combination of symptom screening and use of ultra-portable AI-enabled digital chest x-ray where they were available to increase the yield. The table below shows the TB cascade of care for different populations in 2025.

Table 2.2: TB cascade of care for different populations in 2025

Cascade Indicator	2024 (Q3-Q4)*	2025 (Full Year)
Total Screened	**545**	**57,568**
Symptomatic (Presumptive)	250 (45.9%)	27,879 (48.4%)
X-rays Done	158 (29.0%)	23,365 (40.6%)
Abnormal suggestive of TB	43	2,986
Tested (Laboratory)	251 (46.1%)	22,939 (39.8%)
Diagnosed (TB)	**7**	**1,188**
Bacteriologically Confirmed	5	405
Clinically Diagnosed	2	783
Diagnostic Yield	**1.3%**	**2.1%**

NTP conducted a lung health outreach in Nairobi, Nakuru and Murang'a, individuals with abnormal CXR suggestive of non-TB lung conditions underwent spirometry with 40% showing obstructive features, 7% restrictive, and 5% being inconclusive due to difficulties performing the test. The integrated outreaches identified and initiated treatment for 329 TB, 163 Asthma, 126 COPD, and 54 PTLD cases, highlighting the need for an integrated lung health approach.

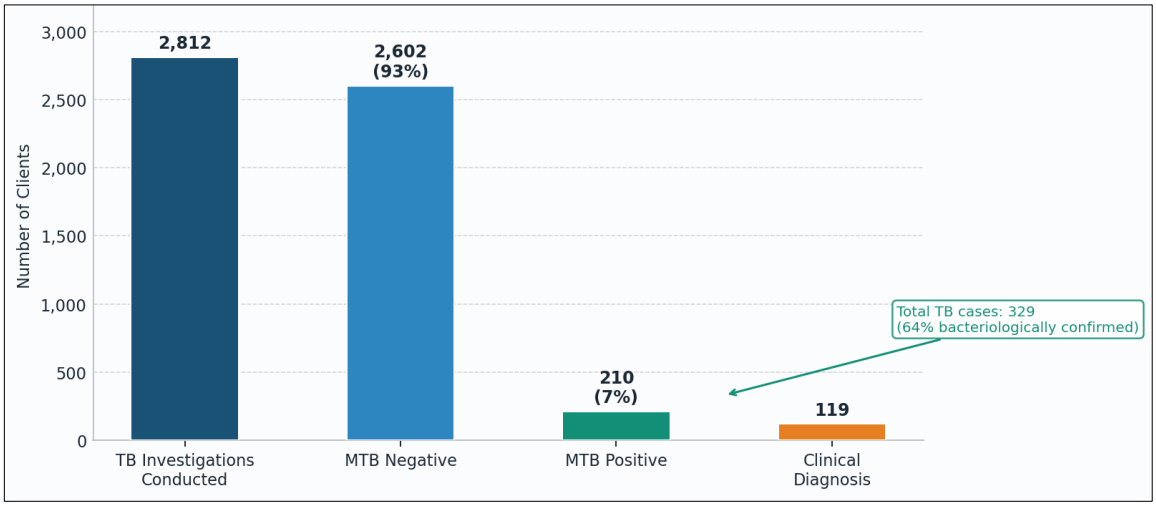

Figure 2.2: TB investigation outcomes

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Spirometry test cascade

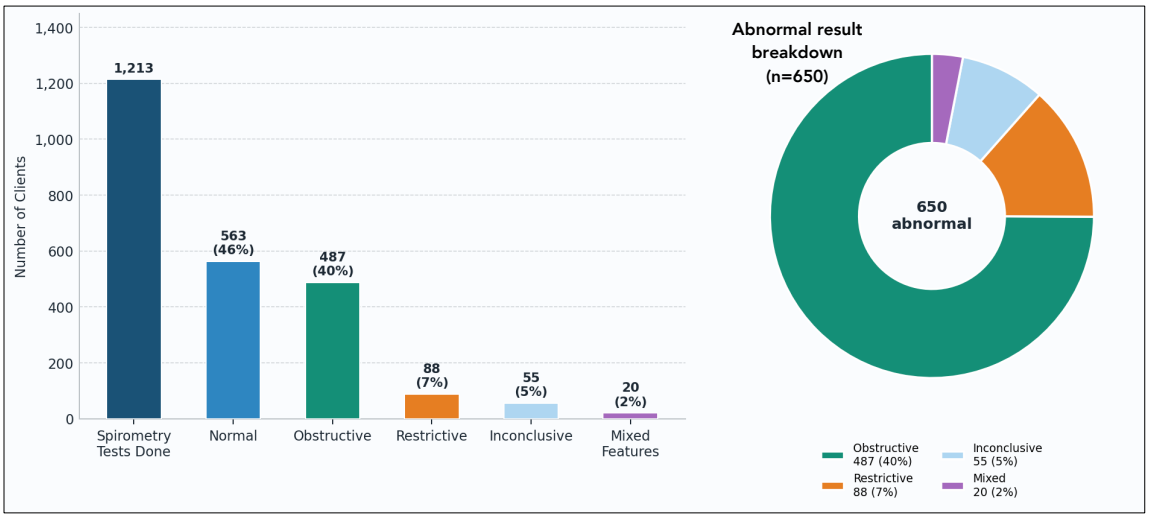


Figure 2.3: Spirometry test cascade

During World TB Day 2025, CHAI also supported counties with demand-generation materials and outreach activities, strengthening awareness and community engagement around TB and lung health.

Support to Linkage Assistants

To strengthen referral and linkages within the health Facilities, a total of 317 Linkage Assistants (LAs) were deployed across 33 counties in public and private health facilities. The aim was to strengthen active case finding, improve laboratory-clinical interface and enhance facility community linkages. In addition, NTP in collaboration with the county teams provided routine supportive supervision and data driven mentorship to strengthen their performance and service delivery.

2.2 KIC TB Mainstreaming Intervention

The following Kenya Innovations Challenge for Tuberculosis (KIC TB) interventions were implemented in 2025 to find missing people with TB in the community;

- TB screening stations were set up along the routes where people from informal urban settlements pass. These stations were manned by CHPs and TB Champions who

provided information on TB, screened people for TB and referred those with TB symptoms for further evaluation and testing.. This was implemented in Kisumu, Mombasa, Nairobi, Nakuru

- **TB Screening and Sputum collection for Truck drivers, transport Corridor community and Mobile population**. This was implemented in Busia, Machakos, Makueni, Mombasa, Nakuru, Taita Taveta, Uasin Gishu.
- Through these interventions, a total of 15, 624 people were screened for TB, 2,210 presumptive identified and 1,810 (84%) tested and 180 diagnosed and 162 (90%) initiated on treatment.

2.3 Public Private Mix (PPM)

Kenya made progress in strengthening public–private partnerships for tuberculosis and lung health. This was done through the continued implementation of the PPM strategy. Overall, PPM interventions were implemented across 28 counties, expanding the role of private and non-state health service providers in TB prevention, detection, treatment, and care. Implementation focused majorly on 4 of the 5 recognised PPM models in Kenya including, Private Sector, Chemist/Pharmacy, Diagnostic (Stand-alone Laboratory and Radiology centers) and workplaces.

The implemented interventions focused on expanding access to quality TB services in private healthcare facilities, workplaces, and learning institutions. The aim was to integrate ACF into routine service delivery; improving the quality of TB care; and strengthening TB surveillance, reporting, and coordination systems in line with NTP priorities. These strategic collaborations contributed to improved TB case detection, timely treatment initiation, improved reporting from the private sector, and stronger coordination of TB control efforts across the participating counties.

2.3.1 Interventions Implemented

The following interventions were implemented:

- **Engagement of the private facilities:** Private health facilities were engaged to offer TB services through signing of MOUs. A total of 945 facilities were engaged in the year.
- **Sensitization of HCWs from the Private Sector:** A total of 506 clinicians and nurses were sensitized on TB and 479 laboratory staff sensitized on TB laboratory diagnosis. Additionally, virtual CMEs sessions were carried out where different pertinent topics

were discussed to improve performance of TB services in the private sector. About 8,000 Health Care Workers were reached through the CMEs.

- **Support for motor bike riders to strengthen sample networking:** A total of 62 riders were supported and routinely transported samples from the private facilities in the 28 counties.
- **Technical support:** Routine technical support was provided by the project officers engaged by the SRs. A quarterly joint support supervision was carried out by the County and the implementing organization.
- Technical Working Group meetings were supported in all the 20 **counties.**

2.3.2 Case notification in Private sector:

During the year, service delivery continued to be predominantly driven by the public sector, which reported 70,858 of the total 90,878 people notified with TB nationwide. This shows that public systems remain central in ensuring essential services and fair access across counties. The private sector, comprising private facilities, Faith-Based Organizations (FBOs), and other providers, accounted for 21% of notifications. Their role is important in extending reach, improving responsiveness, and supporting service continuity in different settings.

Trends in total notifications and the private sector's contribution over four years (2022–2025)

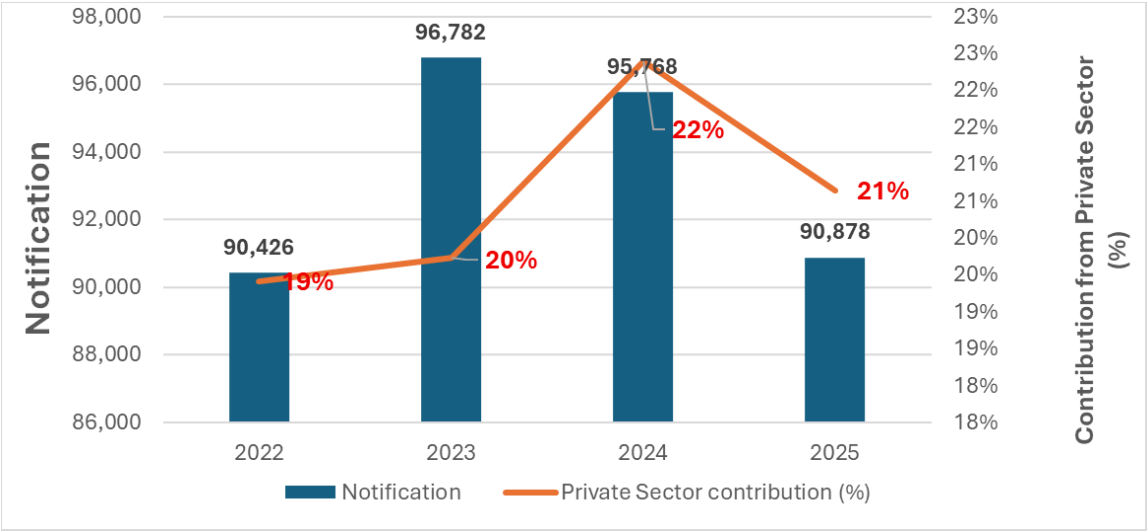


Figure 2.4: The figure shows trends in total notifications and the private sector's contribution over four years (2022–2025).

FBOs contributed 5,713 beneficiaries, representing approximately 30% of total PPM output. This demonstrates the continued relevance of FBOs as a core pillar of private sector engagement, particularly in areas where public provision alone may be insufficient. They remain uniquely positioned due to their deep community embeddedness, trust, and long-standing presence in underserved and hard-to-reach areas, making them critical partners in advancing inclusive and people-centered service delivery. The contribution of FBOs in 2025 was highly heterogeneous across counties, revealing both areas of strong reliance and zones of limited or absent engagement:

- Four counties (Baringo, Elgeyo Marakwet, West Pokot, and Makueni), recorded over 75% of PPM contribution from FBOs, indicating that faith-based providers were the primary service delivery channel in these settings.
- Seven counties (Kiambu, Tharaka Nithi, Kericho, Narok, Taita Taveta, Lamu, and Baringo), reported moderate to high reliance (50–75%) on FBOs, reflecting strong public-FBO complementarities.
- Eighteen counties recorded intermediate contribution levels (25–75%), suggesting diversified service delivery models with shared roles between public, private, and faith-based actors.
- Conversely, 28 counties registered less than 25% FBO contribution, including nine counties with no recorded FBO service delivery, signalling geographic inequities in faith-based engagement and untapped partnership opportunities.

TB Treatment outcomes for the 2024 cohort in the private sector:

In 2024, the private sectors achieved a treatment success rate of 91% (19,420 out of 21,451) which is slightly higher than the country's average TSR of 89%.

2.2.3 PPM Achievements

Quality of Care (QoC) was prioritized through 35 meetings, with five counties achieving 100% of planned sessions. The FAST Strategy was rolled out in 20 high-volume private facilities, complemented by quarterly joint support supervision across all counties. These measures improved adherence to national TB guidelines, strengthened clinical governance, and enhanced linkage from screening to diagnosis and treatment, resulting in better treatment outcomes and continuity of care.

Strengthened Diagnostic and Referral Systems

A robust diagnostic network was established, with 62 motorbike riders supporting sputum transport and 762 private facilities linked to GeneXpert and molecular diagnostic platforms. Integration of digital chest X-ray technology in both facility and outreach settings reduced turnaround times, improved access to quality-assured diagnostics, and enabled earlier treatment initiation, thereby lowering transmission risks.

Strengthened Human Resource Capacity

Capacity-building reached unprecedented levels, with 506 clinicians and nurses, 479 laboratory personnel, and 1,514 healthcare workers trained through structured approaches. Approximately 8,000 workers were reached via virtual CMEs, while 387 were oriented on the FAST Strategy and 432 engaged through quarterly national training. These efforts improved knowledge, competencies, and service delivery capacity, ensuring sustainability despite high staff turnover.

Strengthened TB Surveillance, Monitoring, and Use of Data

Data systems were reinforced, with 255 private facilities actively reporting through TIBU and Tibu Lite. Routine data reviews were embedded in QoC meetings and TWGs, complemented by annual county and national review sessions. This improved completeness, timeliness, and visibility of private sector TB data, enabling stronger evidence-based decision-making and enhancing national surveillance.

Strengthened Coordination, Partnership, and Governance

Collaboration was deepened through quarterly PPM and diagnostic TWG meetings in all counties, four county-level annual experience-sharing forums with 248 private providers, and three national TWG meetings. The National TB and Lung Health Symposium was convened, and expert representation supported at KAP, KPA, and KCOG conferences. These efforts improved coordination, disseminated best practices, and reinforced the institutionalization and sustainability of PPM within the national TB response.

2.4 Treatment Adherence and treatment Interrupters Tracing

Adherence to TB treatment is key to achievement of good treatment outcomes and prevent community transmission. To support the patients adhere to treatment the following interventions were carried out in all the 47 counties.

d. **Facility based patients support:** To provide psychosocial support during TB treatment support group meetings were supported at the facility level. These provided a forum for patients to share their experiences, receive peer support and strengthen treatment adherence and psychosocial well being. A total of 2,332 support group meetings were held in the year across all the 47 counties.
e. **Community based patient centered care**: During the reporting period, NTP strengthened community patient centred care in 16 counties by identifying 1,235 TB patients with specific vulnerabilities for targeted home based follow up. Of these, 180 patients were assigned to 95 sensitized CHPs for daily follow ups and adherence support using a standardized checklist.
f. **Provision of airtime to HCWs** in all TB treatment facilities to call patients who missed scheduled treatment appointments.
g. **Physical tracing of patients who interrupted treatment** - The CHPs were supported to carry out physical tracing of patients who missed scheduled treatment appointments and could not be reached on phone. A total of 3,997 people who interrupted treatment were physically traced by the CHPs and 3,130 (78%) were successfully returned to treatment.

CHAPTER 3

TUBERCULOSIS AND COMORBIDITIES



3.1 TB/HIV

TB and HIV epidemics are closely linked, with HIV increasing the risk of progression to active TB disease, while TB remains a leading cause of morbidity and mortality among people living with HIV (PLHIV). Significant progress has been made in strengthening TB/HIV collaboration through improved policies and guidelines, expanded universal HIV testing, antiretroviral therapy (ART) coverage, and cotrimoxazole preventive therapy (CPT) among eligible TB patients.

HIV testing among TB patients

In 2025, Kenya sustained high HIV testing coverage among notified TB cases, achieving an overall rate of 99%, consistent with 2024. 12 counties recorded 100% HIV testing uptake while 6 counties performed below 95%.

TB/HIV coinfection and ART uptake

The national TB/HIV co-infection rate stood at 25% in 2025, a decline from 26% in 2023, and this varied across the regions. The Lake Victoria and western counties carried the heaviest burden in TB/HIV coinfection rates, these counties require intensified collaborative interventions such as integrated service delivery and community outreach. A total of 5 counties recorded lowest coinfection rates. ART uptake among co-infected patients declined to 96% in 2025 from 98% in 2024.

TB/HIV treatment outcomes

In the 2024 cohort, the treatment success rate among TB/HIV coinfected patients (TSR) was 86% against the national target of 92%. The cure rate stood at 73%, with a death rate of 9% and loss to follow-up (LTFU) at 4%. Outcomes varied widely across regions. Mortality was particularly high in specific counties, reaching up to 21%, attributed to late presentation or co-morbidities that require earlier diagnosis and closer clinical review. High lost to follow up rates was evident in regions with mobile populations highlighting the need for differentiated community-based adherence support to ensure treatment continuity.

TB/HIV supported activities

In the year 2025, the following national and county-level TB/HIV coordination activities were carried out:

Planning, Policy, and Guidelines Development

Joint TB/HIV Work Planning

The NTP and NASCOP convened an annual joint workplan meeting for 2025/2026. The meeting strengthened collaboration across service delivery pillars, coordination, commodities, strategic information, diagnostics, and quality of care, resulting in harmonized work plans, unified commodity management, shared data protocols, and commitments to joint supervision, integrated M&E, and quarterly reviews through Centers of Excellence.

Joint development of guidelines

The national TB program and NASCOP, jointly developed and revised integrated national guidelines to strengthen TB, HIV, and comorbidity care. This effort resulted in development of updated differentiated service delivery (DSD) guidelines, integrated TB-comorbidity policies with practical screening tools, TB sections within HIV/STI/Hepatitis guidelines, and HIV component, Lung Health guidelines, Advanced HIV Disease (AHD) and opportunistic infection manuals. The initiative reflects Kenya's commitment to harmonizing responses to overlapping health challenges by embedding integration into routine practice, ensuring equitable, patient-centered, and evidence-based care across all counties.

Finalization and validation of the Kenya TB Acceleration Plan (K-TAP)



Kenya finalized and validated the TB/HIV Acceleration Plan (K-TAP) policy document 2025–2030 with support from NTP and NASCOP. The plan focuses on advancing TB case detection and reducing mortality among people living with HIV (PLHIV).It outlines strategies to strengthen TB/HIV program coordination, accelerate case finding, improve care and prevention quality, ensure commodity security, enhance laboratory diagnostics, and reinforce health systems and strategic information, marking a comprehensive roadmap to combat TB and HIV more effectively. The plan implementation is expected to contribute to finding 156,912 TB cases among PLHIV by 2030 and achieve the UNHLM targets for TPT, significantly improving TB treatment coverage and outcomes, and ultimately supporting Kenya's efforts to end TB and AIDS as public health concerns.

Coordination

TB/HIV&TPT Quarterly Committee of Experts (CoE) Meetings

In 2025, the National Tuberculosis Program and NASCOP held three TB/HIV Committee of Experts quarterly meetings to review progress, share innovations, and address challenges in TB/HIV co-infection management. The forums emphasized improving TB/HIV indicators, scaling up TPT, and strengthening multisectoral collaboration for integrated, patient-centered care. Key resolutions included nationwide adoption of pediatric 3HP regimens in line with WHO 2024 guidelines. Additionally, the revised TB screening algorithm incorporated chest X-ray and C-reactive protein for PLHIV with advanced HIV disease. These steps, alongside digital innovations, nutrition support, and improved documentation, reaffirmed the country's commitment to reducing TB/HIV co-infection and enhancing treatment outcomes.

Capacity-Building and mentorship initiatives

TB/HIV Advanced HIV Disease Management (AHD) Virtual Webinars

In 2025, the National TB Program and NASCOP, conducted a series of AHD virtual webinars through regional HIV Technical Working Groups across seven counties. These

sessions strengthened the clinical capacity of frontline healthcare workers by focusing on HIV-associated TB management, handling complications of advanced HIV disease, and integrating revised national guidelines into practice. The webinars provided a platform for experience-sharing, clarifying complex cases, and building confidence in delivering integrated, patient-centered care. By embedding training within regional technical working groups (RTWG's) the initiative ensured sustainability and system-wide impact, ultimately engaging 1,257 healthcare workers across Nairobi/Kajiado, Mlima Kenya, Bonde la Ufa, Mashariki, Lakati, Nyawest, Pwani, and South Rift.

TB/HIV Technical Assistance Visits





In 2025, the National TB Program and NASCOP conducted a series of technical assistance visits across eleven counties with high TB/HIV co-infection and mortality rates. These joint supervision visits aimed to strengthen TB/HIV service integration at facility and county levels by building the capacity of CHMTs and SCHMTs, enhancing AHD management, and improving data use for program decisions. Activities included on-site coaching, mentorship, external quality assurance for diagnostics, and sharing best practices to foster cross-learning. A total of 11 counties benefitted with expected outcomes of improved service quality, diagnostic accuracy, stronger county health systems, and better alignment with national TB/HIV integration strategies. This effort focused specifically on screening among PLHIV using chest X-ray.

3.2 Other Comorbidities

TB patients often present with other comorbidities such as diabetes, chronic kidney and liver disease, asthma, COPD, malnutrition, substance use disorders, and cardiovascular conditions, all of which can affect disease progression and treatment outcomes. Effective management requires an integrated, patient-centered approach with bi-directional

screening, timely diagnosis, and linkage to comprehensive care. In 2025, treatment success was highest among patients with smoking history (83%), alcoholism (80%), and asthma (80%), though high loss to follow-up rates were seen in asthma, COPD, and drug abuse cases (12% each). Mortality was most pronounced among TB patients with cancer (50%), liver disease (45%), and cardiovascular conditions (35%), underscoring the need for stronger clinical management and early detection of high-risk groups.

3.3 TB Prevention

TB Preventive Therapy/Tuberculosis Infection (TBI)

TB Preventive Therapy (TPT) prevents progression from TB infection to active disease and is a central pillar of the WHO End TB Strategy. It targets people living with HIV (PLHIV), household contacts of pulmonary TB cases, and other high-risk groups including health care workers, prisoners, and people with clinical vulnerabilities. Kenya offers 6H, 3RH, and the shorter 3HP regimen, with the continued shift toward shorter regimens supporting better adherence and completion.

In 2025, the uptake of TPT across these priority groups is detailed in Table 1 below. Kenya has adopted shorter TPT regimens to meet diverse patient needs, including 6 months of Isoniazid (6H), 3 months of Isoniazid and Rifampicin (3RH), and the shorter 3-month regimen of Isoniazid and Rifapentine (3HP). The increased use of shorter regimens, particularly among adults, has been instrumental in improving adherence and completion rates.

Table 3.1: Overall status of progress

TPT indication	2025	2025 proportion
Household contacts	55,416	88%
Health care workers	5,561	9%
Prisoners and prison staff	1,910	3%
Other clinical at-risk groups	232	<1%
Total	63,119	100%

a. Household contacts

In 2025, a total of 50,516 bacteriologically confirmed pulmonary TB cases were notified, of which 22,376 (44%) were line-listed for contact management, a marked improvement from 21% in 2024. These index cases yielded 78,709 contacts listed against 151,548 expected, representing 52% contact-listing coverage. Of the listed contacts, 68,189 (87%) were screened symptomatically for TB disease; 57,727 (85%) were asymptomatic, while 10,462 (15%) presented with TB symptoms. Further investigation of the symptomatic contacts led to the diagnosis of 2,018 TB cases. The asymptomatic contacts formed the target population for Tuberculosis Preventive Therapy (TPT). Of the 66,095 eligible contacts, 55,416 (84%) were initiated on TPT:

1. 37,460 on 3HP
2. 16,846 on 3RH
3. 672 on 6H

For the TPT outcomes, 64,112 (95%) of those initiated had completed their course at the time of reporting. Unfavorable outcomes were minimal, discontinuation and loss to follow-up each below 0.6% and 0.04% not yet evaluated.

b. Health care workers

A total of 5,595 health care workers were screened for TB and notified in TIBU in 2025. Of these, 5,351 (96%) were asymptomatic while 244 (4%) were symptomatic and investigations conducted. A total of 392 HCW were diagnosed with TB in 2025.A total of 5, 5484 were initiated on TPT initiated (3HP)

c. Other risk groups (prisoners, prison staff, and other clinical groups)

In 2025, 1,910 prisoners and prison staff were initiated on TPT, a 49% increase from 1,282 in 2024. Of these, 1,354 (71%) had completed therapy.

Other clinical risk groups accounted for 232 initiations, an increase of 59% from 146 initiated in 2024, of whom 153 (66%) had completed. Both groups were initiated predominantly on 3HP.

d. People Living with HIV (PLHIV)

Among newly enrolled PLHIV (TX New), 39,720 of 63,295 (63%) were initiated on TPT in 2025, down from 76% in 2024. The decline was higher among children: adults dropped to 64% (38,598 of 60,728) and children to 44% (1,122 of 2,567), underscoring a persistent pediatric initiation gap.

Coverage among the established treatment population remained strong. Of the 1,173,511 PLHIV currently on ART (TX_Curr) in 2025, 1,127,171 (96%) had ever been initiated on TPT, and 945,514 had completed a course (84% completion). This held across age groups; adults had 96% ever initiated and 84% completion, and children had 91% ever initiated and 79% completion, indicating sustained cumulative coverage among PLHIV already in care.

TB prevention supported activities in 2025

The country's TPT uptake across at-risk populations has been improving gradually; however, this progress remains far from the United Nations High-Level Meeting (UNHLM) target of 90% coverage among PLHIV and contacts by 2027. Kenya aligned with this commitment and set targets to increase TB preventive treatment coverage among eligible populations from 32% in 2021 to 80% by 2028 and to increase TPT coverage among PLHIV from 69% in 2021 to 95% by 2028. In 2025, there were several initiatives to scale up TPT uptake among at-risk groups. In the reporting period, the following national and county-level TB/HIV coordination activities were carried out:

3.4 Planning, Policy and Guidelines Development

Adoption of Pediatric Shorter-Term TPT Regimens (3HP)

The adoption of pediatric 3HP regimens in 2025 marked a major step toward improving TB preventive therapy, offering a shorter and more convenient alternative to 6H and 3RH with better adherence and comparable protection for all eligible children regardless of HIV status. The regimen was endorsed for inclusion in the national TB/HIV pediatric framework, advancing regulatory and programmatic readiness. Members of the Committee of Experts participated in guideline review workshops to update TB screening and diagnostic algorithms, aligning them with WHO guidance.

Coordination

TPT scale up and Commodity Utilization Review Meetings

In 2025, the National TB Program launched Rapid Results Initiative (RRI) to boost Tuberculosis Preventive Treatment (TPT) uptake and improve commodity use, aiming to

increase household contact initiation rates from 38% to 43%. Virtual peer-to-peer review meetings with county and sub-county TB coordinators and pharmacists were held bi-monthly, achieving 93% participation by September. These sessions drove best practices such as engaging Community Health Promoters and weekly county data reviews, resulting in an increase in household contact initiations rates.

Capacity-Building and mentorship initiatives

Healthcare Worker TPT Sensitizations

To address the suboptimal TPT initiation rates in specific sub-counties, the National Tuberculosis program supported Continuous Medical Education (CME) sessions. These sessions targeted 22 sub-counties with suboptimal TPT performance. Sensitization efforts in 2025 strengthened TB contact management through one-day sub-county sessions that trained 1,780 healthcare workers in screening, documentation, and reporting. To support pediatric 3HP rollout, the program trained 134 national and county officers as Tots, including pharmacists and HIV/TB coordinators. Virtual health care worker sessions were conducted across 47 counties to prepare for adoption of new regimens (3HP and 6LFX) in 2026, focusing on eligibility, drug administration, adherence counselling, adverse reaction management, and documentation.

Community as the Bridge; Community health actors' sensitization, virtual sensitization session for community health actors was conducted. The sessions focused on understanding TB Preventive Therapy, adherence, follow up to treatment, and its critical role in community-led TB elimination efforts, primarily through advocacy and demand creation.

Infection Prevention and Control Measures.

Effective infection prevention and control (IPC) measures are essential for safeguarding public health and ensuring the safety of patients, healthcare workers, and communities. These practices aim to reduce the risk of transmission of infectious agents by promoting hygiene, implementing protective protocols, and maintaining safe environments in both clinical and non-clinical settings. In 2025, NTP incorporated IPC supervisions during the integrated technical assistant visits. Development of IPC framework, health facilities IPC assessments and HCW sensitization is planned for 2026.

CHAPTER 4

SOCIAL SUPPORT AND NUTRITION



4.1 Social Support for patients with DR-TB, January-November 2025

The National Tuberculosis Program (NTP) has instituted cash transfer support to reduce catastrophic costs among drug-resistant TB (DR-TB) patients. Under this program, patients on treatment receive Ksh 300 per day, while healthcare workers delivering community-based directly observed therapy (DOT) receive Ksh 200 per day for transport.

Between January and November 2025, a total of 1,373 (85%) of the 1,612 eligible DR-TB patients and 1,126 DOT workers were supported, with monthly averages of 651 patients and 533 DOT workers, respectively. Program targets anticipated coverage of at least 860 patients per month between January and June 2025 and 727 patients per month between July and December 2025, with expected 50% uptake of community-based care. However, actual coverage of DR-TB patients under social support ranged between 80% and 85% during the period, resulting in overachievement of support provided to DOT workers.

The graph below shows the quarterly trends in the number of patients and DOT workers supported from January to November 2025.

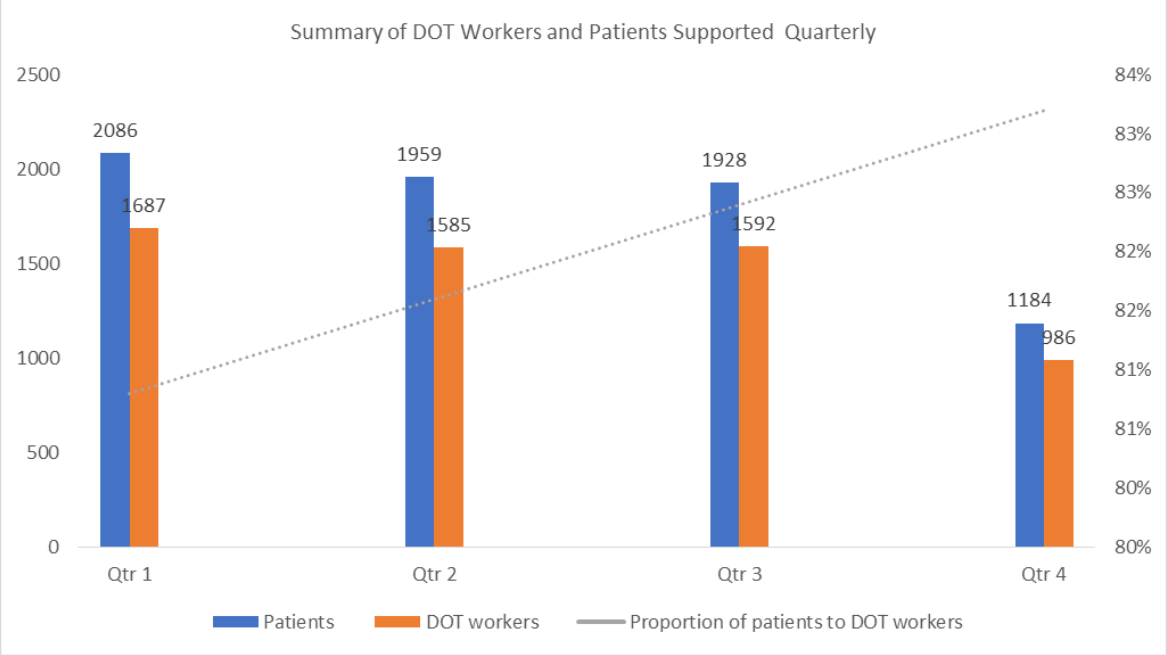


Figure 4.1: Summary of DOT workers and patient supported quartely

In addition, social support in the form of cash transfers was provided to 2,810 drug-susceptible tuberculosis (DS-TB) patients with Severe Acute Malnutrition (SAM) across 21 counties during the reporting year.

4.2 Social Health Insurance Fund Support for DRTB patients



The National TB Program continues to support patients with drug-resistant tuberculosis (DR-TB) through a sponsorship program that provides Social Health Insurance Fund (SHIF) coverage throughout the duration of treatment. Under this initiative, each enrolled patient receives SHIF support valued at KES 500 per month, with the aim of reducing catastrophic out-of-pocket health expenditures and ensuring uninterrupted access to essential healthcare services.

Following diagnosis at a health facility, eligible patients are registered for SHIF, and their details are submitted to the National TB Program for processing and payment of the SHIF premiums. In 2025, of the 815 patients eligible for SHIF sponsorship, only 185 (23%) were successfully enrolled and benefited from the program. This represents a decline from 2024, when 348 patients (40%) were enrolled. The lower enrolment rate in 2025 was largely attributed to the lack of national identity cards among eligible patients, as possession of a national ID is a mandatory requirement for SHIF registration.

4.3 Nutrition in Tuberculosis, Leprosy and Lung Disease



90,900
notified cases, 47.1% were undernourished

Optimal nutrition is fundamental to the proper functioning of the immune system and serves as a critical defense against infection and diseases. For individuals with Tuberculosis (TB), under-nutrition is a significant risk factor for the progression from TB infection to active TB disease. Furthermore, poor nutritional status at the time of diagnosis is a documented predictor of delayed recovery, increased risk of adverse drug reactions, and higher mortality. Evidence indicates that TB treatment alone is often insufficient to optimize outcomes, necessitating the integration of nutrition screening, assessment, and management as essential components of TB care.

In 2025, the National TB Program prioritized the integration of nutritional support for TB patients. Data indicates a high prevalence of malnutrition among those notified with TB:

Drug-Susceptible TB (DSTB): Of the 90,900 notified cases, 47.1% were undernourished. This included 18.9% (17,196) with Severe Acute Malnutrition (SAM) and 28.2% (25,640) with Moderate Acute Malnutrition (MAM).

Drug-Resistant TB (DRTB): 51% of the 815 cases were reported to be undernourished at the time of diagnosis 20% (SAM) and 31% (MAM).

Pediatric TB: Of the 9907 pediatric cases, 29.6% were undernourished 17.6% (3069) SAM and 12% (1189) MAM.

Table 4.1: Summary of Nutritional Assessment and Support (2025)

Category	Cases	SAM %	Proportion on support	MAM %	Proportion on support	Normal%	Overweight %	Obese %
DSTB	90,900	18.9	17.2%	28.2	10.1%	41.2	6.1	5.4
DRTB	815	20	-	31	-	38	-	-
Paeds TB	9907	31	17.6	12	13.4	6.5	7.2	3.7

Note: Major challenges identified included frequent stock-outs of Nutrition Health Products (NHPs), which limited interventions primarily to nutrition counseling, negatively impacting overall TB treatment outcomes.

4.4 Capacity Building and Mentorship

In 2025, NTP trained 1,840 frontline workers across 46 counties. The Nutrition Management Protocol Guide was disseminated during the sensitization sessions to support standardized service delivery. The sensitization strategy aims to:

1. Enhance assessment of nutrition management for patients with Tuberculosis, Leprosy, and lung disease.

2. Disseminate updated protocols on nutrition care and management for TB, Leprosy and Lung Disease patients.

Table 4.2: Challenges and priority areas of nutrition

Key challenges	Key Priority areas
Inconsistent TB screening in nutrition clinics	Institutionalize routine TB screening in all nutrition service points; provide standard tools, job aids, and registers
Inconsistency in capacity building for Frontline health workers	Continue periodic on job training/mentorship and sensitization for frontline workers to reinforce the updated Nutrition Care and Management for patients with TB. Note: h. Eligibility for nutrition support in TB patients is determined through systematic nutritional assessment using standardized anthropometric indicators i. To provide comprehensive, patient-centered care, this primary method must be complemented by a broader, multidimensional assessment approach. j. A holistic assessment allows for the identification of underlying factors that may contribute to malnutrition or hinder treatment adherence.
Frequent stock-outs of Nutrition Health Products (NHPs)	Prioritize budget allocation for Nutrition Health Products and stabilize supply chain management

CHAPTER 5

SUPPLY CHAIN MANAGEMENT



Pharmacovigilance and ADSM

5.1 Governance and Coordination

The NTP has 4 technical working groups that manage all areas related to Health Products and Technologies within PSM.

1. **Procurement Committee:** Responsible for quantification, supply planning and procurement
2. **National Order Allocation and Management (NOMT) committee:** Responsible for order allocation and distribution approval.
3. **National TB Health Products and Technologies Security Committee:** Responsible for ensuring appropriate measures are taken to optimize stock availability while guarding against commodity expiry.
4. **National Pharmacovigilance and ADSM Committee:** Responsible for ensuring the quality of all TB Health Products and Technologies (HPTs) and patient safety.

5.2 TB Supply Chain Management

5.2.1 Quantification, Forecasting and Supply Planning

The NTP conducted annual quantification in June and a mid-year review in December 2025, securing TB HPT supply plans through 2027/28. The table below outlines the 2025/26 first-line tracer supply plan, funding sources and key supply risks.

Table 5.1: Supply plan summary for first line medicines tracer commodities

Key products	Annual need (packs)	Funding source	Key risks/notes
TB Patient Packs	96,802	GF/CPF	Delays in getting DIP/DAC
RHZ 75/50/150mg Dispersible tablets	15,158	GF	Delivered
Ethambutol 100mg Dispersible tablets	12,733	GF	Delivered
RH 75/50mg Dispersible tablets	30,315	GF	Order split to minimize expiries
Pyridoxine 50mg tablets	153,693	GF	Delay in delivery

Paediatric formulations were delivered in full, while adult patient packs remained exposed to importation delays and pyridoxine to delayed delivery — risks that informed the 2026 mitigation agenda.

5.2.2 Distribution and Order Management

The NTP runs a pull-based distribution system, triggered by county orders. The table below shows 2025 order fill rates against a 100% target.

Table 5.2: Order fill rates for selected TB tracer commodities

Commodity	Target	Result
Adult TB Patient Packs	100%	97.8%
RHZ 75/50/150mg tablets	100%	147.3%
Ethambutol 100mg tablets	100%	102.2%

Adult packs were filled at 97.8%, while paediatric RHZ (147.3%) and ethambutol (102.2%) exceeded 100%. Volumes declined from 2024 for all commodities except RHZ, consistent with fewer notified cases.

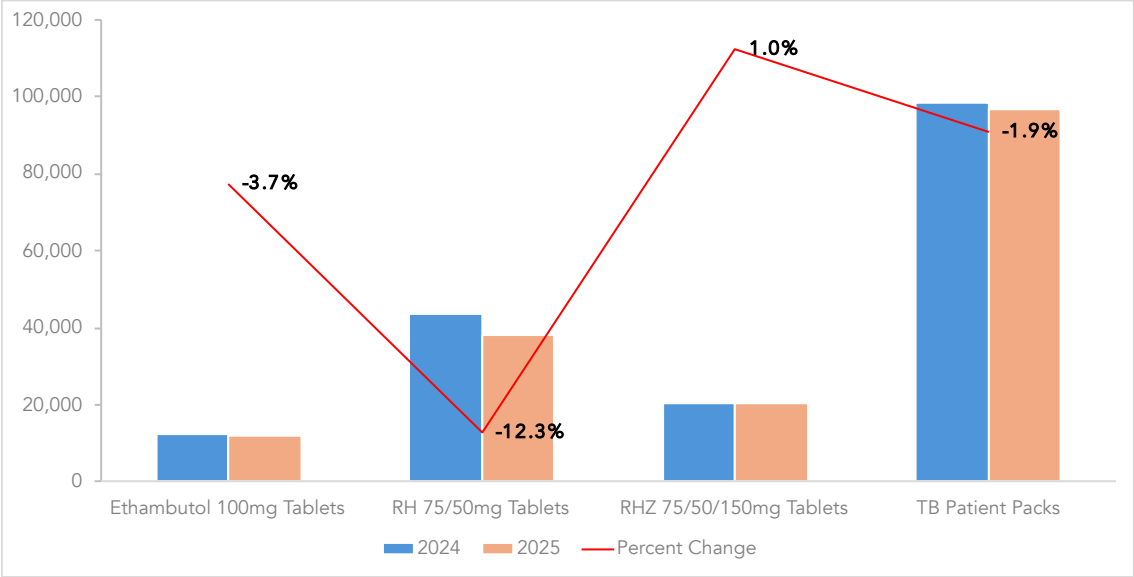


Figure 5.1: Comparison of the distribution of first line medicines between 2024 and 2025

As shown above, volumes contracted for TB patient packs (-1.9%), ethambutol (-3.7%) and RH 75/50mg (-12.3%), while RHZ rose 1.0.

Order turnaround time (TaT), from order approval to receipt, is a key KEMSA service-level indicator; 2025 averages against target are shown below.

Table 5.3: KEMSA turnaround times for first- and second-line TB medicines

Category	Target (Days)	Average TaT Days
First line medicines	7	14
Second line medicines	3	8

TaT ran at double the first-line target (14 vs 7 days) and nearly triple the second-line target (8 vs 3), delaying replenishment and heightening stock-out risk, especially for time-critical DR-TB regimens.

5.2.3 LMIS and Data Quality

First-line orders are managed through the KEMSA LMIS, which draws facility data directly from KHIS — making KHIS completeness and timeliness a direct determinant of order accuracy. 2025 performance is shown below.

Table 5.4: KHIS reporting rate and timeliness for TB commodity reports

Indicator	Target	Result	Trend vs 2024
KHIS reporting rate (%)	90%	93.1%	↓ (-1.3%)
KHIS reporting timeliness (%)	90%	79.1%	↓ (-13.2%)

Reporting (93.1%) beat the 90% target despite a 1.3-point dip from 2024, but timeliness fell 13.2 points to 79.1% — roughly one in five facility reports arrived too late to inform ordering.

A complementary data-quality measure is the alignment between closing and subsequent opening balances; misalignment signals unrecorded stock movements, entry errors or reporting gaps. Performance against the 90% target is shown below.

Table 5.5: Data quality performance based on opening and closing balance alignment

Commodity	Target	Result	Trend vs 2024
TB Patient Packs	90%	62%	↑ (+6%)
RHZ 75/50/150mg Dispersible tablets	90%	78%	(0%)
Ethambutol 100mg Dispersible tablets	90%	80%	↑ (+1%)
RH 75/50mg Dispersible tablets	90%	75%	↑ (+4%)

No tracer met the 90% target: patient packs were lowest (62%, up six points from 2024) and ethambutol closest (80%). Misalignment traces largely to irregular treatment-site reporting, reinforcing the case for facility mapping and data-quality support in 2026.

5.3 Product Quality and Patient Safety

5.3.1 Post-Market Surveillance of TB Medicines

PPB and WHO conducted post-market surveillance of TB medicines in January 2025; four sampled adult patient packs failed assay specifications, however the preliminary report was submitted only after the affected batches had been distributed and used.

5.3.2 Product Quality Complaints and Investigation

Three product quality complaints were reported to PPB, each involving patients not converting by month two of treatment. Insufficient remaining medicine units prevented batch testing to confirm whether product quality caused the failures.

5.3.3 Pharmacovigilance System Overview and Governance

The NTP uses targeted spontaneous reporting for first-line medicines and active surveillance for second-line medicines, with reports submitted through the PPB PvERS and TIBU pharmacovigilance modules.

5.3.3.1 Adverse Events Reporting

The 2025 report volumes and reporting rates are shown below.

Table 5.6: Adverse event reporting rates in TIBU and PvERS

Indicator	TIBU	PVERS
# Adverse events (AEs) reports received	144	339
DSTB AE reporting rate	0.1%	0.3%
DRTB AE reporting rate	5.4%	6.1%

DSTB reporting stayed below 1% in both systems, versus 5.4% (TIBU) and 6.1% (PvERS) for DRTB — pointing to substantial underreporting, while the divergent counts (144 vs 339) illustrate the fragmentation of parallel channels.

Reported DRTB adverse events by regimen and reporting system are shown below.

Table 5.7: Most common adverse events by DRTB regimen and reporting system

Reporting System	Regimen	# AEs	% Incidence
TIBU	Bdq/Lfx/Lzd/Cs/Cfz	20	45%
	BPaLM	14	32%
PvERS	Bdq/Lfx/Lzd/Cs/Cfz	39	78%
	BPaLM	5	10%

The most frequently reported reactions in each system were:

Table 5.8: Top reported adverse reactions by reporting system

Reporting System	Top reported reaction(s)
TIBU	Skin Reaction (21.5%), Neuropathy (19.4%), Liver Injury (17.4%), Musculoskeletal Reaction (15.3%), Gastrointestinal Reaction (6.3%)
PvERS	Skin Reactions (25.7%), Urine Discoloration (25.4%), Musculoskeletal Reactions (9.7%), Neuropathy (8.8%), Liver Injury (8.0%), Gastrointestinal Reactions (7.4%)

Both systems identified Bdq/Lfx/Lzd/Cs/Cfz as the regimen most associated with AEs, followed by BPaLM. Skin reactions, neuropathy, liver injury and musculoskeletal reactions dominated — consistent with known bedaquiline/linezolid safety signals and underscoring routine aDSM monitoring.

5.3.3.2 Active Drug Safety Monitoring and Management (aDSM)

In 2025 the NTP strengthened aDSM and MTM through readiness assessments in 16 counties, staff training, digital-tool integration, equipment procurement and MTM centre set-up. Stakeholder workshops produced an aDSM monitoring framework, updated guidelines and finalized tool variables. By December 2025, 34 DR-TB patients were enrolled, the TB medicines guideline was finalized, and a PV-aDSM implementation committee established. Priorities ahead: further training, routine data reviews, system interoperability and routine enrolment.

5.4 Capacity Building Activities to Improve TB Commodity Management and Patient Safety

In 2025 the NTP invested in the workforce behind the supply chain and safety systems through cascade training, on-site mentorship and continuous professional development, summarized below.

Table 5.9: Capacity building activities for TB commodity management and patient safety

Activity	Reach / Output	Purpose / Contribution to TB Commodity Management and Patient Safety
Training of Trainers (ToT) on TB Commodity Management	20 trained trainers established.	Built staff capacity to cascade TB commodity management knowledge at county and facility levels.
Pharmacovigilance Training for Healthcare Workers	250 HCWs trained from eight deep-focus counties.	Improved HCWs' ability to identify, manage, document, and report ADRs and adverse events associated with TB treatment.
Facility-Based Pharmacovigilance Mentorship	30 health facilities mentored across eight counties.	Provided on-site technical support on ADR detection, reporting processes, causality assessment, and patient monitoring.
Continuous Medical Education Sessions for Pharmacists through PSK	770 pharmacists reached in July, and 834 pharmacists reached in November.	Supported continuous professional development and enhanced pharmacists' knowledge of TB commodity management, pharmacovigilance, and patient safety.

5.5 Risks and Mitigation Actions for 2026

5.5.1 Supply Chain

Table 5.10: Supply chain risks and mitigation actions for 2026

Risk	Mitigation planned
Prolonged order turnaround times: 2025 KEMSA delivery averaged 14 days for first-line (target 7) and 8 days for second-line (target 3). Delayed replenishment risks facility stock-outs, treatment interruption and, for DR-TB, regimen failure and amplified resistance.	Establish county-level DSTB buffer stocks; decentralize DRTB distribution to high-burden counties; track TaT quarterly through NOMT.
Low and untimely county commodity reporting: KHIS timeliness fell to 79.1% and balance alignment missed target for all tracers. As KEMSA LMIS orders draw on KHIS data, poor reporting distorts resupply — risking both stock-outs and expiries.	Map facilities to update TB treatment sites in KHIS; targeted technical assistance for low-performing counties; institutionalize virtual commodity audit reviews.
Weak accountability for distributed TB medicines: gaps between quantities issued and accounted for limit detection of leakage, wastage and expiries, and weaken donor confidence in stewardship.	Institutionalize annual commodity audits with follow-up of findings, plus routine triangulation of KEMSA issue data against facility reports and cases notified.
Incorrect reporting and poor inventory management, especially of paediatric formulations: recording errors and weak store practices drive the balance misalignment seen in 2025 and avoidable stock imbalances.	Cascade commodity management training via the ToT pool, prioritizing facilities with recurrent data issues, reinforced by supportive supervision.

Pharmacovigilance

Table 5.11: Pharmacovigilance challenges and mitigation actions for 2026

Challenge	Mitigation planned/implemented
Fragmented reporting across TIBU and PvERS: divergent report counts (144 vs 339 in 2025) yield an incomplete national safety picture, delayed signal detection and harder causality assessment.	Integrate PvERS and TIBU into one interoperable pathway with harmonized variables and shared case identifiers.
Severe, non-standardized AE underreporting: DSTB below 1% and DRTB below 7% in 2025, with frequent omission of suspected drugs, reaction details and outcomes — limiting signal detection and response.	Pair clinicians and pharmacists in case review; sustain PV training for healthcare workers; scale county-based mentorship; enforce standardized reporting fields.

CHAPTER 6

PREVENTION, HEALTH PROMOTION AND COMMUNITY ENGAGEMENT



6.1 Community Engagement and Institutional Approaches in TB control

Strengthening TB Response in Prisons

The NTP in partnership with the Kenya Prisons Service (KPS) and National Police Service (NPS) through Global Fund support, prioritized training for prison officers working in high-volume congregate settings as part of the national TB response among incarcerated populations. Prisoners remain a priority group due to the elevated TB burden driven by overcrowding, weak infection prevention and control practices, and high annual turnover.

In 2025, a total of 165 prison officers including healthcare workers and documentation staff were trained across six regions: Nairobi (29), Nyanza (27), Western (25), Rift Valley (27), Coast (28), and Eastern (27).

Continued support and resources for this initiative will be essential in sustaining momentum and promoting the widespread adoption of KeEMR as a cornerstone in tuberculosis service delivery and reporting.

Targeted outreaches in prisons

During the year, prisoners in various prisons were screened for TB during targeted outreaches, reaching over 10,000 individuals. Following systematic symptom screening, all TB presumptive clients had Chest X-ray imaging done prior to linkage to laboratory for those suggestive. 105 individuals were diagnosed with TB and promptly started on treatment and notified on TIBU by SCTLC.

Table 6.1. Prisons TB screening outreach cascade

County	Prison/ Station	No Screened	No. CXR done	CXR Suggestive & Xpert testing done	Xpert Positive	Started TB treatment
Meru	Kangeta	755	300	47	5	8
Meru	Meru	1200	447	33	6	9
Meru	Uruku	400	151	26	3	5
Nyeri	Nyeri	2200	705	60	12	21
Nyandarua	Nyandarua	375	175	35	3	6
Mombasa	Shimo Main	2200	916	106	8	13
Mombasa	Mombasa	400	505	103	4	7
Elgeyo Marakwet	Tambach	350	180	43	3	5
Baringo	Kabarnet	600	297	53	4	9
Baringo	Eldama Ravine	250	165	38	2	4
Nakuru	Nakuru	1800	146	48	7	12
Laikipia	Nyahururu	300	102	36	4	6
TOTAL		**10930**	**489**	**628**	**60**	**105**

Capacity Building of Community actors

- Training of CHPs on Community Health Basic Modules - NTP in collaboration with Division of Community Health 6,711 Community Health Promoters (CHPs) from across all the 47 counties were trained on Community Health Basic Modules in partnership with the Division of Community Health (DCH).
- Sensitization of Community Health Workforce on Tuberculosis: A total of 942 CHAs/CHOs/CHEWs and 8065 CHPs across 47 counties were sensitized on community active case finding, contact management, TB prevention, stigma reduction, treatment adherence support and bi-directional referrals strengthening their capacity to support community engagement in TB service delivery.
- CHPs training on TIBU: A total of 3,771 CHPs across 28 counties were trained on how to use TIBU for community TB screening and reporting. During the reporting period, CHPs used the system to screen 4,721 individuals for TB.
- Community Led Monitoring (CLM) Training: To strengthen community feedback and improve health service delivery, the I-monitor system that allows the

communities to give feedback was supported, 1,000 peer monitors across 25 counties were trained and supported to implement CLM and support the community to give feedback. In addition, CHMT, SCHMT and health facility staff were sensitized as super users to address issues raised by the community. Through the i-Monitor system 23,933 health services related cases were reported and among them 13,353 (56%) by the community.

6.2 Communication, Advocacy and Public Engagement

Overview

Effective communication, advocacy and community engagement remain central pillars of Kenya's tuberculosis (TB) and lung health response. During the reporting period, the NTP implemented an integrated communication strategy aimed at increasing public awareness, promoting positive health-seeking behaviour, reducing stigma and discrimination, and strengthening public demand for quality TB prevention, diagnosis and treatment services.

Recognizing that communication is a critical enabler of programme performance, the Division adopted a multi-sectoral approach that combined strategic partnerships, mass media, digital platforms, community engagement, documentation of success stories and stakeholder advocacy. These interventions were implemented in collaboration with county governments, development partners, media organizations, civil society, community networks and TB champions to ensure accurate, timely and people-centred information reached diverse audiences across the country.

The communication interventions complemented broader national efforts to find the missing people with TB, improve treatment outcomes, strengthen accountability and support implementation of Kenya's National Strategic Plan for Tuberculosis, Leprosy and Lung Health.

Enhancing Public Awareness and Demand for TB Services

During the year, the NTP implemented nationwide public awareness campaigns designed to improve knowledge of TB symptoms, encourage early health-seeking behaviour and promote treatment adherence. Communication messages emphasized that TB is preventable, detectable and curable, while addressing persistent myths and misconceptions that continue to fuel stigma and delay diagnosis.

A comprehensive multimedia communication strategy was employed, integrating television, radio, digital media and community-based platforms. National television stations, vernacular radio stations and online media were strategically utilized to reach diverse population groups, ensuring consistent dissemination of key messages on TB prevention, free diagnosis and treatment services, infection prevention, and the importance of completing treatment.

Through targeted Social and Behaviour Change Communication (SBCC) interventions, the Division reached an estimated 9.877 million people through mainstream national and vernacular media platforms. These campaigns significantly expanded the visibility of TB and contributed to sustained public engagement on TB prevention and care.

Media coverage through major national broadcasters, including Citizen TV, NTV, KBC, K24 and other regional stations, generated an estimated audience reach of over 4.8 million people during key campaign periods. The strategic use of television and radio enabled the programme to communicate evidence-based information while encouraging communities to access TB screening and treatment services.

Table 6.2: News/ feature stories on TB

Station	Dissemination Date	Link	Estimated Reach
Citizen TV	26/03/2025	https://www.youtube.com/watch?v=OOAuv9ZjCek	1,500,000
KBC	30/03/2025	https://www.youtube.com/watch?v=gS8yqTAdjh0&t=4s	200,000
NTV	25/03/2025	https://www.youtube.com/watch?v=KhR2coexYsk&t=8s	1,200,000
K24	24/03/2025	https://www.youtube.com/watch?v=3I8OLVvvmHk&t=2s	200,000
West FM	15/6/2025	https://youtu.be/1Un0BqduNco?si=IQebZILPpokYvKZw	215,650
Citizen TV	21/6/2025	https://youtu.be/TgGeEwoU7ao?si=wRpr2D2gr77JWJ_c	1,500,000
Total			**4,815,000**

Table 6.3: Media Campaigns

Media Station	Campaign dates	Estimated reach
Citizen Tv	28th July – 24th August	3,737,825
Radio Citizen	28th July – 24th August	780,000
Ramogi FM	28th July – 24th August	205,000
Chamgei FM	28th July – 2nd August	155,000
Inooro FM	26th July – 24th August	185,000
Total		**5,062,000**

Leveraging Digital Platforms for Community Engagement

Recognizing the growing influence of digital platforms in shaping public opinion, particularly among young people, the Division strengthened its digital communication strategy by investing in innovative and audience-centred content.

NTP in collaboration with Amref implemented a one-month social media campaign featuring digital content creator Fatboy Animation, whose creative storytelling translated technical TB information into relatable and engaging messages. The campaign generated an estimated reach of between 635,000 and 770,000 people, while accumulating between over one (1) million views on TikTok and Instagram, demonstrating the effectiveness of digital storytelling in increasing awareness and stimulating public conversations on TB.

The NTP also maintained active engagement across its institutional social media platforms. Facebook remained the strongest-performing platform, recording over 1.7 million people reached, more than 2.2 million impressions, and over 3,800 engagements during the reporting period. LinkedIn continued to strengthen professional engagement with partners and stakeholders, while Instagram generated high audience interaction despite a smaller number of posts. Collectively, these platforms enhanced dissemination of programme updates, policy information, success stories and advocacy messages while providing opportunities for direct public engagement.

The increased use of digital platforms enabled the programme to reach audiences who may not traditionally access health information through conventional media and strengthened the Division's capacity to communicate rapidly during national campaigns and commemorative events.

Table 6.4: NTP Social Media Platforms Performance Overview

Platform	Posts	Reach	Impressions	Engagement
Facebook	89	1,706,505	2,218,058	3,841+
Instagram	6	123	341,367	12,000+
LinkedIn	66	25,955	56,888	1,644+
X	68	-	15,163	306+

Strengthening Advocacy through Strategic Media Partnerships and Capacity for Quality TB Reporting

NTP continued to recognize the media as a strategic partner in influencing public perception, shaping policy dialogue and promoting accountability in the national TB response. During the reporting period, significant investments were made to strengthen the capacity of journalists to report accurately, ethically and consistently on TB and lung health.

A total of 120 journalists from high TB burden counties received specialized training on TB epidemiology, stigma reduction, ethical reporting, interpretation of programme data and effective health storytelling. The training adopted a practical approach by combining technical sessions with field-based learning experiences, enabling journalists to interact directly with healthcare workers, TB champions and people affected by TB.

These investments resulted in improved quality and frequency of TB reporting across mainstream and local media outlets, contributing to increased public understanding of TB while reducing misinformation and discrimination associated with the disease.

Beyond formal media training, the NTP strengthened partnerships with media organizations through structured engagement forums aimed at sustaining interest in TB reporting.

Working closely with Stop TB Partnership Kenya and CHS Kenya, the programme convened media cafés that brought together journalists, County Directors of Communications, County TB and Leprosy Coordinators and advocacy partners from eight high-burden counties. These forums provided opportunities to discuss county-specific TB trends, emerging communication priorities, stigma reduction strategies and the role of the media in supporting public accountability.

The engagements shifted media reporting from routine event coverage towards compelling human-interest stories that highlighted the lived experiences of TB survivors, health workers and affected communities. Journalists were equipped with county-specific data, access to technical experts and patient stories that strengthened evidence-based reporting.

As a result, several television and radio stations, including Citizen TV, K24 TV, Pwani FM and other local broadcasters, aired interviews, feature stories and live discussions on TB. Prime-time broadcasts featuring County TB Coordinators and TB champions provided audiences with practical information on TB symptoms, available services and treatment outcomes, while creating opportunities for the public to interact directly with experts through live call-in programmes.

These strategic partnerships contributed to a noticeable increase in TB visibility across national and county media platforms and reinforced media engagement as an important advocacy mechanism for strengthening political commitment and community awareness.

Bill boards with TB Messages

To enhance TB awareness among the track drivers, people along the transport corridor and the general public, bill boards with TB messages were put up in strategic locations along the transport corridors in Busia, Machakos and Mombasa.

Bill Board in Busia Town



Figure 6.1 TB Bill Board in Busia Town

Documentation, Knowledge Management and Storytelling

The NTP continued to prioritize documentation of programme achievements as an important component of advocacy, accountability and institutional learning.

Communication teams undertook field visits across several counties to document patient experiences, county innovations and programme successes that demonstrated the impact of TB interventions on individuals and communities. The documented stories showcased successful treatment journeys, early diagnosis, community participation, stigma reduction and the contribution of healthcare workers and community volunteers in improving access to TB services.

These human-interest stories complemented routine programme data by illustrating the real-life impact of investments in TB control. They also informed development of newsletters, digital stories, advocacy materials, partner reports and other knowledge products that supported resource mobilization and dissemination of best practices.

The Division further strengthened visibility of programme achievements through regular production of communication materials, including newsletters, feature articles, photography, social media content and multimedia products that highlighted progress made across counties.

World TB Day Commemoration

The Division played a central role in planning, coordinating and implementing World TB Day commemorations, one of the programme's flagship advocacy events.
The commemorations brought together government ministries, county governments, development partners, civil society organizations, professional associations, media houses, TB champions and affected communities to reaffirm Kenya's commitment to ending TB.
Communication activities focused on widespread dissemination of information, education and communication (IEC) materials, media engagement, public exhibitions and community awareness activities aimed at increasing knowledge on TB symptoms, prevention, diagnosis and treatment.
The event also provided an important platform for policy dialogue, stakeholder engagement and advocacy for sustained investment in TB prevention and care. Extensive media coverage generated during the commemorations significantly expanded national visibility of TB while reinforcing key public health messages on early diagnosis, free treatment services and stigma reduction.

Mobilizing Support for the Global Fund 8th replenishment.

To support the Global Fund 8th replenishment conference and in light of the changing donor landscape, Kenya supported high level delegations from different donor countries to showcase the impact of Global Fund Support at the facility and community level. During the visits the delegations interacted with County Health leadership, Health Care Workers, People with TB, CHPs, TB Champions and other beneficiaries of Global Fund support.

Table 6.5 Country delegation

Country/Organization	Delegation
Norway	Norwegian Members of Parliament
Japan	Japan Members of Parliament and Save the Children
Japan	Japan Budget Examiner
Italy	Italy Members of Parliament
Germany	German Members of Parliament
UK	UK Members of Parliament
Gates and Tsinghua University (China)	Gates and Tsinghua University (China) Media visit – Over 10 media houses from China
Spain	Spanish State Secretary
Sweden	Sweden State Secretary
The Red Team	The Red Team

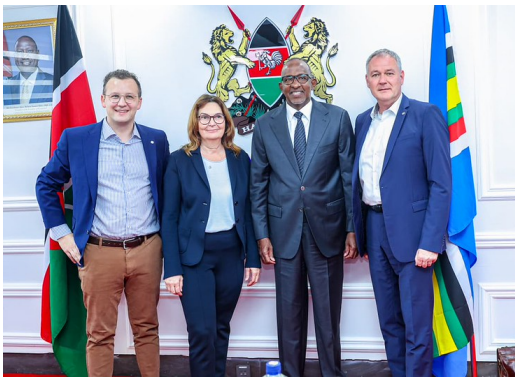




Photo: Visit by German Bundestag led by Hon. Mechthild Heil aimed to deepen global health solidarity through the Global Fund a key pillar in advancing Kenya's Universal Health Coverage (UHC) agenda.





Photo: CHPs Shares about the Work Done through Global Fund Support During Italy MP's Visit

CHAPTER 7

LUNG HEALTH



7.1 Integrated Lung Health

The National Tuberculosis Program (NTP) continues to transform respiratory healthcare through the implementation of an Integrated Lung Health approach, shifting from a disease-specific TB program to a comprehensive respiratory care that addresses both communicable and chronic respiratory diseases. Anchored in the National Strategic Plan for Tuberculosis, Leprosy and Lung Health (2023/24–2027/28), the program leverages Kenya's established TB infrastructure to improve prevention, early diagnosis, treatment, and long-term management of lung diseases while accelerating progress towards ending TB by 2030.

7.2 Rationale and Scope

The burden of chronic respiratory diseases extends beyond TB, underscoring the need for an integrated lung health approach across the continuum of care.

CRDs are a major yet under-recognized public health challenge in Kenya. An estimated 21.7% of the population is affected. Among symptomatic patients, asthma (36%), chronic bronchitis (25%), COPD (8%), bronchiectasis (5%), and PTLD (4%) are the leading conditions.

The program targets seven priority respiratory conditions—TB, PTLD, asthma, COPD, cystic fibrosis, occupational lung diseases, and lung cancer. It addresses key risk factors, including tobacco use, air pollution, occupational exposure, and previous TB, through an integrated, patient-centered care model that leverages TB investments to expand access to quality lung health services.

Strategic Implementation Approach

The implementation was anchored on a comprehensive roadmap structured around key strategic focus areas.



Figure 7.1 Roadmap on key strategic focus areas

Stakeholder Engagement

The stakeholder inventory provided a robust platform for coordinated lung health implementation nationwide.

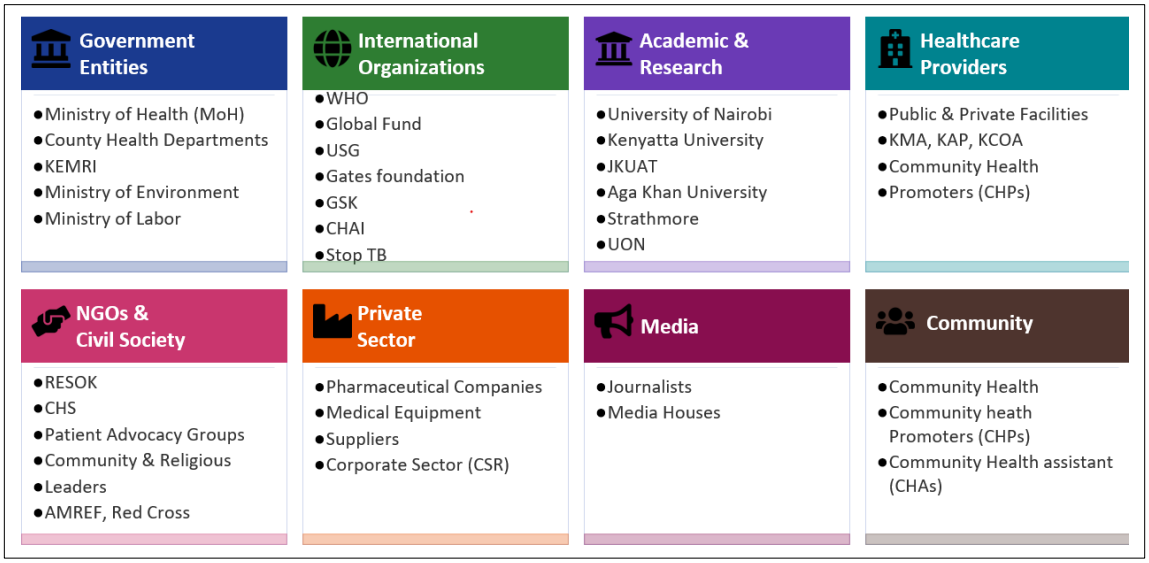


Figure 7.2: List of stakeholders engaged

7.3 Key Achievements (April-Dec 2025)

Significant progress has been achieved since the phased national scale-up of integrated lung health services, demonstrating increased access to comprehensive respiratory care and strengthened health system capacity.

- Reviewed and disseminated policies, guidelines, SOPs, and job aids to support the integrated lung health response

To strengthen integrated lung health implementation, the National Tuberculosis Program (NTP), in collaboration with key partners, reviewed and developed priority policy, technical, and programmatic documents to strengthen the integration and improve the prevention, diagnosis, treatment, and management of TB and chronic respiratory diseases.

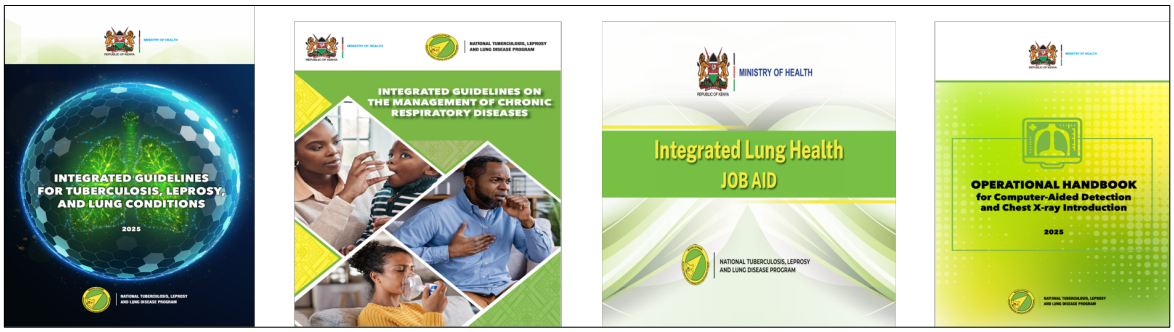
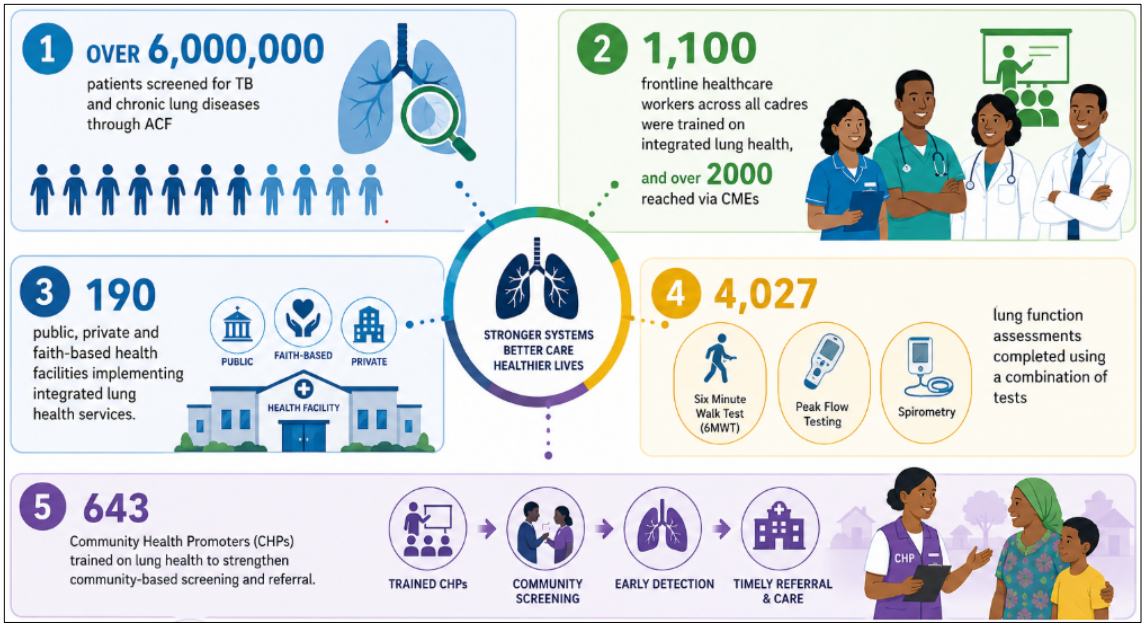


Figure 7.3: Integrated TB and Lung Health guidelines, SOPS, Job aids, 2025

- Expanded Service Delivery

The program strengthened integrated lung health service delivery through the procurement and deployment of 15 spirometers, 50 peak flow meters, and 50 pulse oximeters, complemented by a continuous supply of consumables (mouthpieces, flow tubes, and filters). These investments increased facility capacity to conduct standardized lung function assessments, improve early diagnosis of asthma, COPD, and post-TB lung disease and provide evidence-based clinical management, leading to the following key results:



- Improved Case Detection

The integration of tuberculosis (TB) and chronic respiratory disease (CRD) services strengthened early diagnosis, clinical management, and patient outcomes through an integrated lung health approach. In Nairobi, Nakuru, and Murang'a counties, the initiative contributed to a 6% increase in TB case notifications and a 7% increase in bacteriological confirmation. It also identified 80,915 asthma, 1,278 COPD, 425 PTLD, and 137 lung nodule cases, demonstrating the high burden of undiagnosed respiratory disease. Among 905 patients assessed for PTLD, 36.4% had another chronic lung condition and 12.7% had recurrent TB. Additionally, 6,939 lung function assessments revealed abnormal findings in 40% of chest radiographs, 45% of peak flow tests, and 41% of spirometry tests, underscoring the value of integrated lung health services in improving diagnosis and quality of care.

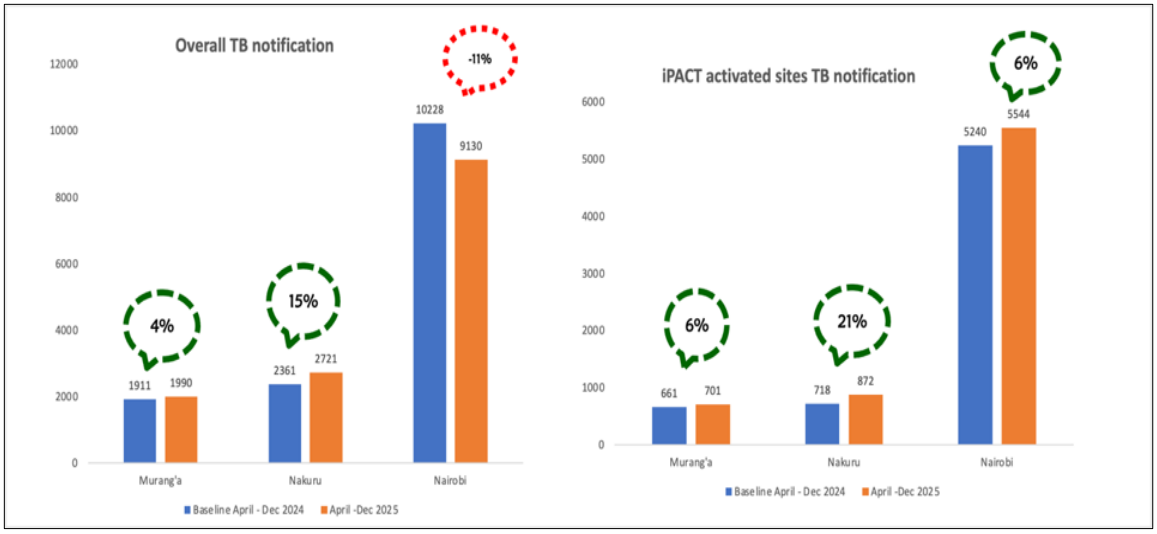
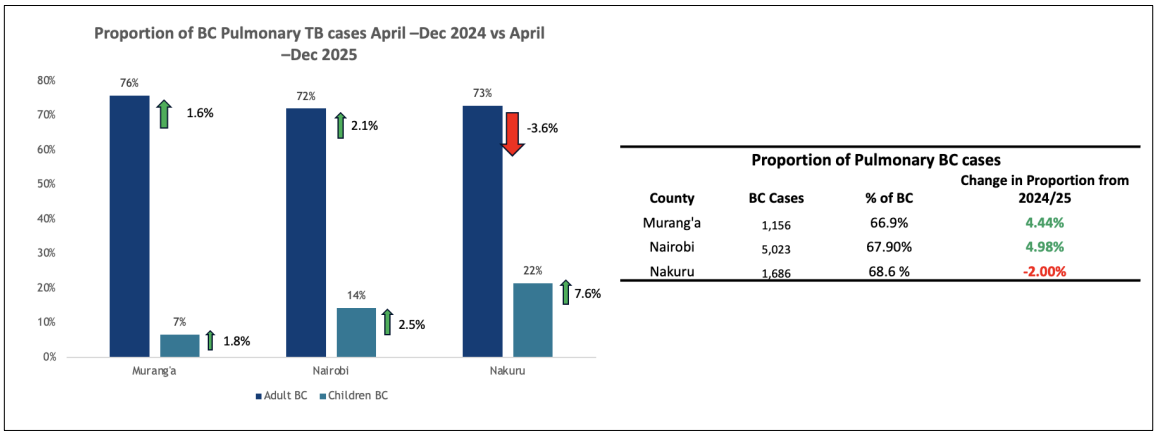


Figure 7.4 TB case notification rates in Nakuru, Nairobi, and Murang'a counties 2024 vs 2025



Proportion of Pulmonary BC cases

County	BC Cases	% of BC	Change in Proportion from 2024/25
Murang'a	1,156	66.9%	4.44%
Nairobi	5,023	67.90%	4.98%
Nakuru	1,686	68.6 %	-2.00%

Figure 7.5: Change in TB bacteriological confirmation rates in Nakuru, Nairobi, and Murang'a counties 2024 vs 2025

Post TB lung diseases assessment and outcome

Among the 905 patients assessed for PTLD, 53% had normal findings,12.7% had recurrence of TB diseases while 36.4% were diagnosed with other lung diseases.

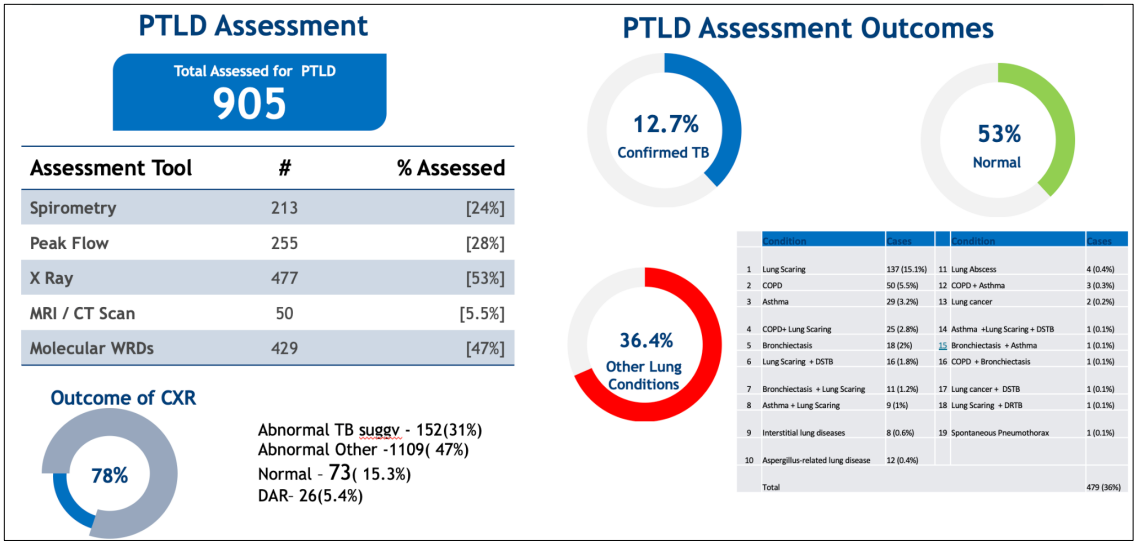
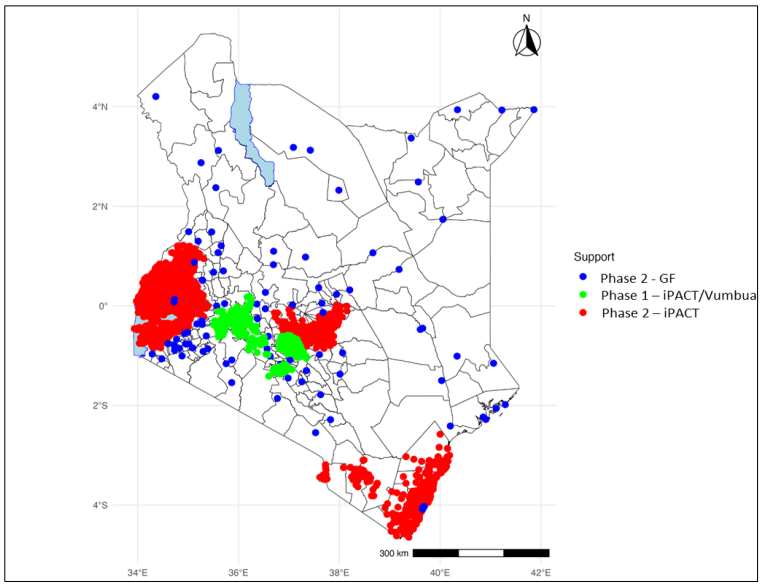


Figure 7.6: PTLD assessment and outcomes

National Scale-up Roadmap



NTP is scaling up integrated lung health services across all 4,676 TB treatment facilities through a phased hub-and-spoke approach. Phase I focuses on saturation of the initial three counties, Phase II expands implementation to an additional fifteen counties with CHAI support, while Phase III will extend services to the remaining twenty-nine counties through Centers of Excellence. Implementation is guided by a nine-pillar framework covering governance, service delivery, workforce development, community engagement, operational research, sustainability, and monitoring and evaluation.

7.4 Priorities for 2026/2027

During 2026/2027, the program will focus on expanding integrated lung health services to all remaining TB treatment sites, strengthening county capacity for diagnosis and management of chronic respiratory diseases, increasing access to Digital Chest X-Ray, spirometry and molecular diagnostics, and enhancing community-based screening through Community Health Promoters. Additional priorities include advocating for inclusion of chronic respiratory diseases within the Social Health Authority benefits package, strengthening procurement of lung health commodities, improving routine reporting through TIBU and KHIS, generating operational research to inform policy, and mobilizing sustainable domestic financing to ensure long-term program ownership and impact.

The Integrated Lung Health Program has established a strong foundation for comprehensive respiratory care in Kenya. Continued investment in health systems, workforce capacity, digital innovation and sustainable financing will be essential to achieving equitable access to quality lung health services while accelerating progress towards ending TB and reducing the burden of chronic respiratory diseases.

7.5 Gaps and Bottlenecks

Despite significant progress, several health system challenges continue to limit scale-up and sustainability.

a. Only 41% of health facilities had staff trained in integrated lung health, while lung specialists remain concentrated in Nairobi with limited availability at county referral facilities
b. Access to diagnostics remains limited, with spirometry available in only 8% of facilities and peak flow meters in 26%
c. Health financing remains inadequate, with no dedicated national budget line for asthma, COPD or lung cancer. Chronic respiratory diseases are not comprehensively covered within the Social Health Authority (SHA) benefits package, resulting in substantial out-of-pocket expenditure for patients.
d. Although digital reporting has improved considerably, interoperability of reporting system with the TIBU system was a challenge

CHAPTER 8

MONITORING, EVALUATION AND RESEARCH



The Monitoring, Evaluation and Research (MER) section is responsible for strengthening monitoring and evaluation systems that support evidence-based decision-making for TB, Leprosy, and lung disease programming. The section facilitates the flow and use of strategic information, tracks performance against planned activities, monitors key TB indicators, and supports corrective actions to improve service delivery. It also leads data quality improvement efforts, coordinates performance reviews, updates recording and reporting tools in line with current guidelines, and supports surveys, evaluations, and impact assessments to enhance program effectiveness.

8.1 Annual National Strategic Plan Review

The Annual National Strategic Plan (NSP) Review for Tuberculosis, Leprosy and Lung Health was conducted in Nakuru and Kericho Counties in October 2025 to assess progress in implementation of the Kenya NSP 2023/24–2027/28. The review focused on key thematic areas including policy and governance, laboratory and diagnostic services, integrated TB care, drug-resistant TB management, childhood TB, public-private mix, lung health integration, and monitoring and evaluation.

The review findings indicate that Kenya continues to make notable progress in TB prevention, diagnosis, and treatment outcomes, with several annual targets surpassed. TB incidence declined from 287 to 261 per 100,000 population, exceeding the 2024 target of 264, while TB mortality reduced from 7.3% to 6.0%, outperforming the target of 6.5%. In addition, the TB case notification rate increased from 179 to 204 per 100,000, reflecting improved case detection efforts. Integration of TB/HIV services remained strong, with 98% of TB patients tested for HIV and 98% of HIV-positive TB patients initiated on ART, demonstrating effective service integration.

Despite these gains, the review identified several persistent challenges that continue to hinder full implementation of the NSP. These include insufficient domestic financing, with government contribution to the TB budget declining to 1%, delayed disbursement of county funds, human resource shortages, and recurring stock-outs of diagnostics and nutrition commodities. Under-diagnosis remains a concern among children and key populations, while catastrophic costs due to TB remain high at 27%, far from the goal of eliminating TB-related financial hardship by 2030. In addition, lung health services remain inadequately integrated, with limited surveillance systems, inadequate diagnostic equipment, and low capacity among healthcare workers.

The review also highlighted areas requiring urgent attention in drug-resistant TB management, including limited access to second-line drug susceptibility testing, incomplete contact tracing, and heavy reliance on donor support for diagnostics and clinical review. Leprosy indicators also showed gaps, with the proportion of patients presenting with grade-2 disabilities rising to 32%, indicating delayed diagnosis and inadequate early case detection.

Overall, the review demonstrates that while the TB, Leprosy and Lung Health Programme is on course in several strategic areas, sustainability and equity challenges remain significant. To sustain progress, the review recommends increased domestic financing, strengthened supply chain systems, expanded diagnostic access, enhanced workforce capacity, improved data use, and stronger integration of lung health services. Addressing these gaps will be critical in accelerating progress toward the national targets and ensuring resilient, equitable, and sustainable TB and lung health services in Kenya.

8.2 Revamping Research Activities

8.2.1. Research Framework for Tuberculosis, Leprosy and Other Lung Diseases

In 2025 the NTP revamped the Research Taskforce by streamlining the quarterly meetings and developing a Research Framework for Tuberculosis, Leprosy and Other Lung Diseases.

The TB and Lung Health Research Framework outlines a coordinated approach to generating and using evidence to improve TB and broader lung health outcomes. It emphasizes aligning research with national priorities and program needs, with a strong focus on operational and implementation research to address practical gaps in service delivery. The framework promotes structured coordination through national leadership mechanisms, while strengthening research capacity at both national and sub-national levels.

It also underscores the importance of robust data systems, development of a research repository and the translation of evidence into policy and practice. Collaboration is central, encouraging partnerships between government, academia, and implementing partners. Cross-cutting principles such as ethics, equity, and community engagement are integrated throughout. The framework covers key areas including TB prevention,

diagnosis and treatment, TB/HIV, drug-resistant TB, pediatric populations, health systems, emerging lung health conditions and leprosy. Overall, it seeks to bridge the gap between research and implementation of interventions to enhance program performance and health outcomes.

8.2.2. Research dissemination forums and publications

The NTP placed emphasis on the dissemination of research findings and the development of manuscripts to ensure that generated evidence is effectively shared with key stakeholders and informs policy and program implementation. During the year, three research dissemination forums were successfully convened, providing a platform for researchers, program staff, and partners to present and discuss a wide range of studies and abstracts. These forums facilitated knowledge exchange, encouraged uptake of findings into practice, and strengthened collaboration across institutions.

In addition, a dedicated manuscript development workshop was conducted to enhance scientific writing capacity and accelerate publication of programmatic and operational research. As a result of this effort, seventeen manuscripts were developed, of which 10 have since been successfully submitted to peer-reviewed journals, with 5 already published. This represents a significant step toward increasing the visibility of locally generated evidence and contributing to the global body of knowledge on TB and lung health.

The NTP continues to actively advocate for the integration of research as a core component of programming. Several research protocols have been developed in line with identified priority areas, with a number already submitted for ethical review and others in advanced stages of data collection. This ongoing work is expected to further strengthen evidence generation and support data-driven decision-making within the program.

8.2.3. Structured Operational Research and Training (SORT IT)

The Structured Operational Research and Training (SORT IT) program is a global initiative led by the Special Programme for Research and Training in Tropical Diseases at the World Health Organization (TDR). What makes this approach unique is that participants learn by undergoing training while simultaneously conducting their own research projects. This hands-on method helps them build real skills in writing study protocols, ensuring high-

quality data collection and analysis, publishing their work in peer-reviewed journals, and using evidence to make better public health decisions

In 2025, the national TB program conducted cohort II of Structured Operational Research and Training. This target-oriented training is designed for frontline healthcare workers who have been competitively selected from various counties to empower them to make practical use of routinely collected data. The primary objective of this course is to develop practical skills for conducting operational research, from the initial concept through to publishing findings in a peer-reviewed journal. To achieve this, the course curriculum is structured into three intensive, hands-on modules delivered over 8–10 months. The first module focuses on formulating research questions and developing a complete research protocol alongside an ethics submission form. The second module equips one with essential skills for data management and analysis, including designing efficient electronic data entry tools. The third module guides through the process of data interpretation and writing a scientific manuscript, preparation on navigating online submission and the peer review process. By completing these milestones, one gains the experience needed to use operational research to identify programmatic challenges and drive sustainable improvements in your own health setting.

During the year, 15 participants were selected from 105 applicants. Of these, 93% successfully completed the entire course, including protocol development, data analysis, and manuscript development. All participants submitted their manuscripts to peer-reviewed journals, and the manuscripts are currently at various stages of the review process.

8.3 Strengthening Digital TB Case Management through TIBU Lite User Engagement and System Enhancements (2025)

In 2025, NTP in collaboration with implementing partners, focused on strengthening digital TB surveillance through a combination of user engagement sessions, system architecture improvements, and targeted ICT infrastructure deployment. These efforts were aimed at improving real-time TB screening, case registration, patient follow-up, treatment outcome documentation, and overall data use for decision-making.

8.3.1. Scale-up of TIBU-Lite point of care implementation

With the support of the U.S. government through the Tamatisha TB mechanism, a total of 317 healthcare workers were reached across five counties—Kitui, Mombasa, Kiambu, Nakuru, and Kirinyaga—through structured, hands-on TIBU/TIBU Lite user engagement sessions. These sessions targeted county and sub-county TB coordinators as well as facility-based healthcare workers and focused on practical system utilization. Key areas included patient registration workflows, case management, use of TIBU dashboards for monitoring and verification, and strengthening linkages with the Patient Management System (PMS). In addition, emphasis was placed on data quality improvement, including facility name standardization, user account realignment, and correction of inconsistencies within the system. These engagements resulted in improved completeness and accuracy of TIBU Lite data, enhanced utilization of PMS workflows, and strengthened ownership of data quality at both county and facility levels. Data cleaning exercises conducted during the sessions supported alignment of facility records and user accounts, contributing to more consistent and reliable reporting across the system.

To support sustained system utilization, these efforts were complemented by deployment of digital infrastructure across health facilities. In Kirinyaga County, 20 desktops and 50 tablets were installed across 66 health facilities, while in Nakuru County, 18 desktops and 30 tablets were deployed across 38 facilities, significantly improving access to digital tools for TB service delivery.

The deployment approach included facility mapping exercises to ensure optimal distribution of equipment and avoid duplication in facilities already supported by other digital health platforms. On-site orientation and mentorship were also provided to healthcare workers to reinforce system adoption and integration into routine workflows.

Some implementation challenges noted across sites included intermittent internet connectivity, reliance on shared or personal devices, high staff turnover resulting in inactive user accounts, and persistence of manual workflows in some facilities. Additionally, the coexistence of multiple digital systems led to duplication of data entry efforts, underscoring the need for accelerated system integration and harmonization.

To address these challenges, the program prioritized strengthening enforcement of TIBU Lite use at facility level, conducting routine user audits, expanding ICT infrastructure, and enhancing on-site technical mentorship. There is also continued focus on system interoperability, integration of digital platforms, and promotion of routine use of TIBU dashboards to support data-driven decision-making.



Photo: Onsite Tibulite point of care mentorship in a health facility

8.3.2. Scale-up of TIBU-Lite for community data

In line with the transition from manual to digital data collection and reporting, community-level TB interventions were also digitized. A total of 3,771 Community Health Promoters (CHPs) across 28 counties were trained on the use of TIBU Lite to document TB screening activities conducted within communities. These activities included household contact screening as well as TB screening activities integrated from the KIC mainstreamed activities. This results in availability of the data in the national surveillance system.

Despite these gains, the use of personal mobile phones by CHPs for data collection presents challenges. Not all CHPs own compatible smartphones, limiting universal adoption and use of personal devices raises data protection and information security concerns.

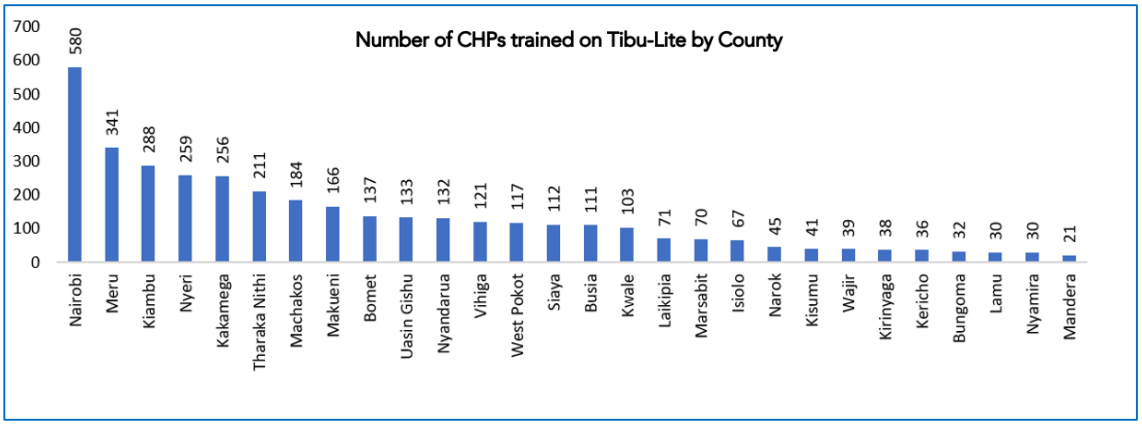


Figure 8.1 Number of CHPs trained on Tibu-Lite by county

8.3.3. TIBU PMS, TIBU CASH and TIBU LIMS system enhancements

During the reporting period, the program undertook system architecture enhancements for TIBU PMS and TIBU LIMS to address performance, scalability, and interoperability challenges. The PMS architecture revamp focused on restructuring the underlying database, modernizing APIs, and transitioning towards a more modular, service-oriented architecture to support real-time data exchange across platforms. This included strengthening integration layers with key systems such as TIBU Lite and national reporting platforms, enabling improved data synchronization, reduced latency, and enhanced system reliability.

Similarly, enhancements to TIBU LIMS focused on improving laboratory data capture, transmission, and integration with PMS. This included optimization of data flows from diagnostic platforms (e.g., GeneXpert and other molecular testing systems), strengthening of API-based interoperability, and improvements in data validation processes to ensure accuracy and completeness of laboratory results within the national surveillance system. These changes were critical in supporting timely diagnosis, treatment initiation, and monitoring of both drug-sensitive and drug-resistant TB cases.

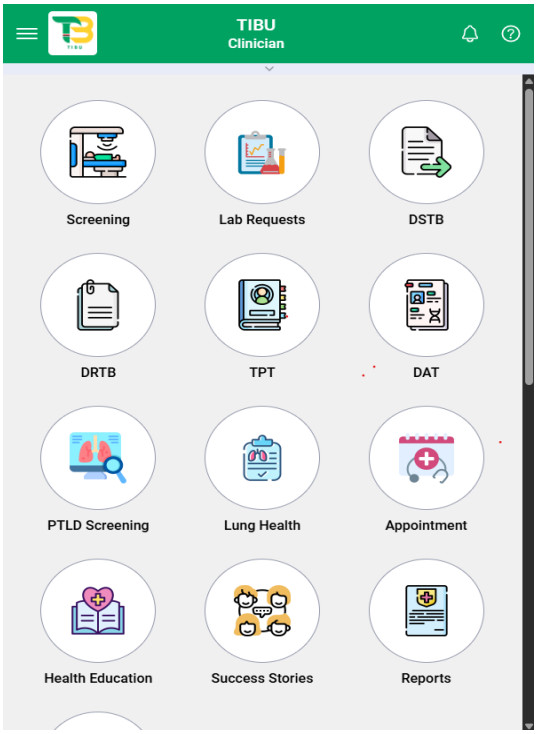
In addition, enhancements to TIBU Cash were implemented to strengthen financial workflows linked to TB program activities. These improvements focused on streamlining disbursement processes, improving integration with TIBU PMS for verification of beneficiaries and services, and enhancing accountability and traceability of funds. The system continued to support efficient transfer of funds to patients, healthcare workers, and community structures, while laying the groundwork for tighter integration with

program data systems to enable automated validation and reduce manual reconciliation processes.

8.3.4. TIBU Connectivity Support

In 2025 the TB program sustained support for TIBU connectivity support, contributing to improved system performance, enhanced data quality, and increased adoption of digital tools for real time data transmission. These interventions supported more efficient case detection, patient management, and program monitoring at sub-national levels. During the period, the program supported server hosting for TIBU Cash and Patient Management System components. The program also provided airtime and data bundles to support timely synchronization of TB data into TIBU, enhance communication for TB control activities, and facilitate the relay of GeneXpert results. This support reached 363 TB coordinators with airtime and included data bundles for 215 GeneXpert machines, 78 Truenat machines, 65 digital chest X-ray machines, and 341 TB coordinators. To further strengthen digital operations, the program procured 800,000 bulk SMS messages through Tangazo Letu Limited to support the TIBU Cash component, enabling payments to healthcare workers, dissemination of SMS-based test results, and processing of supervision claims for TB control engagements.

8.3.5. TIBU Screening Enhancement, Lung Health and Post-TB Lung Disease Module Development



In 2025, NTP enhanced the screening module on the TIBU Patient Management System (PMS) to incorporate risk factor screening for chronic lung conditions, X-ray investigations and outcomes, and lung health assessments including pulse oximetry, six-minute walk test, peak flow measurement, and spirometry. Diagnosis outcomes were also updated to align with the revised national algorithm.

Two new modules were subsequently developed. The **Lung Health Module**, a patient management module enabling documentation of baseline investigations, follow-up and monitoring tests, and treatment outcomes for asthma, COPD, and post-TB lung disease (PTLD). **The PTLD Module** enables systematic screening of all TB patients following treatment completion to evaluate for post-TB lung disease, supporting early identification and management of this previously under-documented condition.

To support utilization, over 400 healthcare workers from three Phase 1 iPACT implementation counties were trained on the three modules. By the end of 2025, over 4,000 patients with chronic lung conditions had been documented on TIBU, strengthening data-driven decision-making and laying the foundation for a comprehensive national lung health surveillance system.

In addition, the Kenya Health Information System (KHIS) was also updated to include reporting for lung health commodities

8.4 Strengthening Data Quality and Use for Decision-Making

8.4.1. Data quality audit (DQA)

From May 18 to June 20, 2025, the program conducted a comprehensive Data Quality Assessment (DQA) across five counties (Baringo, Kajiado, Machakos, Makueni, and Meru), covering 119 health facilities. The primary objective was to evaluate key dimensions of data quality including completeness, accuracy, consistency, timeliness, and validity for tuberculosis and leprosy data, specifically focusing on 2024 and the first quarter of 2025. The DQA identified important strengths in Kenya's TB reporting system, particularly the relatively strong alignment between TIBU and TB4 for routine case notification. However, the assessment also revealed persistent gaps in patient-level documentation, treatment outcome recording, laboratory-clinic linkage, TPT and DR-TB reporting, timeliness, and use of updated M&E tools. These gaps affect the reliability of TB surveillance data, cohort reporting, patient traceability, and program decision-making. The table below provides a high-level summary of the 2025 DQA findings. A comprehensive report has been disseminated to counties to guide corrective actions and continuous data quality improvement efforts

Table 8.1: High-level 2025 data quality findings

Area	Finding	DQA Score	Interpretation
All TB cases	TIBU-TB4 agreement strong	97.7% in 2024; 96.2% in 2025	Within acceptable range overall.
All TB cases	TB5-TB4 agreement weak	74.9% in 2024; 81.7% in 2025	Patient cards remain incompletely aligned with registers.
Bacteriologically confirmed TB	TIBU-TB4 agreement high	105.2% in 2024; 103.7% in 2025	Good electronic-register alignment, with some overreporting.
Clinically diagnosed TB	TB5-TB4 agreement declined	71.3% in 2024; 64.1% in 2025	Growing misalignment for clinically diagnosed cases.
Extra-pulmonary TB	Agreement unstable	TIBU-TB4: 87.9% in 2024; 114.8% in 2025	Low case counts created large percentage swings.

Treatment outcomes	TB5 documentation very poor	Cured 28.1%; Completed 20.3%; Died 17.7%	Major gap in updating final outcomes on TB5 cards.
TPT	Moderate but below acceptable agreement	86.0% in 2024; 88.5% in 2025	Discrepancies persist between registers and TIBU.
DR-TB	TIBU overreported relative to logbooks	144.4% in 2024; 150.0% in 2025	Needs logbook-TIBU synchronization and cleanup.
MDR-TB	Near-perfect agreement but very low volumes	2 cases in 2024; 1 case in 2025	May indicate under-detection or underreporting.
M&E Tool Utilization	M&E tools were partially used across facilities despite high availability	TB5 Patient Record Card (66%), Lab Request Form (52%), TB4 Register (50%), Commodity Reporting Tool (45%)	Inconsistently use of recording and reporting tools, limiting data quality and completeness.

8.4.2. Annual data quality improvement forums (DQI)

The annual DQI forums are aimed at strengthening the accuracy, completeness, and reliability of TB data. The 47 counties were grouped by epidemiological zones and considered their unique strengths and challenges which enabled targeted interventions and tailored support for each cluster. Through data cleaning, validation, and the sharing of best practices in patient management, the forums promote collaboration, continuous learning, and quality improvement across all levels of the program.

The DQI forum provided a platform to review county performance, identify solutions to emerging challenges, facilitate benchmarking among counties, and disseminate quarterly national program updates. Specifically, the forum evaluated TB programming in collaboration with key stakeholders, reviewing trends in TB detection, the TB/HIV care cascade, and mortality audits. The forum highlighted the need for continuous monitoring, especially at high-volume sites, with support from Sub-County TB and Leprosy Coordinators. Counties were encouraged to embrace self-reliance, with those

experiencing high mortality rates advised to utilize the mortality prediction module available in the TIBU PMS, which aids healthcare workers in proactively identifying and intervening for patients at risk. Counties facing high lost-to-follow-up rates were encouraged to collaborate with neighboring regions to enhance patient retention. The collaboration between the National TB Program and implementing partners in conducting annual forums across counties demonstrates a strong commitment to addressing data quality challenges comprehensively.

8.4.3. Advancing Predictive Modeling for Precision Programming

Precision programming is key to accelerating progress toward the End TB 2030 targets . The NTP continues to collaborate with development partners to leverage artificial intelligence to predict potential hotspots, outbreaks, and seasonal targeting for case finding, as well as predict risk of loss to follow-up and mortality.

During fiscal year 2025, a critical milestone was a three-day co-creation workshop which brought together modeling stakeholders to define use cases, workflows, and integration roadmap for the EPCON modeling platform. The workshop identified four key use cases: Active Case Finding, TB Preventive Therapy, Adherence Monitoring, and Network Optimization. Key outputs included development of an implementation roadmap for data hosting, integration with TIBU, and dashboard design, with agreement on local cloud hosting and consensus achieved on roles and responsibilities across implementing organizations. Thematic teams were developed for the implementation processes, establishing clear mechanisms for sustained collaboration. The initial phase of the TB model development also included sourcing contextual data encompassing administrative boundaries, demographic and environmental data, human development and socio-economic indicators, and health data including HIV prevalence and immunization coverage.

The AI-driven geospatial EPCON platform has demonstrated effectiveness in improving TB outcomes in countries such as Pakistan and Uganda. Once finalized and deployed in Kenya, the model is expected to generate actionable insights that are currently obscured within the county- and facility-level aggregate data traditionally used by the program. By enabling more granular analysis, EPCON will help uncover underlying patterns, trends, and risk factors that are not readily visible through aggregated reporting, thereby supporting more targeted and data-driven programmatic decision-making.

8.5. Annual Joint Workplan

During Fiscal Year 2025, the National Tuberculosis Program (NTP) successfully convened a three-day Joint Work Planning Meeting held from 22nd to 26th June 2025. The meeting brought together key stakeholders, including development partners such as the Global Fund, U.S. Department of State (DOS), and the World Health Organization (WHO), alongside implementing partners including Centre for Health Solutions–Kenya (CHS), Clinton Health Access Initiative (CHAI), Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN), Respiratory Society of Kenya (RESOK), Stop TB Kenya and AMREF Health Africa.

This institutionalized annual planning forum served as a critical platform to strengthen stakeholder coordination, enhance alignment, and foster synergy across partner-supported interventions. Through collaborative review and planning processes, participants aligned priorities, strategies, and resource allocations with the objectives outlined in the National Strategic Plan. The joint work planning approach further ensured that financial and technical resources for tuberculosis programming are optimally coordinated and directed toward national and sub-national priorities for the fiscal year 2026. This alignment minimized duplication of efforts, enhanced program efficiency, and strengthened the collective contribution of partners toward achieving national TB control targets.

8.6 M&E Recording and Reporting Tools

Standardized recording and reporting tools are essential for effective TB surveillance, patient monitoring, and programme management. They support accurate case documentation, routine progress tracking, and timely reporting across service delivery levels. During the fiscal year 2025, DNTLD-P reviewed and updated key tools for drug-susceptible TB, drug-resistant TB, laboratory services, leprosy, commodity reporting, and community TB activities, while aligning specifications with ISO requirements and introducing serialization for version control. To strengthen continuous data capture and minimize reporting gaps, printing and distribution of assorted recording and reporting tools was done to all counties, as summarized below.

Table 8.2: Printed M&E Recording and Reporting Tools

S/no.	M&E Tool	Quantity printed
1	TB Patient Record cards	100,000
2	DSTB Appointment cards	100,000
3	DRTB Logbooks	1,000
4	DRTB Appointment cards	1,000
5	DADR Register	4,000
6	FCDRR	4,000
7	Contact Management registers	4,000
8	Lab request forms	9,000
9	TB Lab register	1,000

CHAPTER 9

FINANCE, ADMINISTRATION AND HUMAN RESOURCES



9.1 Funding Summary and Performance

The total National Strategic Plan (NSP) resource requirement for tuberculosis (TB) control in Kenya for Financial Year 2024/25 was Kshs 17,748 million. Against this requirement, the program received Kshs 4,412 million from reported financing sources, translating to an overall funding rate of 25%. Consequently, the program operated with a funding gap of 75%, underscoring the continued need for expanded and sustained financing to support implementation of priority TB interventions.

Reported funding was derived from three principal sources: the Global Fund to Fight AIDS, Tuberculosis and Malaria, which contributed 67% of total funding and primarily supported the procurement of health commodities, capacity building for healthcare workers, updating of policies and guidelines, surveys, technical assistance to counties, patient support, and office administration costs; the United States Government, which contributed 29% and supported capacity building for healthcare workers in counties; and domestic resources, which accounted for 4% and were utilized for the procurement of TB health commodities, excluding human-resource costs for healthcare workers involved in TB care and health infrastructure costs.

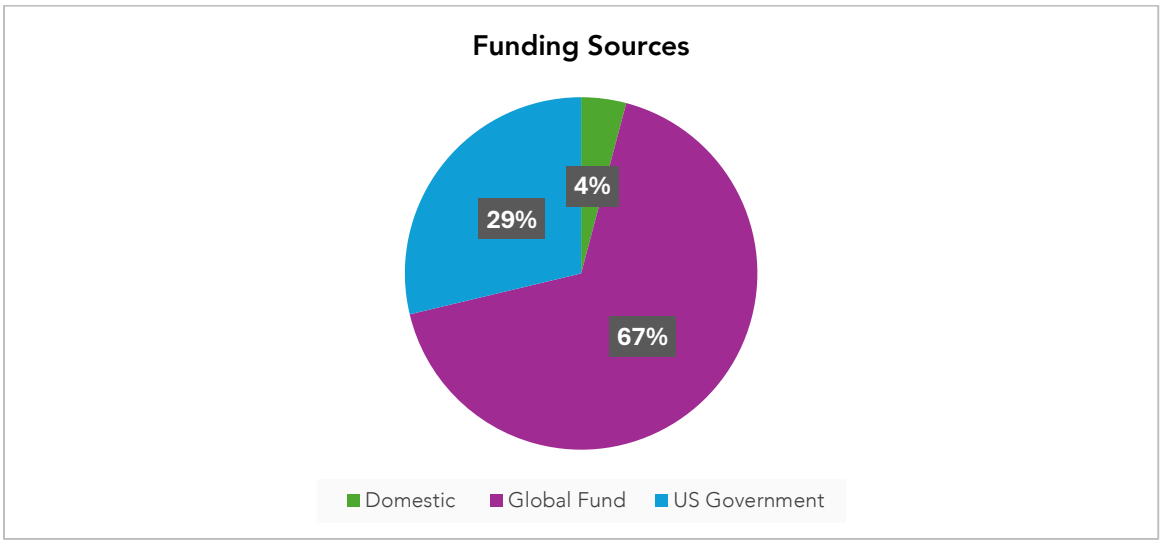


Figure 9.1 Funding Sources

For the reporting period, available resources were channeled toward priority interventions intended to sustain service delivery, strengthen program operations and maintain progress in TB prevention, diagnosis, treatment and care. The funded interventions reflect the program's continued focus on protecting essential services despite the constrained financing environment.

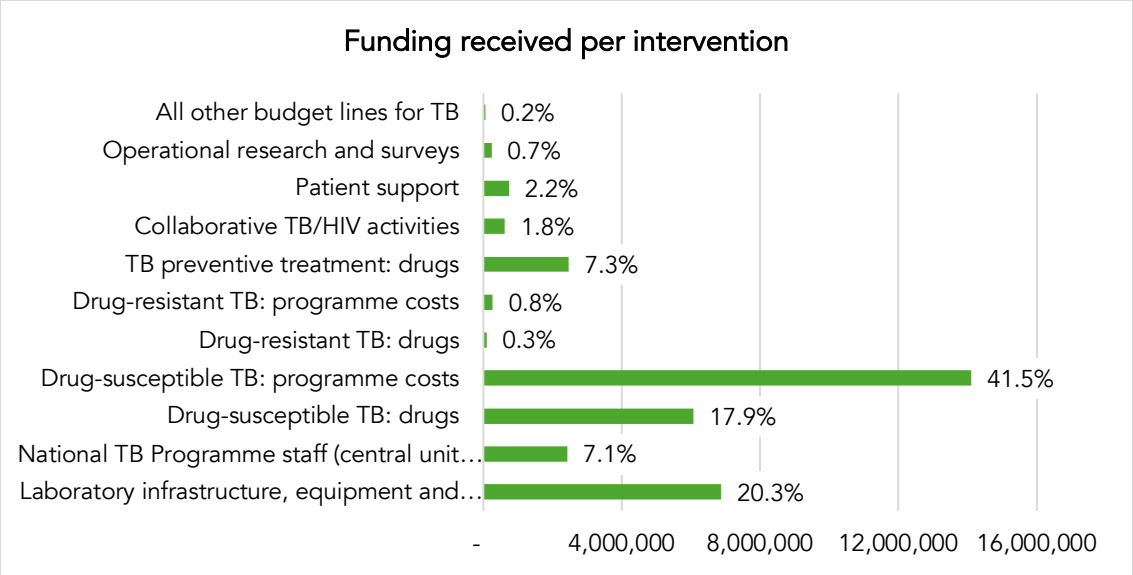


Figure 9.2 Funding received per intervention

9.2 Financial Controls, Audits and Compliance

With support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the TB program fully transitioned to the use of the Enterprise Resource Planning (ERP) system for core financial and administrative processes. These processes include budgeting, procurement, payroll, invoicing, cashbook management and financial reporting. Full adoption of the ERP system has strengthened internal controls by improving process standardization, enhancing transaction visibility and enabling more timely monitoring of financial performance. It has also contributed to improved accountability, audit readiness and the generation of real-time management information to support decision-making.

The program will continue to prioritize compliance with applicable financial management policies, partner requirements and government procedures. Emphasis will be placed on timely documentation, periodic reconciliations, adherence to procurement plans, and

regular review of expenditure against approved budgets to ensure resources are used efficiently and in line with intended program objectives.

9.3 Human-Resource Establishment and Staffing Gaps

During the reporting year, the TB program had a total of 51 supported staff against an proposed establishment of 70 staff. This represents a staffing gap of 19 positions, equivalent to approximately 27% of the required establishment. The gap has implications for workload distribution, timely implementation of planned activities, supervision, reporting and the program's ability to provide adequate technical support across functional areas.

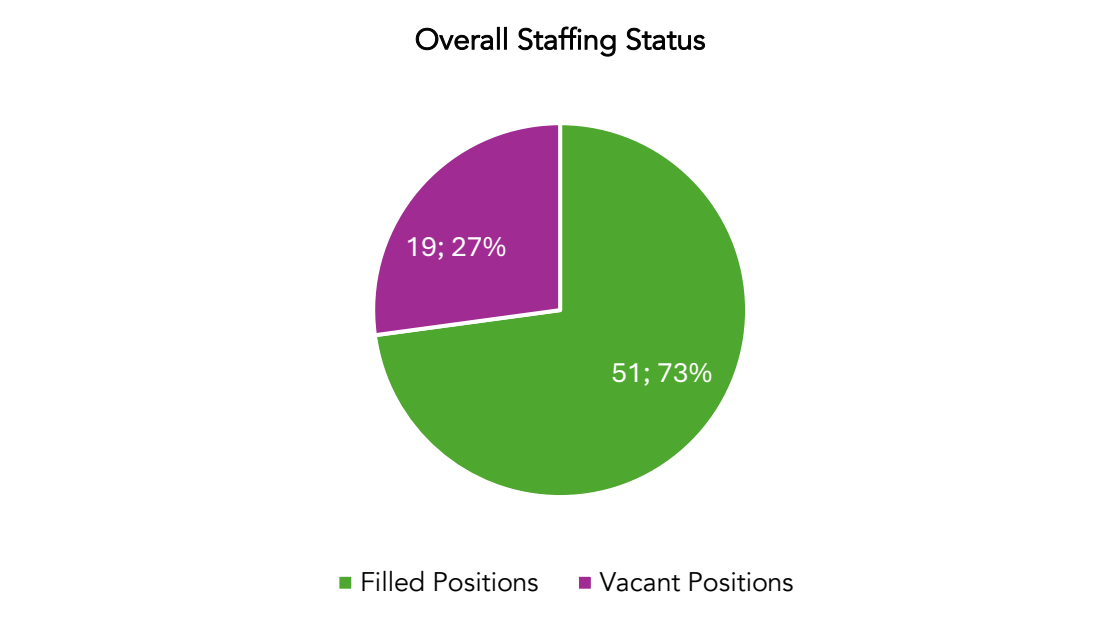


Figure 9.3: Overall staffing status

The staff distribution by section/category is presented below. The distribution provides an overview of existing human-resource capacity across the program and highlights areas that may require further strengthening to support effective implementation.

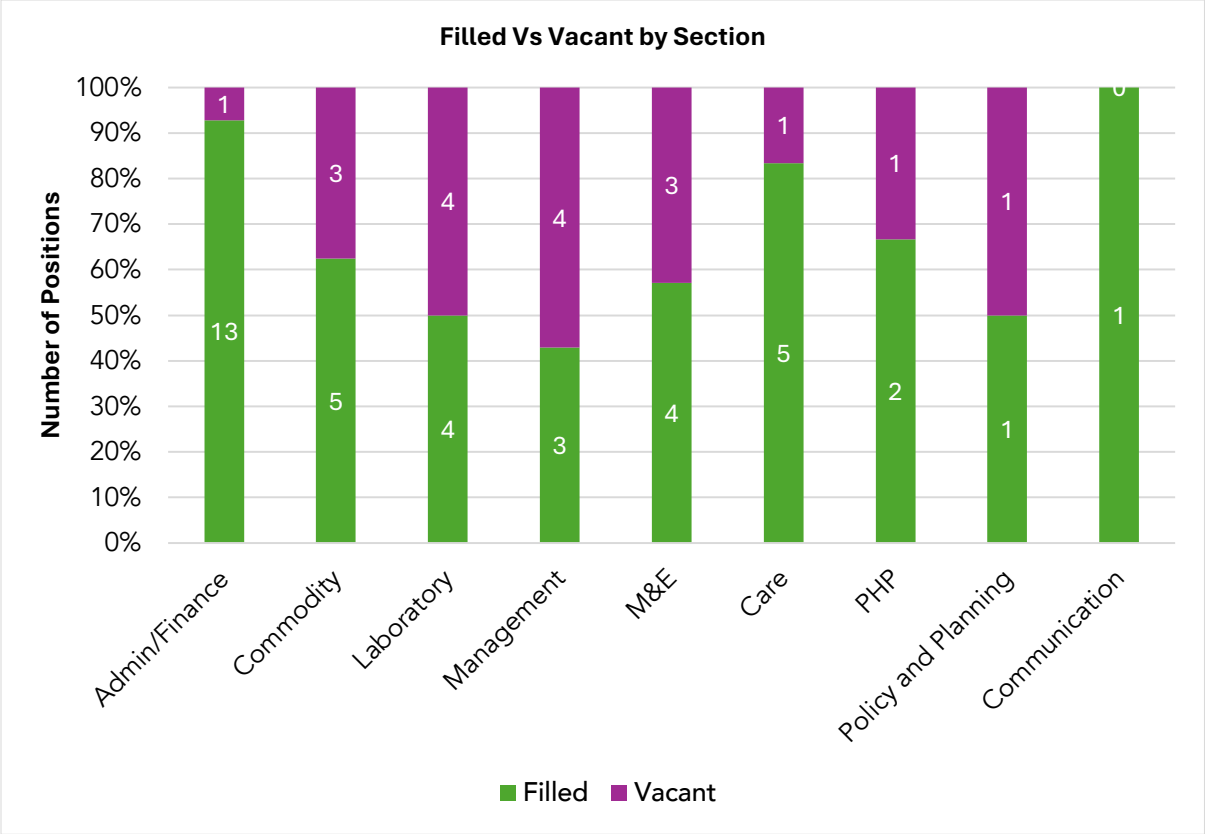


Figure 9.4: Positions filled vs vacant

9.4 Capacity Development and Staff Welfare

Capacity development remained an important enabler of program performance during the reporting period. Continuous professional development, targeted mentorship and on-the-job support are essential for maintaining staff competency, improving service quality and ensuring that personnel remain responsive to evolving program priorities, reporting requirements and technological systems.

With support from the U.S. Department of State through Tamatisha TB, the National TB Program (NTP) strengthened person-centered TB care through mixed methods of capacity building including didactic training, continuing medical education (CME) sessions and facility-level sensitizations. The sessions focused on active case finding, raising the index of suspicion among frontline healthcare workers particularly in high-burden and underserved areas, and improving diagnosis rates across both adult and

pediatric populations. Facilities that had recorded a decline in case notification were prioritized to ensure targeted support where it was most needed. Other areas of capacity building included TPT, IPC, community linkage, quality of care and TB M&E systems. The sessions were conducted across 16 priority counties, targeting high-volume public and private facilities and reaching a total of 5,525 healthcare workers. These results reflect the NTP sustained investment in building a skilled, data-informed, and patient-centered health workforce a critical foundation for achieving Kenya's End TB Strategy goals. A detailed breakdown of the capacity building data is illustrated in the table below:

Table 9.1: Detailed breakdown of the capacity building data

Sub Purpose	Gender	CME	Sensitization	Training
Enhance TB diagnostic capacity	M	112	0	10
	F	126	0	13
Improve quality of care	M	120	82	8
	F	140	49	12
Increase PPM	M	0	20	0
	F	0	43	0
Increase Detection of all forms of TB	M	1151	102	24
	F	1118	75	15
Increase TPT uptake among at-risk populations	M	107	147	0
	F	164	181	0
Strengthening facility and community linkages	M	0	225	0
	F	0	476	0
Strengthen TB M&E systems	M	59	0	0
	F	61	0	0
Strengthen TB surveillance	M	20		0
	F	38	70	0
Strengthen implementation of TB infection control through: IPC	M	239	105	0
	F	361		0
Strengthening capacity for TB control at national and county levels	M	0	22	0
	F	0	30	0
Total		**3,816**	**1,627**	**82**
Grand Total	**5,525**			

9.5 Key Operational Risks and Priorities for 2026

The persistent high funding gap for the NSP for TB control remains the most significant operational risk to the attainment of national End TB targets, including commitments aligned with the Sustainable Development Goals and the United Nations High-Level Meeting targets. For the next financial year 2025/26, the total NSP budget requirement is projected at Kshs 21,541 million against anticipated funding of Kshs 4,676 million. This represents a funding rate of 22% and leaves an estimated financing gap of 78%. If not addressed, this gap may constrain implementation of planned interventions, limit service expansion, delay procurement and weaken program support functions.

With support from partners, the TB program is exploring innovative financing mechanisms to complement domestic resource mobilization efforts in the wane of declining financial aid to sustain the gains made in TB control. Priority areas for 2026 include strengthening advocacy for increased domestic financing from National and County governments, exploring alternative innovative financing models, improving efficiency in the use of available resources, and maintaining capacity development initiatives to support program resilience and continuity.

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