Ministry of Health
National Tuberculosis, Leprosy and Lung Disease Program

TiBa

A magazine for DNTLD-P

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Betna:
A razor-like focus to triumph, and support helped me defeat TB

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TB ARC II Accelerated Response and Care

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National Tuberculosis, Leprosy and Lung Disease Program

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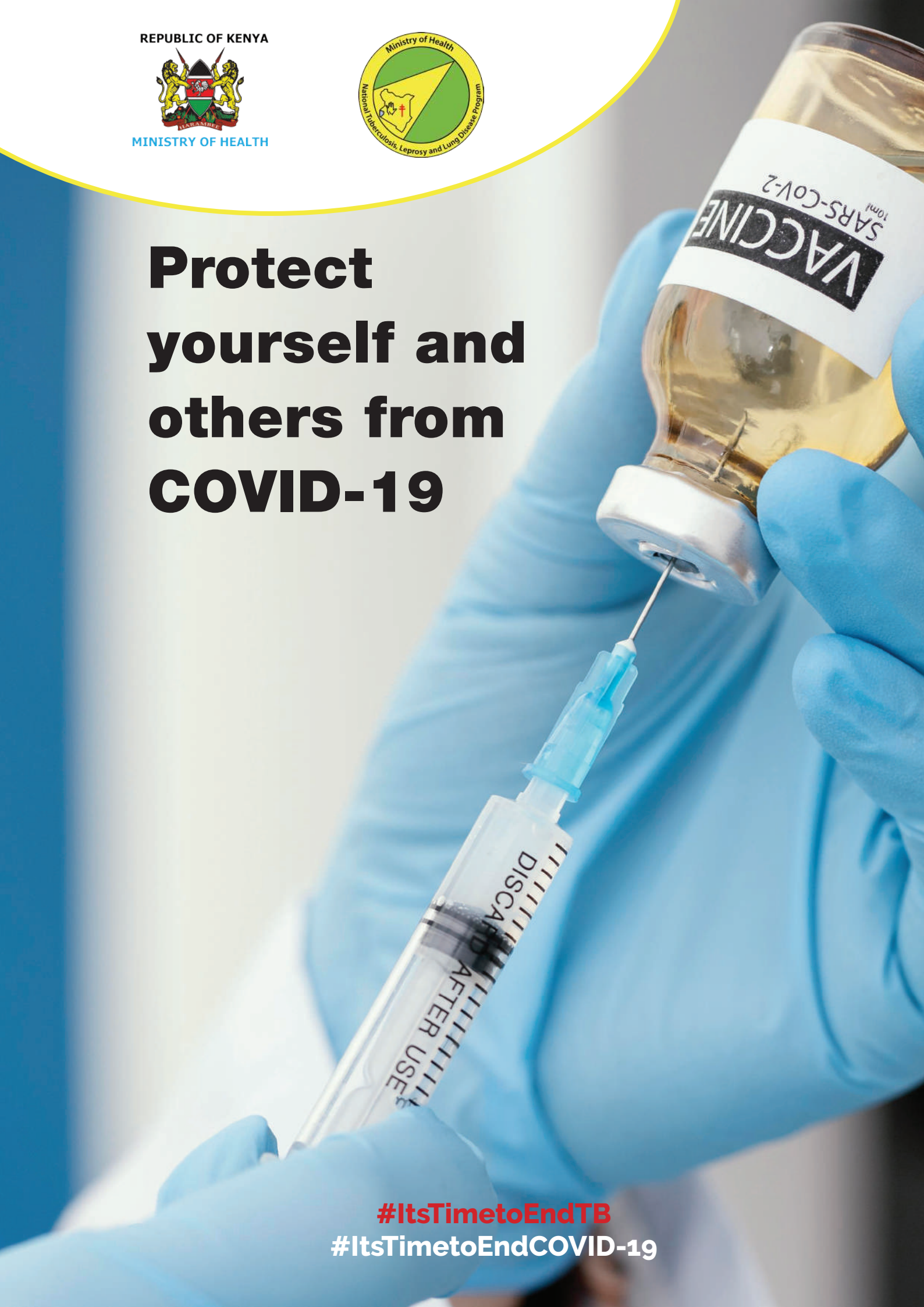

#ItsTimetoEndTB

#ItsTimetoEndCOVID-19

inside

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The editor welcomes articles from readers and stakeholders of DNTLD-P

Word from...

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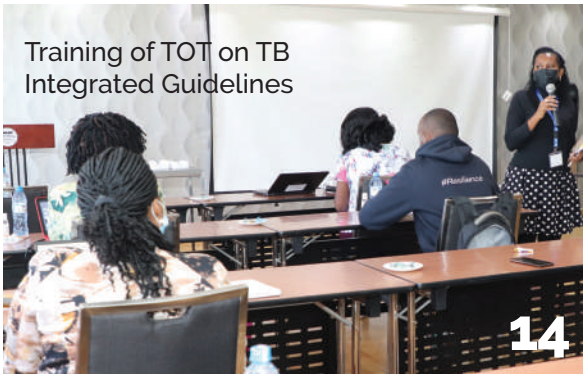
Ag. Director General for Health

Dr. Waqo Ejersa
Head, DNTLD-P



Word from the **Ag. Director General for Health**

There is need for deliberate collaboration among all stakeholders in government, civil society, the private sector and other sectors in the fight against TB. All public policies across sectors should systematically factor in the health implications during implementation. The essence of synergies in health in all policies should be geared towards avoiding harmful health impacts and improving health of the societies we are serving.

The engagement of multiple sectors and partners will see the National TB Program leverage not only on knowledge and expertise, but also reach and resource that will benefit our course as a Ministry. Our combined and varied strengths will also help the government end TB by 2035 in line with the End TB Strategy.

On 26 September 2018, led by his Excellency President Uhuru Kenyatta, Kenya took part in UN High Level Meeting (UNHLM), the first-ever high-level meeting of the United Nations General Assembly on TB in New York. Themed, "United to End Tuberculosis: An Urgent Global Response to a Global Epidemic," the meeting aimed to accelerate efforts in ending TB and to reach all affected people with prevention and care.

The UNHLM theme reiterated collaboration through purposive unity. We committed to increase efforts to diagnose and successfully treat those with TB and champion for better health outcomes.

Through Multi-Sectoral Approach (MSA), it will be easier to devise common objectives and optimize the scarce resources we pool together. Further, the effectiveness and efficiency of the National TB Program by avoiding duplication of inputs and activities cannot be reemphasized due to the synergies.

Whereas it is important to look at our health system, it is also crucial for MSA to critically look at all the determinants of health in TB management. The approach should make reference to evidence-informed actions by multiple sectors for optimal health among Kenyans. As we enhance public health disease prevention and health promotion functions, it is imperative we unearth political, social, environmental, behavioural, cultural, ecological, commercial and other determinants of health that might impede our course in the fight against TB.

As a ministry, we accept our role as the champion of quality health. Our focus is both preventive and curative and we strive to promote health agenda across government entities and communities.

Through broad-based leadership, both political and administrative, our health sector assumes this champion role that focuses on health equity as societal priority. Already our President and our Cabinet Secretary have shown willingness and commitment which is critical at the top leadership level. The coordination team should, therefore, promote MSA and engage all line ministries and the non-engaged stakeholders, particularly those in the non-health sector.

Dr. Patrick Amoth, EBS
Ag. Director General for Health

Word from the
Head of Division of National Tuberculosis Leprosy and Lung Disease Program

The private health care sector remains an important player in the delivery of health services in Kenya. It offers numerous opportunities for advancing public health gains in Tuberculosis (TB) prevention and care due to its vibrant, growing and always competitive mode which could be utilized to enhance access and quality of TB prevention and care services.

In collaboration with partners, the Division of National TB Leprosy and Lung Disease Program is developing a Public-Private Mix (PPM) action plan for 2021 – 2023 that is informed by lessons learnt from the 2017-2020 PPM action plan and is aligned to the National TB strategic plan.

In line with WHO recommendation, the National TB program continues to engage all providers and strengthens the contribution of the private sector towards achieving TB targets. The End TB Strategy also lays emphasis on building strong linkages with all health care providers and engaging all towards ending TB.

The private sector, both private for-profit and Non-Governmental Organizations, play a big role in delivering key services for the fight against TB as well as strengthening health systems. For the past 4 years, the National TB program has worked with partners to strengthen the delivery of TB services. In 2020, the sector contributed up to 20% of the case finding.

Poor quality treatment can lead to the development of Multi Drug-Resistant TB. Great progress has been made, but there is still need to accelerate efforts to end TB and ensure better health and wellbeing for all by 2030.

Dr. Waqo Ejersa
Head, National TB Program

JUSTMEN: Fighting Tuberculosis among men in Kenya

Photo: courtesy

Sam Makau, Alvan Gatitu, Paul Wakimani, Fundi Frank, YY comedian, Dr Waqo Erjesa -Head, DNTLD-P, Eko Dyda, Wakimbizi, Sam Osewe, Stephen Anguva, Dr. Kinyanjui during the forum.

By DNTLD-P

Nelson Mandela once said, "It always seems impossible until it's done". The "JUSTMEN " only forum organized by Stop TB Partnership-Kenya and WACI Health captured part of our dream of making the impossible possible by bringing men together, as we strive to fight and end Tuberculosis (TB) among men in Kenya.

TB remains a major public health threat as it is the leading cause of mortality in Kenya. The burden for TB, TB/HIV and Drug-Resistant TB, over the years, has remained high in Kenya. In 2020, the incidence was estimated to be 140,000 people while that of DR TB to be 2,500. Further, 33,000 people died of TB while the Program diagnosed and started on treatment 72,943 people with drug-susceptible tuberculosis (DSTB) and an additional 961 with DRTB respectively.

Men remain the most affected population by TB with 66% of all cases notified with TB in 2020 being men. In terms of age group, people between the ages of 20 and 44 years carried the majority of the TB burden. The country, however, continues to miss approximately 40% of incident TB cases with the highest burden of the disease being twice as high in men compared to women and among the most economically productive age group.

In many settings, men have a higher prevalence of TB. They remain infectious in the community for a longer period than women. They, therefore, generate a greater number of secondary infections than women. In addition, social mixing patterns suggest that men are responsible for the majority of infections in men, women and children. They also are likely to have higher rates of exposure to TB, because on average, they have more contact with other adult men than they do with children who tend to have less infectious TB disease. The higher prevalence of TB in men is not due to under-diagnosis in women but it seems to be more related to late presentation, thus delayed diagnosis of TB in men.

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Whereas the targets for the End TB Strategy are ambitious, they are still achievable, but they will only come to pass if we improve diagnosis and treatment among men. While addressing TB and gender-related issues, we should not continue to insist on addressing the needs of women and girls whilst ignoring the inequity faced by men and boys. They carry a higher burden of the disease and often have less access to timely diagnosis and treatment. Addressing men's burden of disease and disadvantage in TB care is not only an issue for men's health but for broader TB prevention and care. Both national and global TB discourse and policies on key populations need to include a focus on men.

The World Health Organization's End TB Strategy emphasizes the importance of equity in access to diagnosis and treatment. It calls for the prioritization of systematic screening of high-risk groups to ensure early diagnosis of individuals with TB. Our 2019-2023 National Strategy considers men as a high-risk group for TB.

Why are men disadvantaged in the TB care pathway? Why do male TB patients often delay care-seeking longer than female TB patients? Is it that our screening procedures in community and facility-based active case finding are less effective in identifying TB disease in men than women? Is it that men refuse to report symptoms or are the sub-clinical phase of the disease longer for men? Are we addressing the wrong barriers related to visiting of healthcare facilities?

Evidence has shown that factors such as loss of income and financial barriers, as well as stigma, affect men's healthcare decisions. Care-seeking decisions are further influenced by perceptions of masculinity that discourage admission of illness, and systems of care that might take away men's sense of control and leave feelings of inadequacy. While the prevalence of HIV is slightly higher among women than men, the prevalence of TB is higher among men, even in countries with generalized HIV epidemics. Men face a relative disadvantage in accessing and remaining in HIV care and so men's risk of TB is likely to be further increased as a result of undiagnosed and untreated HIV co-infection and missed opportunities for TB screening within HIV care.

Interventions to improve case detection among men, therefore, must recognize and address the aforementioned barriers. In addition, case detection efforts, whilst not ignoring women and children, should be greatly strengthened for men. This will require concerted efforts to address the barriers that men face in accessing care.

Our healthcare system should be cognizant of and sensitive to men's needs. We should consider offering dedicated clinic times and outreach services that are men targeted. Comparable opportunities for TB strategies offering convenient access to TB care while maintaining men's sense of control should be explored as well. Also, the effectiveness of TB diagnostic services that incorporate men's peer networks or workplaces to promote wellness and reduce stigma cannot be understated.

The Ministry of Health through the National TB, Leprosy and Lung Diseases Program (NTLD-P) has made significant progress towards achieving the objectives set to end Tuberculosis (TB) in Kenya. In the current implementation plan, we have placed greater emphasis on the high burden of disease in men and the need to invest in male-friendly diagnostic and screening services to reduce undiagnosed TB. This is in line with our vision as projected in NSP geared towards a Kenya free from TB and Leprosy, and reduced burden of Lung Disease.

As a country, we are committed to diagnose and cure at least 597,000 people with TB by the year 2023, including 55,000 children, 542,000 adults and 4,500 people with Multiple Drug Resistant (MDR) TB in addition to providing TB Preventive Therapy to all Kenyans at risk who also include men.

We all have a role to play in the fight against TB in Kenya particularly among men. We must come up with collaborative measures to promote and undertake TB care and control activities. We need, therefore, to leverage the untapped potential of manpower among men to roll out awareness, detection and treatment programs that are male-centered. The National TB Program cannot win this war alone. With togetherness, we will progress and succeed as one nation. ■

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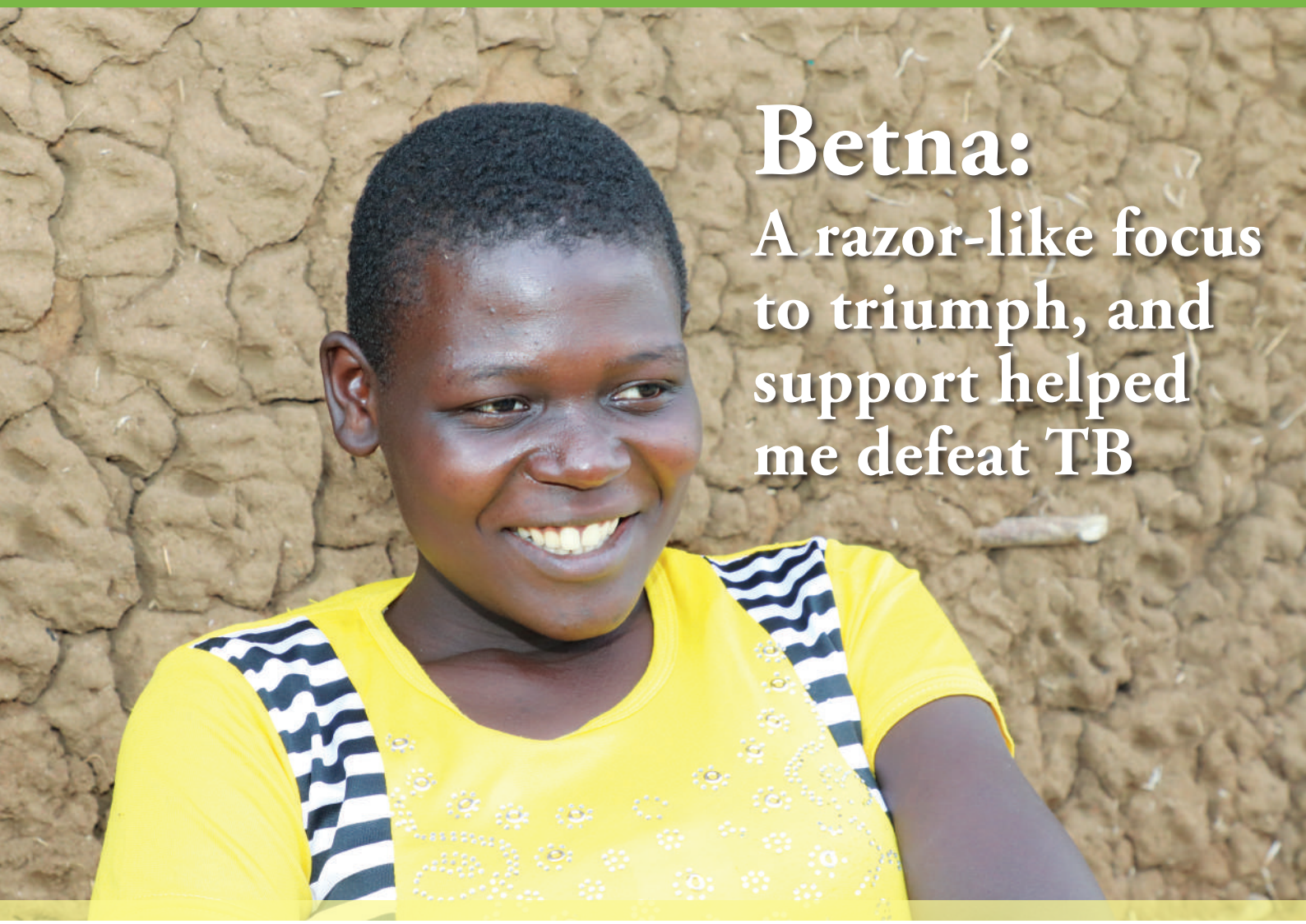

Betna:
A razor-like focus to triumph, and support helped me defeat TB

By Mbetera Felix | DNTLD-P

"We are looking forward to adopting the latest improved diagnostics for children which will use stool sample to replace the invasive sputum sample which has been difficult to obtain from younger children."

Betna's story is about hope and despair and how to cultivate the fortitude that buoys a person to the positive side of life; ensuring one doesn't drown in the storm of desperation. Through her fighting spirit, we are able to see the shining beacon of hope: TB is curable.

At 13 years and in class eight, she was looking forward to sitting for her Kenya Certificate of Primary Education examination. Unfortunately, sickness was about to dim her light to success as she was ill.

According to her mother Evelyne, several health care workers used to say that Betna was suffering from Ulcers. At times, she was advised to get pregnancy tests because she was vomiting a lot. Others thought because she was scrawny, she had probably mingled and slept with boys and as a result contracted HIV/AIDS, thus her alarming weight loss.

"These misconceptions delayed her TB diagnosis and treatment for two years. She visited Bungoma Hospital, but they couldn't establish with certainty what ailed her. When they did a chest x-ray and she was diagnosed with TB, her condition was critical and her lungs were found to have decayed", says Evelyne.

"After the diagnosis, she was referred to Khalaba where, again, she was referred to Matungu and initiated on TB treatment for six months".

Besides the severe loss of weight and vomiting, Betna had other TB symptoms such as cough, severe chest pains when coughing, feeling tired and always sleepy. She would also

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complain about headaches and itching eyes.

When she was finally diagnosed with TB, her worries lessened. "I was relieved; I had been thrown to the deepest end and I couldn't swim. I had been to many hospitals, used a lot of drugs and I wasn't getting any better. I just wanted to die. I felt it was better for angels to take me home. I had given up and resigned my fate to death".

To her family, the diagnosis took off the anxiety that tormented them for two years, puzzling out what was affecting their loved one. "We were relieved because what ailed her had been identified and she could now be treated. We were relieved of the agony of many futile tests because everywhere we went for medical examinations nothing was found", says Evelyne.

She adds, "The number of times Betna visited Bungoma Hospital before it was established she had TB are countless. The moment they did a chest x-ray, that is when she was diagnosed with TB and initiated on treatment".

This treatment wasn't successful as she faced a lot of challenges. She persistently vomited and was terribly weak, hence wasn't able to walk to the hospital. Although, doctors and other Medicare workers closely monitored her progress and availed to her provisions like nutrition supplements, the first phase of her TB treatment failed and thus put on Multi-Drigu Resistant (MDR) treatment that included tablets and injection.

Whilst she was initiated on MDR treatment, Betna had already come into contact with her baby brother who was diagnosed with TB adenitis. Prior to their treatment, her mother says she had gotten them over the counter drugs.

The medical team sought Betna's head teacher's permission to allow her to stay home due to the daily injections. Though she was allowed to be off school for medication, her teachers and colleagues shunned her even after treatment. She was chased away from school when she went back to sit for her class eight exams.

"I felt bad that my friends were sitting for an exam that I also spent so much of my time preparing for, but was denied that chance. They couldn't even allow me to sit for the exam alone from other students! But even then, I felt bad at the thought that I couldn't freely be with other students, but now I'm very much okay, I am thankful I don't experience this stigma", says Betna.

The hospital wrote a letter to the school making a formal notification that Betna had completed her treatment and had been cured. Oblivious of the facts, the school refused to take Betna back and the mother opted to take her daughter to another school. Also, a request to conduct a mass TB screening in the school was declined.

Her neighbours used to say she had HIV/AIDS. A claim they reinforced after reading the packets of nutrition commodities given by health workers. "people told her that the flour was meant for people with HIV and so she was HIV positive. The good thing is that she didn't give up, she continued taking the porridge. She joked that if that was the case, after taking this porridge together with drugs people with HIV get healthy and it is better that she remained healthy. And indeed today, Betna is healthy", says Evelyne.

For a single mother of five who depends on subsistence farming and small business of selling fish for her family's livelihood, the monthly stipend that Betna got from AMREF after being initiated on MDR TB treatment was a boon.

Besides catering for Betna's food as she needed a special diet to help her recuperate, the mother saved some money and used it to pay for her school fees. "I would buy her the food she liked, however, we were prudent in our expenses. We used part of the money to pay for her school fee. We have cleared all her form three school fee.", says Evelyne.

While commending the Ministry of Health for an excellent job in finding and treating TB cases through the National TB Program, Evelyne calls for civic education amongst educators and the general public on TB.

Betna with her baby brother who recovered from TB adenitis

Kenya signs Sh48Bn Global Fund grant for TB, Malaria and HIV Interventions

By Mbetera Felix | DNTLD-P

The fight against Malaria, Tuberculosis (TB) and HIV in Kenya has received a major boost after the government signed Sh48 billion three-year Global Fund grant.

The grant which will be implemented between July 2021 and June 2024 will support initiatives in gender and human rights, community case management, strategic innovations, prevention, care, treatment and mitigation of the impact of Covid-19 on the aforementioned diseases.

During the signing ceremony, Health CAS Dr Rashid Aman noted that the Ministry of Health will ensure the grant is implemented as per the designed and agreed framework, and in ways that contribute to the attainment of Universal Health Coverage

"We hope to achieve comprehensive prevention, treatment and care for people infected with HIV, TB, Leprosy and lung disease as well as reduce malaria incidence and deaths by at least 75 percent of the 2016 levels by 2023," Aman said.

Under the coordination of the Kenya Coordinating Mechanism, the implementation will be undertaken by the Ministry of Health through the National Treasury, Amref Health Africa, Kenya Red Cross Society, and other sub-recipients who will be competitively selected

The National Treasury, Amref Health Africa and Kenya Red Cross Society will manage Sh31.3 billion for HIV, TB and Malaria grants, Sh7.4 billion for TB and malaria grants, and Sh8.1 billion for HIV grant respectively.

Over the years, Kenya has had remarkable progress in the fight against the three diseases as a result of the Global Fund support. Treatment success rate, for instance, among TB patients has improved from 81 percent in 2018 to 85 percent in 2020 while the incidence rate has been declining by eight percent annually. Patients with Multi-Drug Resistant TB have also been enrolled in the National Health Insurance Fund for social protection.

Dr Rashid Aman, Chief Administrative Secretary-Health during the grant signing ceremony

Also, there has been a steady decrease of HIV prevalence from as high as 11 percent in 1998 to the current level of 4.9 percent. More than 75 percent of the 1.49 million people living with HIV in the country have also been put on Anti Retro Viral therapy.

During the previous grant, the Ministry procured and distributed countrywide over 7.5 million doses of antimalaria drugs, seven million rapid test kits and 16 million long-lasting mosquito nets countrywide.

The Global Fund is a partnership between governments through the National Treasury and the Ministry of Health, civil society, private sector and people affected by diseases. It is designed to accelerate the end of AIDS, Tuberculosis and Malaria epidemics globally.

The National Treasury, Amref Health Africa and Kenya Red Cross Society will manage Sh31.3 billion for HIV, TB and Malaria grants, Sh7.4 billion for TB and malaria grants, and Sh8.1 billion for HIV grant respectively.

Status of National Tuberculosis Epidemic and Response

Quarter Three 2021

Drug susceptible TB

18,900
Number of TB cases Notified

79.5%
Treatment success rate (All forms)

7.1%
Case fatality ratio

9.4%
Poportions of children

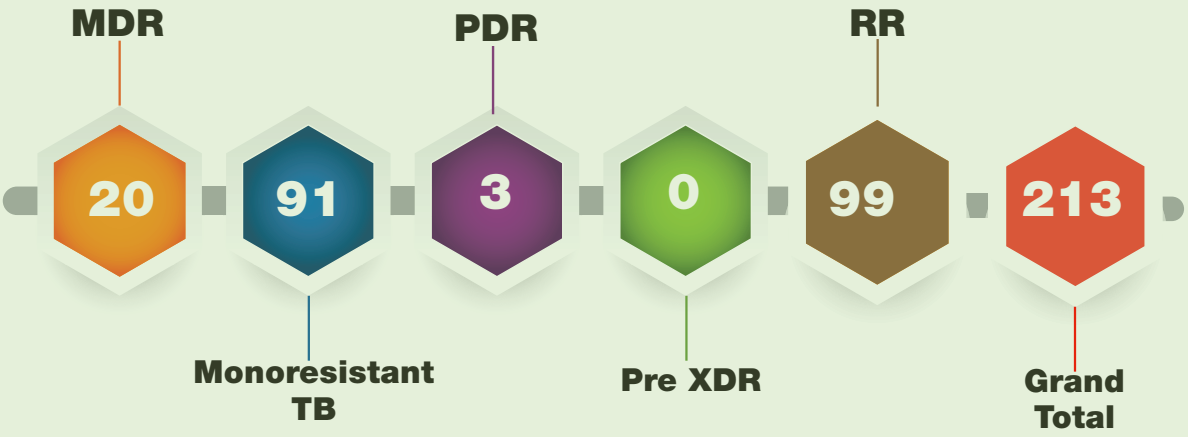
79%
Previously treated (DSTB) with DST results

94.4%
Proportion of DSTB with Known HIV status

5.6%
Lost to Follow Up

91%
Proportions on ART

Drug resistant TB



Leprosy

33
Number of Leprosy Cases reported

TB Prevention Therapy

1,381
Children <5 initiated on IPT (contacts of bacterilogically confirmed cases

Finding Missing Cases among Key Populations in Kisumu County

Jua kali artisans being screened using a mobile X-ray machine in Kisumu town during an outreach

Kisumu is one of the counties with the highest TB burden in Kenya. A key vulnerable population in the County is the fisher-folk who comprise roughly 30% of the county population.

By Mbetera Felix | DNTLD-P

The Division of National Tuberculosis Leprosy and Lung Disease Program (DNTLD-P) in collaboration with the County Government of Kisumu, Department of Health carried out community outreaches in key hotspots within Kisumu.

The outreaches which brought TB diagnostic clinics closer to where people live and work aimed to increase case detection in settings where undiagnosed TB is widespread.

According to Timothy Malika, TB and Leprosy Coordinator, Kisumu County, it is important for the national and county governments to decentralize and expand health care through more horizontal and community-based forms of service delivery, thus expanding the provision of TB screening, diagnosis and treatment.

"More often than not, our health centers are overburdened as there are not enough health workers to care for the number of people presenting at facilities for health services. With appropriate resources and training, TB screening and care activities should be placed into the hands of community members if we are to find the missing cases," he said.

Based on the 2016 prevalence survey, Kenya has a TB prevalence of 426 per 100,000 population. Kisumu is one of the counties with the highest TB burden in Kenya. A key vulnerable population in the County is the fisher-folk who comprise roughly 30% of the county population. The fisher-folk take a priority population for HIV interventions given the demonstrated high HIV prevalence, but TB interventions have been limited.

During the exercise, the county in collaboration with DNTLD-P used two approaches where anyone with at least one TB symptom was asked to provide a sputum specimen for GeneXpert testing and medical camps equipped with x-ray vans, implemented at central locations within the county. The two mobile digital X-ray machines are owned by the National TB Program to screen those exhibiting TB signs and symptoms. Those whose chests were suggestive of TB were required to produce sputum for GeneXpert analysis.

The three-week exercise was part of the Stop TB Partnership TB Reach Wave 7 funding which the County has been implementing. It covered Kisumu Central, Kisumu East, Nyando, Nyakach and Seme.

A presumptive client being screened using a mobile digital X-ray machine in juakali, Kisumu town.

Timothy Malika, Kisumu TB and Leprosy County Coordinator guiding an artisan during the outreach.

Members of the public being screened for TB.

A radiographer from Kisumu County taken through the settings of the mobile Xray machine during the outreach.

Integration of HIV and TB services during screening.

PRM AWARDS

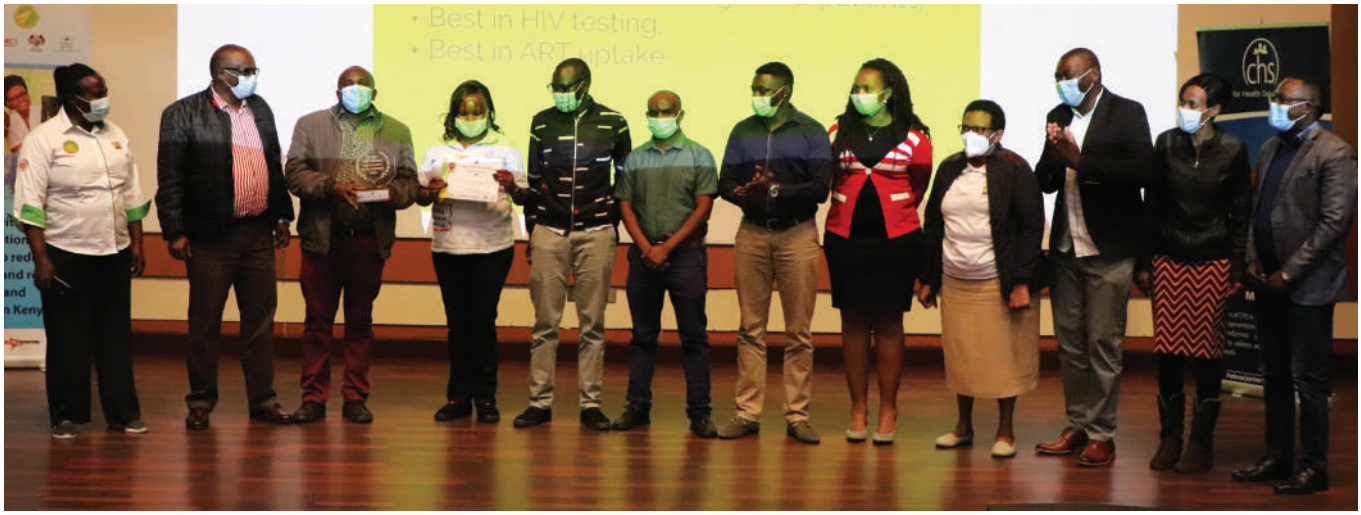
REVIEW OF PERFORMANCE ON TB MANAGEMENT IN KENYA

The best performing counties and sub-counties in TB control for the year 2020 were awarded during the performance review meeting held at the Lake Naivasha Country Resort in Nakuru County. The award ceremony which was held on 20th August, 2021 reviewed the performance of TB indicators across all 47 counties. It brought together TB managers and Key partners from both National and County levels. The winners included:

1. Kericho - Best Performing County
2. Mandera - 2nd Best Performing County
3. Siaya - 3rd Best Performing County
4. Kipkelion West - Best performing Sub-county
5. Bomachoge Chache - 2nd Best Performing County
6. Mbooni West - 3rd Best Performing County
7. Mandera - Best County in TB Quality of Care
8. Siaya - Most Improved County
9. Kipkelion West - Most Improved Sub-county

Dr Waqo Ejersa, HOP-DNTLD-P awarding the Kericho team for being the Best Performing County in 2020.

Dr Lorraine Mugambi, Chief of Party USAID TB ARC II-CHS, awarding Mandera team, the 2nd Best Performing County in 2020.



Dr Waqo awarding Mbooni West team for being the 3rd Best Performing Sub-County in 2020.

Annual Joint Work Planning for the Financial Year 2021/2022

Dr Waqo Ejersa, Head of Prgram, DNTDL-P, giving openning remarks during the workshop.

By Mbetera Felix | DNTLD-P

The Division of National Tuberculosis Leprosy and Lung Disease Program (DNTLD-P) undertook a week-long joint work planning exercise with all its supporting and implementing partners in the country at the Great Rift Valley Resort.

The exercise was aimed at strengthening The National TB Program stewardship and outline a clear roadmap for TB control in the country for the financial year 2021-2022.

Speaking during the workshop, the head of the TB Program, Dr. Waqo Ejersa noted that it is important for all stakeholders to set out clear actions that capture Kenya's vision of a TB and leprosy-free nation with reduced burden of lung disease.

"Every Kenyan has a right to good health as per our Constitution. Our vision without actions will be mere dreams which won't bear fruits. I am excited that as a country, we are taking bold steps to actualize these strategies," Dr Waqo said.

Dr Waqo was grateful that all partners were on board and that the joint work planning exercise would help the Program strategize without duplication. He added that the exercise would also help in ownership of the strategies to be implemented.

Dr Lorraine Mugambi-Nyaboga, Chief of Party, USAID TB ARC II - CHS also noted that it is prudent to optimize the little resources at both the national and county levels and enhance synergies among the implementers.

The workshop brought together DNTLD-P staff, TB County representatives, National AIDS, and STIs Control Programme, AMREF Health Africa, Centre for Health Solutions-Kenya (CHS) USAID TB ARC II, Kenya Conference of Catholic of Bishops, Health IT, World Health Organization, Centers for Disease Control and Prevention, Clinton Health Access Initiative, and Stop TB Partnership Kenya.

The review of last year's performance, goals and achievements further guided the planning process and helped develop a sense of where the Program is headed in line with the 2019-2023 National Strategic Plan. The workshop was supported by USAID TB ARC II Activity.

Dr Andrew Mulwa, Ag. DMS/PPH.

Dr Nazila A.R Ganatra, Head-National Strategic Programmes.

Dr Waqo Ejersa, HOP, DNTLD-P.

Evaline Kibuchi, CEO, StopTB Partnership Kenya.

Dr Samson Muga, KCCB Komesha TB.

Ulo Benson, Global Fund Project Manager, TB, Amref Health Africa.

Dr Lorraine Mugambi-Nyaboga, Chief of Party, USAID TB ARC II-CHS.

Hesbon Ooko, Deputy Chief of Party, Health IT

Philip Muchiri, Clinton Health Access Initiative

Assessing IGAD TB Grant in Refugee Camps in Kenya

Dr Ogutu Benard from Kenya Coordinating Mechanism assessing a pharmacy during the mission.

By Mbetera Felix | DNTLD-P

The Kenya Coordinating Mechanism (KCM) in partnership with the Division of National Tuberculosis Leprosy and Lung Disease Program (DNTLD-P) undertook a review of the Intergovernmental Authority on Development (IGAD) TB grant in refugee camps in Kenya.

The grant which is being implemented by the Kenya Red Cross Society in Dadaab and Kakuma refugee camps is part of the 2019 – 2022 Global Fund (GF) Programming. It aims to complement member States' efforts to realizing the ending of TB in the region through strengthening capacity for TB and Multi-Drug Resistant TB diagnosis and TB/HIV service provision as well as strengthening in-country and cross border collaboration of National TB Programs.

In Kakuma, the mission which was led by Dr. Ogutu Bernhard from KCM visited a number of treatment sites including Kalobeyei, situated in Turkana West Sub-County. The mission monitored efforts to improve and maintain program quality and performance over time, and give recommendations for improving the quality of TB program implementation and performance with a realistic action plan and timeline.

During a courtesy call with the county top leadership, the mission discussed further synergies and support including allocation of staffs to operate GeneXpert, installation of new Gene-Xpert machines, resource mobilization opportunities, effects of COVID-19 in TB management at the camps, commodity stock-outs, increasing number of unregistered refugees who seek health services and cross border collaborations on referrals and follow-ups

According to Dr Ogutu, KCM is mandated is to attract funds from GF for the TB, HIV and AIDS, and Malaria programs and coordinate, monitor, evaluate and support the implementation of the GF grants.

"KCM is responsible for ensuring that the Global Fund projects are country-owned and implementation of these projects, including the cross border collaborations are country-driven," he said.

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In Daadab, the team visited the county health management team, Refugee Affairs Secretariat (RAS), International Rescue Committee and Dalgahaley health facilities.

IGAD along with member states and stakeholders were awarded the GF grant for multi-country TB interventions among refugees in Eastern Africa. The Kenya Red Cross Society implements the grant as a sub-recipient in collaboration with the Ministry of Health - National TB Program, Refugees Affairs Secretariat, County Governments of Turkana and Garissa and United Nations High Commissioner for Refugees.

The mission at the Natukobenyo Health Centre - Kakuma.

The mission perusing TB recording tools at Dagahaley hospital - Daadab.

Wendy (DNTDL-P) and Njeri (RAS) interviewing a beneficiary Abdul at Dagahaley Health facility.

Hon. Josphat Nanok, Turkana County Governor, addressing the mission during a courtesy call.

Fighting TB in Refugee Camps

Hamed's Story

By Mbetera Felix | DNTLD-P

For Hamed*, it has been a rough couple of years. Whereas at times life is hard for everyone, people find it hard to truly relate to her battle with Tuberculosis (TB) for over 10 years now, no matter how much she attempts to explain. As a 32-year-old refugee at Dadaab camp and a mother of six, her rough life has been a buildup of the bumpy patches she has experienced over the years.

Hamed was first diagnosed with TB while in Ethiopia 11 years ago. To date, she is not sure if it was Drug Resistant or Drug Sensitive TB but she was under medication for a period of one year. The gun battles in her home country, Ethiopia, pushed her family to seek refuge in Kenya. For the last 10 years, Dadaab has been her home. She relocated to Kalobeyie refugee settlement, within Dadaab, where she has been for the last five years.

In 2019, her 70-year-old husband passed on due to TB. Sadly, this was only confirmed after his death due to a late diagnosis. It was not clear if it was DSTB or DRTB as no follow-up was done after his death.

While in Dadaab, Hamed was diagnosed with TB, again. This time around, her two-year-old daughter was also diagnosed with TB and severe acute malnutrition. Despite being under medication and nutrition supplements for six months, her treatment failed necessitating re-initiation to treatment at Kalobeyei Health center which is manned by Red Cross Society- Kenya.

Her six-year-old son, unfortunately, was also diagnosed with Drug-Resistant TB in April, 2020.

"Since he started his treatment, he has really improved. He is doing much better than he was last year" Hamed notes.

Hamed during the interview at the Kalobeyei Health center which is manned by Kenya Red Cross Society.*

The family has been battling stigma at the camp due to TB.

"None of my children leaves the house because they get beaten by the community members.... They are seen as outcasts. My oldest child has been beaten a number of times on the accusation they are spreading TB to community members. They are told because their mother and brother have TB and their father died of TB, they spread TB to the community when they go out to play. I can't go to the market freely because I fear for my life." She says.

The sweltering heat which sometimes reaches 40 degrees Celsius during the day and drops to the low 30s at night offers no relief when they stay indoors. Besides the harsh climate at the camp, the labeling of Hamed* and her family as "*Watu wa TB*" (people with TB) has increased stigma impeding many patients from seeking medical assistance for fear of victimization.

Hamed* represents the growing number of refugees and displaced persons who are at risk of both TB and of inadequate TB services and treatment. Many refugee camps, just like Kakuma, are overcrowded and are often associated with inadequate access to water and sanitation, overdependency and disruption to normal social patterns which affect TB control programmes.

Coexistent illness and the poor nutritional status of many refugees also weaken their immune system making them vulnerable to developing TB. Since TB is more common in both countries of origin and in host countries, it is essential to involve key stakeholders from the region in the implementation of the key strategies.

The National TB Program (NTP) in collaboration with the Red Cross Society -Kenya, Refugees Affairs Secretariat, County Governments of Turkana and Garissa, and United Nations High Commissioner for Refugees has set priority in identifying and treating infectious patients in camps and ensuring they become non-infectious within two weeks of commencing their treatment.

As a sub-recipient of the Intergovernmental Authority on Development (IGAD) TB grant in refugee camps in Kenya, Red Cross supports NTP in ensuring TB patients are treated and cured to prevent the development of drug-resistant TB. They also support community education geared towards removal of stigmatization, early self-referral of TB clients and the importance of adherence to treatment.

Training of Trainers on Integrated Guidelines

Dr Lorraine Mugambi-Nyaboga, Chief of Party, USAID TB ARC II-CHS making a presentation on performance and leadership during the training.

By Mbetera Felix | DNTLD-P

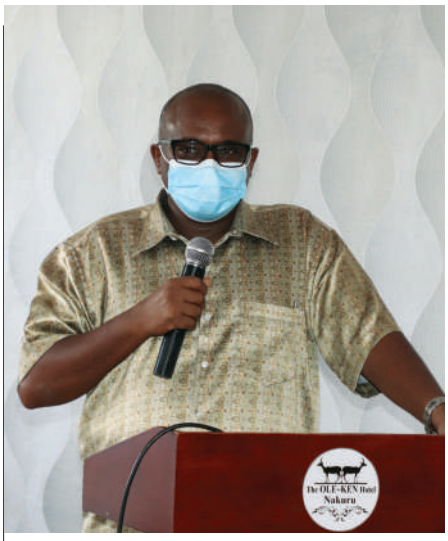
The Division of National Tuberculosis Leprosy and Lung Disease Program held a capacity building workshop for Training of Trainers (ToTs) on the updated Integrated Guidelines on TB management in Kenya.

The two-day sensitization workshop which was supported by the USAID TB ARC II - CHS and Amref Health Africa Capacity Building Project, targeted County Directors of Health, County TB and Leprosy Coordinators, County Medical Laboratory Coordinators, County Pharmacists, Sub-County TB coordinators, Sub-County Medical Laboratory Coordinators, Sub-County Pharmacists and two Health Care Workers from high volume facilities.

The updated guideline integrates new evidence and reinforces previous recommendations that are core to the TB care cascade. The guideline is a revision of the 2017 Integrated TB, Leprosy and Lung disease guideline. The key thematic areas covered were: Diagnosis and treatment of TB, drug resistant TB and TB in special conditions, nutrition, infection prevention and control, lung health, leprosy, pharmacovigilance and commodity management, community engagement as well as communication and advocacy.

The 2021 guideline has incorporated novel thematic areas that will improve the quality of care for patients, these include Active case-finding strategies, Latent TB Infection, Human Rights approaches and differentiated care.

The goal of the sensitization forum was to develop a pool of ToTs who will cascade this information to the other HCWs in their respective counties. ■



Dr Waqo Ejersa, Head DNTLD-P giving his closing remarks during the workshop

The updated guideline integrates new evidence and reinforces previous recommendations that are core to the TB care cascade.

My battle with TB while sitting for my KCSE exams

By Mbetera Felix | DNTLD-P

Lavin Manyasa, a twenty-three-year-old student at the University of Eldoret reflects on her resolute battle with TB at a crucial stage of her secondary education. She prides like a warrior who made it from the battle field back home. Her gratitude to the matron who cared for her shines bright in her infective smile.

It all started with a swelling on her neck. Lavin would wake up with excruciating pain and her mother would think she strained her neck in her sleep. She would advise Lavin to apply *Deep Heat* to ease the pain but nothing changed.

One day during the August holiday when she was in form four, she applied *Deep Heat* as her mother had advised, only for her to feel a severe stinging and burning to the extent that she washed off the spray-ointment. The pain got worse and it is at this moment that she was taken to St. Marys Mission Hospital, Mumias.

A scan showed that she had a 15-cm deep growth on her neck and was guided to undergo an operation. She was about to sit for her KCSE exams in two months' time and she thought the surgery could wait until she was done.

But her condition degenerated. She had no choice but to face the surgeon's knife. She was operated on and a sample taken to Nairobi for further analysis.

"After the operation, samples were sent to Nairobi and after a month the results came in. I had already gone back to school. It was around October, 2016. I was called back home and informed that I had TB although I didn't show other TB signs. TB manifested in me through the painful neck swelling. I was initiated on a TB treatment", says Lavin.

She was in utter disbelief that the results that showed she had TB were hers. She really felt bad. She thought being diagnosed with TB meant she was also HIV positive.

"I doubted if the results were actually mine. I strongly believed that I couldn't have TB. I had been to many places but hadn't seen nor heard anyone with TB. There is no one in our class who had a persistent cough that could say they had TB. I believed they had given me someone else's results", says Lavin Manyasa.

Her parents were also in shock but her mother, also a nurse, told her not to grapple a lot with questions on how a TB patient needed surgery as TB can manifest in many ways. In addition to the support she received from her parents, she was counseled by the TB nurse in charge at St. Mary's thus progressively changing her insight of TB. She understood that TB is treatable and not a life sentence. She accepted her condition and resolved to adhere to her treatment.

"I doubted if the results were actually mine. I strongly believed that I couldn't have TB. I had been to many places but hadn't seen nor heard anyone with TB.

Sseby Inyangu, the nurse in charge at St. Mary's Hospital, recalls from the first impression, Lavin had TB adenitis but her family members couldn't understand what it was apart from her mum. They thought TB affects the lungs and not any other part of the body.

"We explained to them that the swelling was TB adenitis. I remember she cried, it wasn't easy, but through counseling, we explained to them that TB can affect any body part except nails, hair and teeth and she came to terms with her situation. We informed her treatment would take six months, encouraged her to adhere to her drugs and assured her that TB is curable", Inyangu.

In the beginning, she was given medicines to last her one week, but this changed due to the fact that she was a student and weekly follow-ups were unrealistic as they could interfere with her lessons and she was about to sit for her KCSE.

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"By the fact that she was a student, we couldn't go on with weekly follow-ups. We didn't want to interrupt her school session. At first, we gave her a week's dose, after which we gave her a one-month dose. We were in constant follow up especially with her mother. Along the way she accepted her condition, adhered to her treatment and she got cured", says Douglas Makari, a nurse who supported Lavin throughout her treatment journey

Lavin's case wasn't brought to the attention of teachers or the school management. Even her friends didn't know about her struggle with TB. At home, only her immediate family members knew about her condition.

"I feared being singled out and avoided... I was a high school student and a child. I felt people would reject me when we were revising for KCSE. If they knew I had TB maybe they would have told me not to get close to them fearing I would infect them", says Lavin.

Her condition being TB adenitis, the nurses felt there was no need to screen her fellow students. "If it could have been a smear-positive, then that could have prompted us to go the school and conduct screening and maybe find out other students who could be having TB". Says Inyangu.

Lavin's message to TB patients is that TB is manageable and curable. She encourages them not to fear treatment and once initiated they should take the drugs religiously to the end.

Despite not speaking while in school, Lavin feels now is the time she started talking about it so as to encourage others. "My fight with TB has taught me a lot of things like having the right mindset to accept one's condition and the immense impact on adhering to treatment", says Lavina. She looks forward to working with the National TB Program and partners like KCCB to spread the gospel.

Lavin Manyasa, TB champion with Sseby Inyangu, nurse in charge, St Mary's Mumias during the interview.

Lavin's message to TB patients is that TB is manageable and curable. She encourages them not to fear treatment and once initiated they should take the drugs religiously to the end.

SIDEBAR

"The education sector plays a key role in supporting health care delivery to learners, their families, and the community at large. This support is a key pillar as it leverages the structures of the institutions. According to the National TB program, in the 2016 survey, 40% of TB cases are missed across the country and 50% of these cases are children.

Through the USAID-Funded KCCB Komesha TB program, in collaboration with schools health programs, faith-based learning institutions and their affiliated stakeholders are being engaged in TB prevention, control, and facilitate the creation of a supportive environment for learners on TB treatment while optimizing reverse contact management in schools for TB prevention and control.

Dr. Samson Muga
Program Manager - KCCB Komesha TB Program

Elizabeth Glaser
Pediatric AIDS Foundation
Fighting for an AIDS-free generation

Catalyzing Pediatric TB Innovation Project (CaP):

Lessons Learned in Homa Bay and Turkana Counties

By Dr. Mboya Phelix

Period: April 2019-June 2021

Related Outcomes:

1. An enabling policy and regulatory environment at global and national levels to scale-up effective and innovative pediatric TB diagnostic and treatment interventions.
2. Improved detection of pediatric TB cases by introducing effective diagnostic strategies, approaches and tools.
3. Rapid uptake of and access to improved pediatric TB treatments for both active and latent TB.
4. Generation of novel evidence and cost-effectiveness data to inform policy guidelines and further scale up by additional countries, donors, and implementers.
5. Effective and sustainable transition to national programs is achieved: Sustainability package.

Project Description and Key Lessons Learned

Tuberculosis is an infectious disease and a leading cause of death worldwide. It represents a significant public health threat with 7.1 million new tuberculosis patients and 1.3 million deaths reported in 2019 alone. In Kenya, TB remains a major public health problem. It's the leading cause of death among children and adults combined ranking above HIV and AIDS. Childhood TB made up only 8,393(9.7%) of these patients; this was much lower than the estimated 15% a likely indication of significant number of children being undiagnosed and untreated. Turkana is a priority county for the National TB Program due to high burden of TB and being a nomadic county associated with food shortage and high rates of malnutrition In 2019 alone, 2502 new TB patients were notified in the County. Of notified patients, 23% were children. CaP TB seeks to address the existing baseline gaps with informed interventions and to reposition the focus on pediatric TB agenda in the county to address the following gaps: Limited integration of TB screening into other services leading to missed opportunities for identification, Limited capacity for pediatric TB diagnosis services such as and clinical-radiological evaluation, Low pediatric TB case finding, Few Gene Xpert sites with un coordinated sample networking especially for diagnostics, Low awareness of TB in the community, Uncoordinated delays in TB contact tracing activities and enrolment on TPT.

Photo: courtesy

Catalyzing Pediatric Tuberculosis Innovation (CaP TB) is a four-year (2017-2021) project - with a goal to reduce morbidity and mortality due to pediatric TB. The project is funded by Unitaid and implemented by EGPAF in Turkana and Homa Bay Counties. It aims to increase pediatric case detection, initiation on TB treatment and preventive TB therapy through integrated and decentralized models of care, introduction of improved diagnostics and treatment for latent and active TB, as well as household contact tracing. Project implementation data is collected through project designed specific forms for documenting patient-level data (Intensified Case Finding and pediatric CaP TB optimization forms).

The project developed three models of care to include; facility-based for conducting systematic pediatric TB screening in relevant facility entry points (outpatient department (OPD), In patient department (IPD), Maternal child health clinic (MCH), nutrition, and HIV) and training on pediatric TB management for health care workers (HCWs) from all relevant entry points for them to have capacity to manage pediatric TB at sub county level and below. The second intervention is community-based household contact investigation while the third model focus on use of new tools for diagnosis through Xpert RIF/Ultra and clinical radiological diagnosis. The HCWs were also trained on sputum collection procedures to include gastric aspiration (GA), Nasopharyngeal aspirate (NPA) and initiating treatment of shorter TB preventive therapy (TPT) regimens (3RH). New pediatric TB single formulations (Ethambutol and Isoniazid) and Dispersible fixed dose combination (FDC) anti-TB (2RHZ, 4RH).

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CaP TB project managed to successfully introduce universal screening of children in all service delivery points within the health facilities, train and assign cough monitors as first screeners in every service delivery point. Presumptive cases were hence referred to clinicians for further screening and testing. In addition, screening questionnaires through the development of the Intensified Case Finding (ICF) Form were standardized. Implementation and roll-out of pediatric combination of on-site and class-based trainings followed by immediate and extensive on-site mentorship and supervision to increase HCWs knowledge. They include provision of job aids that guide HCWs through the decision-making on clinical diagnosis of TB in children to increase high index of suspicion for TB, and training of HCWs on chest x-ray (CXR) reading and interpretation increases pediatric TB diagnosis through clinical radiological method. Installation of an additional Gene Xpert machine at Lopiding Sub County hospital increased Gene Xpert uptake hence reducing turn-around time (TAT) and costs for sample referral. Community-based contact investigation requires dedicated HR resources hence the project identified focal community health volunteers (CHVs) per facility and trained them on TB contact tracing algorithm. The project identified 4,160 presumptive TB among the children and 2,525(61%) tested with GeneXpert, 395 (9%) microscopy, and 759(18%) x-ray. 738 children were diagnosed with TB and 731(99%) started on treatment. The project also recorded a threefold increase in identification of presumptive TB in children with two-fold increase in number of children diagnosed with TB compared with baseline data.

Key Project Successes:

Strengthened TB stakeholders' meetings to include pediatric TB committee of experts (CoE), Technical Advisory Group, Civil Society Organizations and diagnostic CoE

- In collaboration with NTP and other stakeholders revisions of national guidelines completed to include:
- 3RH (3 months duration of rifampicin and isoniazid) and 3HP regimen for TB preventive therapy (TPT)
- Change of Xpert MTB/RIF to Ultra assay cartridges for TB diagnosis
- Use of stool specimen for TB testing through GeneXpert

Inclusion of Key CaP TB interventions in major donor grants (i.e PEPFAR especially in COP plans and Global Fund continuation application).

Integration of pediatric TB screening and pediatric TB clinical diagnosis in different entry points to include OPD, IPD, MCH, HIV and Nutrition clinics.

Good TB screening in all entry points; MCH-96%, OPD-87%, Nutrition-86%, pediatric inpatients ward-87%.

Pilot of 3 RH regimen for TPT in 1 CaP TB sites which informed roll out to 10 sites whereby 814 (50%) started on 3RH and 815(50%) on INH with good completion rate of 95% among the eligible.

Implementation of community-based contact investigation through engagement of cough monitors and CHVs with strengthened coordination by CHEWs

Implementation of sample collection procedures and sample transportation networks through use of motor bike ridders.

Building healthcare workers (HCWs) capacity for pediatric TB diagnosis and management at lower level facilities (facility-based training).

Improvement of provision of pediatric TB services in advanced sample collection using Gastric Aspiration (511 children) and Sputum Induction (14) procedures which is among the major barrier of TB diagnosis.

Lessons Learned

The CaP TB project ran smoothly and responded timely to all requirements. One of the strong reasons that enabled effective implementation, given the complexity of the implementation process, was the commitment of the National and county government. Aligning of the project objectives with those of the government was essential to ensure institutional support and duly project implementation. The notable lesson learnt includes:

1. Use of dedicated cadres (cough monitors) and lay workers to support and integrate TB screening in child service entry points is critical to increase TB screening
2. Contact investigation, including monitoring and supervision of contact investigation cascades of care, is a critical intervention for pediatric TB management and a key gateway for both case detection and delivery of TB prevention
3. Use of the Child Contact Management Register is critical in identification of eligible children for TPT and prompt linkage for TB diagnostic work up
4. Home visits for TB contact tracing and TPT provision for children is feasible and increases uptake of TB services
5. Integration of TB screening into all departments and use of the ICF screening tool increases TB case finding in children.
6. Timely tracking of presumptive TB clients is paramount given that, left behind, such clients will transition into full-blown TB and/or infect others with TB
7. Use of clinical diagnosis algorithm and chest X-ray improves TB case identification
8. Facility based training of HCWs on pediatric TB management is feasible and cover majority of HCWs than class room trainings
9. Alternative sputum collection methods like Gastric aspiration increase access to GeneXpert testing among the children.

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Cough Monitors' Contribution to the CaP TB Project Implementation:

A Case Study of Homa Bay

Dr Mboya Phelix making a presentation during a training workshop

By Vincent Aloo and Dr. Mboya Phelix

Catalyzing Pediatric Tuberculosis Innovation (CaP TB) is a Pediatric TB project focused on reducing pediatric TB morbidity and mortality by developing, implementing, and documenting innovative models of care and catalyzing their wide-scale implementation to improve case detection and treatment.

The project was being implemented in 24 health facilities comprised of dispensaries, health centers, sub-county hospitals and the county referral hospital. 52 cough monitors were employed to strengthen TB screening and linkage of presumptive to diagnostic workups and treatment.

Dispensaries have one cough monitor; health centers have two and sub-county hospitals/country referral hospitals have between three and five cough monitors stationed in various service delivery points (SDPs). These are; outpatient (OPD), maternal child health clinic (MCH), pediatric inpatient ward, TB clinic, nutrition clinic and HIV clinic (CCC).

A Pediatric TB Intensive Case Finding screening tool was developed and disseminated to support intensive case finding. This followed a three-day training for cough monitors in various service delivery points and linkage of presumptive cases for diagnostics, treatment and TB preventive therapy (TPT).

Cough monitors were further supported by clinicians trained on pediatric TB diagnosis and advanced sample collection methods. The hub

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The project is being implemented in 24 health facilities which comprise of dispensaries, health centers, sub-county hospitals and the county referral hospital. 52 cough monitors were employed to strengthen TB screening and linkage of presumptive to diagnostic workups and treatment.

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and spoke model were used to enable sample referral and testing for the obtained specimens, to improve uptake and access of GeneXpert testing. A pediatric service optimization form that links presumed cases to diagnostic work ups, TB treatment and TPT was also developed for use.

Further, the project engaged the cough monitors and community health volunteers (CHVs) in TB contact investigation and screening at the community level and in the referral of all children presumed with TB cases within households for diagnostic work-up and for TB preventive therapy eligibility assessment and initiation.

The CaP TB Project prioritized improving access and coverage of Latent TB infection treatment among the eligible population. To achieve this, capacity building was done for healthcare workers (HCWs), cough monitors and CHVs on child contact management, listing of contacts in the TB contact management register, and TB screening at household and facility level.

The HCWs support routine TB screening, treatment and follow-ups of TB patients and their contacts while cough monitors help in triaging clients and linkage to TPT initiation, community contact tracing, health education, and facilitation of community-facility linkage.

Listing of all contacts in the TB contact management register is conducted during TB treatment initiation at the facility to enable targeted contact tracing. Community-level contact tracing is performed by cough monitors and CHVs and documentation done in the TB contact management register.

During the baseline period, August 2018 to July 2019, 422 index patients were diagnosed with TB. Contact tracing was conducted for 70 (17%) cases, 42 under 5 years' child contacts identified were eligible for TPT, 35 (83%) were initiated on TB Preventive Therapy. During intervention in the implementation period of August 2019 to July 2020, the Project identified 304 TB index patients out of which 174 (57%) cases had successful contact tracing leading to the identification of 331 under 5 years' eligible child contacts. 303 (92%) children initiated on TB preventive therapy. This is an 866% achievement during the implementation compared to the Baseline. There is also increased TB diagnosis in non-TB service delivery points such as OPD, MCH, IPD and nutrition clinic. In addition, TB awareness, index of suspicion and confidence in pediatric TB diagnosis has shown improvement in cases notified.

CaP TB therefore recommends integration of cough monitors in routine TB services to support intensive case finding and linkage of presumptive cases for diagnostics, treatment and TPT.

Listing of all contacts in the TB contact management register is conducted during TB treatment initiation at the facility to enable targeted contact tracing. Community-level contact tracing is performed by cough monitors and CHVs and documentation done in the TB contact management register.

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Catalyzing Pediatric TB Innovation Project (CaP):

Lessons Learned in Homa Bay and Turkana Counties

Follow-up Actions:

The follow up actions below will focus on National level adoption and roll out, and advocate for quicker adoption in Turkana county

- Routine TPT (3RH) regimen provision in pediatric service entry points to be scaled up
- Adoption of comprehensive facility-based training on Pediatric TB diagnosis and management for better hands-on experience which is key in diagnostic cascade
- Integration of pediatric TB screening and pediatric TB clinical diagnosis in different entry points to reach more children
- Advocate for adoption and roll out of Gene Xpert Ultra cartridge which has high specificity in TB testing among the children, and pilot stool as a sample for testing TB in children
- Scale up sample networking and referral through hub and spoke model
- At least 2 HCWs should be trained in each entry point to conduct gastric aspiration to increase access to Gene Xpert
- Support Training and provision of transport reimbursement to CHVs which is key to success of community contact investigation
- Adoption of facility ACF rubber stump to capture pediatric screening symptoms in all entry points
- Contact investigation roll-out and scale-up be prioritized by National TB programs and County government
- Continue strengthening facility-level forecasting and quantification of commodities to prevent pediatric fixed dose combination (FDC) stock-outs.

Dr Mboya is the Country Implementation Manager
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Young TB Clinician Accelerating Access to TB Services Amid COVID-19

By Diana Kagwiria

On a sunny Sunday afternoon, an upbeat 28 year-old Seth Kagia, TB clinician at Homa Bay County Referral Hospital, is packaging TB patients' drugs for delivery to their homes.

"This has become a routine. Despite being a Sunday, I have to find time to take medicines to my patients as I check on their progress," Seth tells us as we settle down for an interview.

In March 2020, after the first COVID-19 case was reported in Kenya, there was a disruption of health service delivery and the TB clinic at Homabay County Referral Hospital where Seth works was not spared. The number of clients visiting the clinic for treatment and clinic reviews decreased drastically.

"We experienced low case finding brought about by government restrictions on movement to contain the spread of COVID-19. Most patients also stayed at home limiting their hospital visits in fear of contracting the virus. The similarity between COVID-19 and TB symptom caused fear among community members. They avoided showing up for testing as they did not want to be mistaken for having COVID-19 and be quarantined," Seth explains.

The situation was worsened by strikes and go-slows by health workers in the county due to lack of personal protective equipment.

"With lack of health workers in most facilities in the county, the small number of clients we had were unable to access services," Seth sadly notes.

He adds, "The monthly Programmatic Management of Drug Resistant TB (PMDT) meetings were also halted due to COVID-19 restrictions on person-to-person meeting. This resulted in most patients on treatment not being monitored on their progress resulting in poor treatment outcomes."

Another outcome of COVID-19 resulted in some TB clinics being converted to COVID-19 isolation centres, forcing most TB patients to be referred to other clinics in far flung areas. Due to social economic barriers most patients could not visit the facilities.

Noting the challenges faced by the patients, Seth took a personal initiative to ensure continuity of TB services amid COVID-19. He started delivering medicines to the patients who would not manage to come to the health facilities, something he does to date.

When other health workers went on strike, Seth remained at work to attend to patients visiting the clinic.

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Seth Kagia, TB clinician Homa Bay County Referal Hospital during a home visit to one of his patients

"Most patients also stayed at home limiting their hospital visitations in fear of contracting the virus. The similarity between COVID-19 and TB symptom caused fear among community members"

“I am proud of Seth for his immense contributions to this facility and ensuring that the health service provider-patient relationship is created, strengthened and maintained in offering patient care and supporting those around him to seek TB screening and treatment,”

Daniel Okal, Homa Bay town sub-County TB coordinator

Photo: courtesy

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With the support from USAID Tuberculosis Accelerated Response and Care II (TB ARC II), he participated in door-to-door screening in five hot spot areas in the county where 300 TB presumptive samples were collected.

To raise TB awareness and demand creation for TB services amid COVID-19, he participates in local radio talk shows to to educate the community on TB prevention, diagnosis and treatment.

At the facility level, he has championed for the integration of TB and COVID 19 screening in all the departments. As patients are being screened for COVID-19, they are too screened for TB.

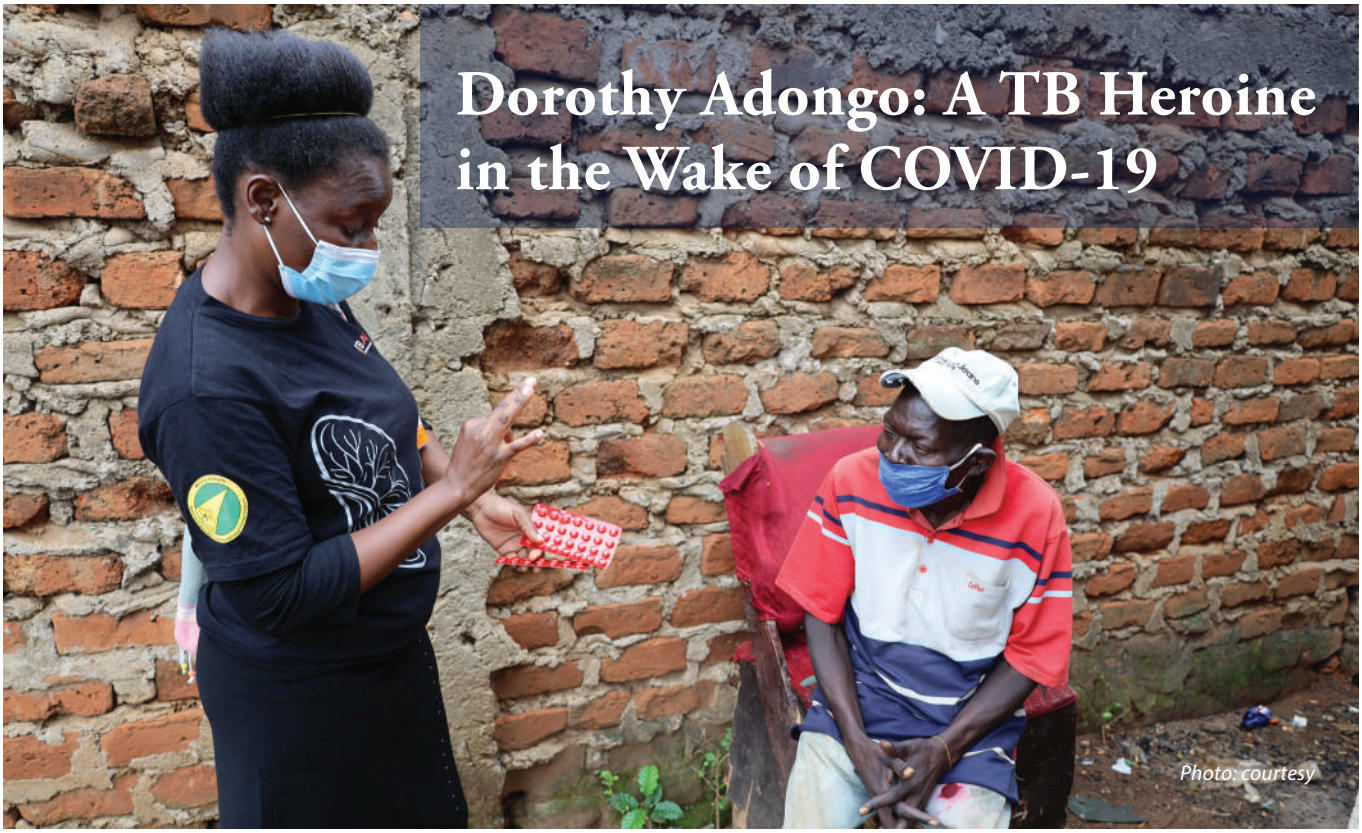
Seth has mentored his fellow health workers to improve TB services. Every two weeks, they review data to monitor gaps and come up with mitigation measures. For newly employed health workers, he mentors them with an aim of improving TB services. He is spreading his wings of mentorship to health workers in other counties through physical and virtual continuous medical education. So far he has trained over 10,000 health workers in 4 counties through support of USAID TB ARC II activity in collaboration with the National TB Program.

Daniel Okal, Homa Bay town sub-County TB coordinator applauds Seth for his exemplary dedication in ensuring continuity of TB services in spite of the challenges brought by COVID-19.

“I am proud of Seth for his immense contributions to this facility and ensuring that the health service provider-patient relationship is created, strengthened and maintained in offering patient care and supporting those around him to seek TB screening and treatment,” Okal shares.

John Mbota one of the patients whom Seth delivers medicine to at home had this to share, “If it were not for Seth, maybe I could be dead. I am afraid of going to the facility for the fear of contracting COVID-19 or being confused of having COVID-19 leading to isolation. He visits me every week to refill my medicines as well as monitor my treatment progress. I am now feeling better. The chest pain and coughing is gone. I hope to resume my work as a taxi driver soon.”

Dorothy Adongo: A TB Heroine in the Wake of COVID-19



Dorothy Adongo explaining to a TB patient, Ali Mohamed living on the streets of Bungoma town, how to take his medication.

By Diana Kagwiria

After losing her beloved sister and husband to TB in 2018, Dorothy Christine Adongo vowed to help fight the disease with all her might. She began volunteering at the Bungoma County Referral hospital- TB clinic as a TB champion. Her work involved supporting the clinic's most vulnerable populations mainly the street families, alcoholics and long distance truck drivers complete treatment through counselling.

When COVID-19 hit Kenya, and began spreading to rural areas, like Dorothy's Bungoma County, located hundreds of miles from the capital, Nairobi, the pandemic created unprecedented health and economic challenges to the already struggling populations. Her clients visiting the clinic reduced drastically as a result of fear of being infected with COVID-19, isolated for being mistaken to have the disease since TB symptoms mimic those of COVID-19, and the national lockdown affecting the movement of people.

Despite the new obstacles brought by the pandemic, Dorothy decided to put an extra effort to ensure her clients access treatment. When they stopped coming to the facility, she began visiting them wherever they are to deliver medicines, collect sputum samples for treatment response monitoring and create awareness on prevention and treatment adherence, a task she continues to date.

Dorothy endures harsh working environment in her day-to-day work manoeuvring through the back streets, noisy bus parks and chaotic drinking dens to reach her clients, every day serving at least 10 clients per week voluntarily.

"The biggest challenge I encounter in my day-to-day work is locating the patient as most don't have a permanent location to stay as well as they lack modern communication gadgets like phones. Some of the patients become hostile and verbally abusive. In-spite of this, I try to understand them and support them in the treatment journey," Dorothy shares.

She sacrifices the little money from her business to support patients who can't afford food.

Ali Mohamed, one of the TB patient living in the street was excited on seeing Dorothy when we accompanied her to deliver medicine to him. He had this to say.

"Dorothy is our hope, especially for us street families who are despised by many people. She is not only my doctor but also like my mother. She is helping me through this treatment journey by bringing me medicine and food when I don't have. Through her I feel loved that is why this time round, I am almost completing my TB treatment. Previously I was a serial treatment defaulter as I have no time to go pick the drugs in facility.

Emmanuel Kimazia, a long distance truck driver and a TB patient shares, "COVID-19 pandemic has really hit us hard. Our nature of work requires us to move from one place to another and with the restrictions on movement by the government so as to contain the spread of COVID-19, I got delays in reaching my destination to go and pick my TB medicines. Dorothy has really assisted me as she is able to bring me medicine at my convenience. This has helped me adhere to treatment. I am now feeling better and more comfortable and confidence as I go about my business.

Elizabeth Mueni: The TB Coordinator Leading the Fight Against TB in Nairobi County

Elizabeth Mueni: Nairobi County TB and Leprosy Coordinator

By Diana Kagwiria

Nairobi has been long grappling with tuberculosis even before the first cases of COVID-19 were confirmed in March, 2020. The pandemic has brought new challenges to a city ranked the highest TB burdened in the country.

According to National TB Program there was a reduction in TB case finding in Nairobi with only 300 cases being reported in April 2020, where over 1,000 cases were reported in previous months. Most facilities were closed temporarily after staff were diagnosed with COVID-19. TB staff were deployed to COVID-19 isolation facilities with 17 out of 23 sub-county TB coordinators being assigned the role of managing quarantine sites.

There was initial resistance in most facilities to handle coughers, due to lack of personal protective equipment for laboratory team who refused to test sputum samples.

There was also low turn-out of patients at facilities for fear of contracting COVID-19, where some patients did self-referral up-county while others became lost to follow up.

Just like the famous anecdote depicts, a leader is forged in times of crisis, Elizabeth Mueni, the County TB Coordinator knew it was time to act before they lost all the they had gained in the fight against the disease. She called her team together; sub county TB Coordinators and TB implementing partners, among them USAID Tuberculosis Accelerated Response and Care II (TB ARC II), and they developed innovative ways of ensuring continuity of TB services amid the pandemic.

The team began by holding a TB data review meeting to help in decision making where they also shared best practices on case finding across the sub-counties. Dissemination of TB performance monitoring charts were immediately initiated across all the facilities to help in reporting.

Differentiated care with longer return dates was adopted. Drug susceptible TB patients on intensive phase were given an appointment after two weeks, while those on continuation phase were given monthly appointments but in-line with follow up smears. Appointment diaries were well documented on each visit. Facility based Drug Resistant TB treatment was converted to community directly observed therapy with the county engaging community health volunteers to provide medicines to the patients in their homes.

The team forged intense joint supervision in facilities with low case finding. Mapping of patient pathways to optimize TB screening in facilities with low outpatient workload was conducted and multi-disciplinary review of complicated clinical cases with partners onsite was initiated.

There was initial resistance in most facilities to handle coughers, due to lack of personal protective equipment for laboratory team who refused to test sputum samples.

A targeted door-to-door community TB screening in hot spot areas was conducted yielding three drug resistant TB cases and 126 drug sensitive cases. Intense contact tracing from this cluster found 61 contacts who had TB.

An integration of TB screening in ongoing polio immunization outreaches was done and, from this exercise, 14 children were diagnosed with TB. At the facility level, an integration of COVID and TB screening was also done.

They adopted the use of virtual platforms to review drug resistant patients through the programmatic drug resistant meetings. In situation where a case was found to be complicated, a home visit was done while adhering to COVID-19 precaution measures. The virtual platforms were also used to conduct TB continuous medical education targeting health workers in both private and public facilities as well as give TB updates.

The team engaged national and community radio stations to raise TB awareness, demand creation for TB services and treatment completion. Experts and TB champions were invited to interactive radio shows to discuss TB.

A TB call center was set up and members of the public were sensitized and urged to call in for free TB consultation. From this, 106 patients were diagnosed with TB through the call center.

Through these interventions, improved case finding has been reported in the county with data showing a positive trajectory trend from 300 cases in April 2020, a month after the first case of COVID-19 was reported in Kenya, to 999 cases in September after the adoption of the above innovations.

Matatu tout fights against TB after police cell discovery

Photo: courtesy

By Amref Health Africa

Japheth Mwenda, a matatu tout from Ruiru, Kiambu County, got arrested for a traffic offence, leading to him being diagnosed with TB and linked to treatment.

He had been experiencing a persistent cough and night sweats for over three months. He noticed that his sputum had traces of blood and it was becoming difficult for him to eat but he did not think too much of it.

He attributed his cough to the cold weather in Ruiru. One day while on duty, he was arrested for not observing traffic rules and taken to Ruiru Police Station.

While in the police cells one morning, staff from Resources Oriented Development Initiative (RODI) conducted a talk on TB for the suspects. From the talk, he realised that his cough could be due to TB. After the talk, they asked whoever had TB symptoms to volunteer to be tested. Mwenda gathered courage and gave his sputum for testing.

On the fourth day, he appeared in court and was fined for the traffic offence. After his relatives paid the fine, he knew it was time to go home. However, things took a different turn. The police informed him that he had tested positive for TB and asked that he be taken to hospital.

Japhet was taken to a hospital in Ruiru and initiated on treatment. He has been taking his medication for almost two months and is already feeling better.

Had it not been for Ruiru Police Station, he would still be walking around without any knowledge of his health status.

Japheth Mwenda: Tested positive for TB while at police station for a traffic offence

"I actually thought I had a bad cold and was taking over-the-counter medicines," he said.

Japheth is one of the many who have benefitted from the Amref Health Africa supported Global Fund intervention that RODI implemented in police stations in Kiambu County.

The organization has played a big role in creating awareness about tuberculosis and ensuring patients such as Mwenda get the full medical attention.

A grant Amref received from the Global Fund to help fight tuberculosis from January 2018 to June 2021 supported interventions. They include finding missing TB cases through the engagement of private providers, targeted outreaches using mobile X-ray and GeneXpert, contact screening, tracing patients who interrupt TB treatment, sputum sample networking, and social support for patients with drug-resistant TB.

"The medication for TB is free of charge and within six months of taking the medicine, as advised by the medics, one is going to be free from tuberculosis," Mwenda said.

Big triumph for Cherono and her three children

When Mercy Cherono started coughing, she bought a syrup from a pharmacy at Farmers' trading centre near her home in Longisa, Bomet County.

"But the cough did not stop," says Mercy, a single mother of four children aged between three and nine years. "I started sweating at night. I had no appetite and quickly lost weight."

She took some money from her business savings of selling roasted groundnuts and went back to the chemist. The shop advised her to go to the hospital for a TB test.

"I had heard TB associated with HIV," says Mercy.

Worried about HIV, she did not immediately go to the hospital.

It was only when she became too frail to run her business that Mercy went to Longisa County Referral Hospital.

Koe Chepngeno, an assistant at the hospital's TB clinic, says: "She was trembling when she was asked for a sample and about HIV and TB."

Koe, a former community volunteer, has been trained with support from Amref Health Africa Global Fund TB programme to counsel TB patients, and guide them through diagnosis and treatment.

She allayed Mercy's fears and assisted her to take a chest X-ray, which revealed that she could be having TB. Mercy gave a sputum sample before Koe escorted her to take an HIV test, which came negative.

Relieved, Mercy went back home to wait for the results of the TB sample, which was sent to the GeneXpert hub at the hospital's laboratory.

Three days later, Koe called Mercy and told that she had TB.

Koe counselled her before she was started on TB treatment.

The volunteer then visited her and screened all her four children. Three of them—two, three and four-year-olds — had TB symptoms and were referred to the hospital where X-ray examination results suggested they had TB. They were promptly put on treatment.

Koe Chepngeno, a treatment supporter, with TB survivor Mercy Cherono and her children

"We all used to take the medicine in the evening. At first, I suffered diarrhoea, but I was not worried as I had been told about the side effects," Mercy recalls.

Koe visited regularly. She also educated neighbours about TB and encouraged them to support Mercy.

With no income, Mercy could not provide enough food for the family. Koe found that her lastborn was underweight and linked the family to the nutrition services section at the hospital, where they were given therapeutic foods.

Mercy and her children completed treatment after six months.

In 2019, Bomet was ranked among 10 top counties in TB notification, reporting 426/100,000 above the 200/100,000 national rate.

Mercy is the beneficiary of a community TB intervention that Amref Health Global Fund TB programme implements through a sub-recipient, Our Lady of Perpetual Support (OLPS), which covers Bomet, Nyamira and Kisumu counties.

Working with the Narok County department of health, OLPS has helped to improve active case finding, defaulter and contact tracing. The number of TB cases identified increased from 1,687 cases in 2018 to 1,802 the following year and 1,721 in 2020, a drop attributed to Covid-19.

In 2019, Bomet was ranked among 10 top counties in TB notification, reporting 426/100,000 above the 200/100,000 national rate.

Bomet County TB and leprosy Coordinator Stanley Korir says the perception that TB is associated with HIV is a major barrier to people accessing diagnosis and treatment. "Other challenges include alcoholism and lack of support for vulnerable households affected by TB."

He adds that some cases had led to contact tracing in schools, but the county does not have a programme to address TB infections in schools.

Annual work planning dinner

Dr Kituzi representing the commodity section

Man from Kuresoi, Aiban Rono showing his new dancing moves

Dr Steven Wanjala-TB ARC II, Simon Ndemo-DNTLD-P, Anne Munene, Amref and Dr Omar Abdullahi, DNTLD-P

Management accepted the challenge: Dr Asin, Oballa, Kibuchi and Dr Waqo

Dressed for the dinner: Anne Mases, Wandia Ikua - TB ARC II and Nkirote Mwrigi DNTLD-P

Sampling the chefs' cuisines: Kerubo and Muriuki, DNTLD-P

Aiban Rono, Rhoda Pola, Drusila Nyaboke, Dr Asin Carol and George Obala from DNTLD-P and Dr Lorraine Mugambi TB ARC II opening the dance floor.

Anachukua, anaweka, Waaa..! Weslye Tomno tried to match Rhoda Pola

Dennis Oira, TB ARC II with great Embarambamba moves

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Division of National Tuberculosis, Leprosy and Lung Disease Program,

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