CIVIL SOCIETY UNGASS TB/HIV COUNTRY REPORT

KENYA

Commissioned By:

Treatment Action Group (TAG) and International Community of Women living with HIV/AIDS (ICW-EA).

Conducted By:

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ACRONYMS AND ABBREVIATIONS

ACSM	Advocacy, Communication and Social mobilization
ART	Antiretroviral Therapy
CDC	United States Canters for Disease Control and Prevention
CPT	Co-trimoxazole Preventive Therapy
DOTS	The basic package that underpins the Stop TB Strategy
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HMIS	Health Management Information Systems
IEC	Information, Education and Communication
IPT	Isoniazid Preventive Therapy
ICF	Intensified Case Finding
ICW	International Community of women living with HIV/AIDS
MDG	Millennium Development Goal
MDR-TB	Multidrug-Resistant Tuberculosis
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NEPHAK	National Network of People Living in
NETMA+	Network of Men Living With HIV/AIDS in Kenya
NTP	National TB Control Programme
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPM	Public Private Mix
TAG	Treatment Action Group
TB	Tuberculosis
TB/HIV	The intersecting epidemics of TB and HIV
TBPT	Tuberculosis Preventive Therapy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VCT	Voluntary Counselling and HIV testing
WHO	World Health Organization

SECTION ONE

1.0 Introduction and Background

Tuberculosis continues to be a public health and development problem in Kenya. The reason for TB resurgence in the country has been attributed to the high and rising number of HIV/AIDS cases. According to the World Health Organization's (WHO's) Global TB Report 2009, Kenya had approximately more than 132,000 new TB cases and an incidence rate of 142 new sputum smear-positive (SS+) cases per 100,000 population (Global TB Control, 2009, Pg 117). Kenya's National Division of Leprosy, TB & Lung Disease (DLTLD) began to implement the WHO-recommended DOTS, the internationally recommended strategy for TB control, in 1993 and reported 100 percent DOTS coverage by 1996. In 2005, the DOTS case detection rate reached WHO's target of 70 percent and rose to 72 percent in 2007. The DOTS treatment success rate also met WHO's target of 85 percent in 2007 (USAID Kenya TB profile, 2009). WHO estimates there were around 2,000 cases of multi-drug-resistant (MDR) TB in Kenya in 2007, although only 4.1 percent of these cases were diagnosed and notified. There is a policy supporting MDR-TB diagnosis and treatment, and since 2008, the country conducts routine MDR-TB surveillance (USAID Kenya TB profile, 2009).

Kenya is the first country in sub-sharan Africa to have achieved the global targets for both case detection and treatment success and the country continues to treat more and more TB patients each year. However, widespread co-infection with HIV (close to 48 percent of new TB patients) makes TB diagnoses and treatment difficult. While the number of new TB cases appears to be declining, the number of patients requiring re-treatment has increased. To better address TB/HIV co-infection, the government placed the National Leprosy and Tuberculosis Program (NLTP) renamed as Division of Leprosy, TB, and Lung Disease (DLTLD) and the national HIV/AIDS program in the same division in the Ministry of Public Health and Sanitation (MOPHS) thereby accelerating collaborative TB-HIV/AIDS activities across the country. In 2007, the government demonstrated increased political commitment by upgrading the then-NLTP to a division within the MOH (DLTLD**)** and increased funding for TB control. The DLTLD implements TB/HIV treatment services, community-based DOTS (C-DOTS), and public-private mix (PPM) DOTS, as well as activities to address MDR-TB (USAID Kenya TB profile, 2009).

Kenya's HIV/AIDS policy has evolved over the years. By 2004, the Ministry of Health published a policy paper on HIV testing in clinical settings, and provider-initiated counselling and testing of patients with suspected HIV-related diseases, including TB, was introduced and rapidly gained widespread acceptance. The NLTP provided leadership by developing and implementing a national TB/HIV training curriculum, in collaboration with partners, including guidelines for HIV testing, provision of cotrimoxazole preventive therapy (CPT) and antiretroviral therapy (ART) for HIV-positive TB patients.

In 2005, the NLTP data recording and reporting system was adapted to include additional HIV-related information and was introduced in the second half of that year. WHO's "3 by 5" initiative helped to increase awareness of the need to provide ART on a wide scale, including among TB patients. HIV testing and the provision of CPT and ART were further encouraged by donors such as PEPFAR and the Global Fund, which linked their funding to the provision of collaborative TB/HIV activities. As a result of these decisions and activities, the proportion of TB patients who were tested for HIV increased from 20% in the third quarter of 2005 to 74% in the first quarter of 2007 when 50% of those tested were HIV-positive. Sadly, though the actual number of patients starting ART increased, the proportion of those who were HIV-positive and started on ART remained more or less constant at a low of 23%. The actual number provided with ART may be rather higher, as the current recording and reporting system does not capture patients who start ART after the third month of TB treatment (WHO/HTM/TB/2008.398).

The past UNGASS reports from Kenya have not provided sufficient information about the current situation of TB in HIV populations, this research and report is an attempt for civil society organizations (CSO) to take centre stage in ensuring national response are strengthened through the creation and implementation TB/HIV collaborative policies and implementation of these policies. It should be noted that even though Kenya is the first county in Sub-Saharan Africa to have achieved the global targets for both case detection and treatment success, the challenge posed by TB/HIV co-infection remain a big one. HIV-associated TB and drug-resistant TB pose particular diagnostic challenges, given that sputum smear microscopy (the cornerstone of TB diagnosis) lacks sensitivity to detect many TB patients with HIV co-infection, can only identify acid-fast bacilli as a group (ie. not individual mycobacterial species), and cannot distinguish drug-susceptible from drug-resistant TB. Besides, Multidrug-resistant TB (MDR-TB) is particularly difficult to diagnose.

SECTION TWO

2.0 Methodology and Approach

This report has been developed from information gathered through a qualitative monitoring process focused on the implementation of TB/HIV collaborative policy. This policy focuses on strategies to increase collaborative surveillance, planning and evaluation activities between the TB and HIV programs, reduce the burden of TB in people living with HIV and also reduce the burden of HIV/AIDS among the TB affected community.

2.1 Data – Gathering Procedures

To ensure consistency and comparability of information from key players in TB and HIV settings, including policy makers, implementers and communities affected by both TB and HIV/AIDS, a pre-determined instrument was developed to guide the data gathering process. The instruments were developed by the International Community of Women living with HIV/AIDS East Africa (ICW) and Treatment Action Group (TAG). The instrument had different sections and was meant to identify the policy and implementation successes and gaps in TB/HIV collaborative activities in key health institutions, assess TB/HIV Universal Access in TB care settings and in HIV care settings, and to establish the perspectives of TB/HIV affected community on availability of TB and HIV services in various health facilities in Kenya. A total of 37 Questionnaires were administered to HIV clinics, TB clinics, policy makers and people infected/ affected by TB/HIV. The findings were then analyzed with the view to establish the existence of the policy and the degree of its implementation.

2.2 Sampling Procedure

Simple random sampling and purposive technique were used to select respondents in TB and HIV care settings to assess the degree of universal assess to TB and HIV collaborative activities and CSOs to get their perspectives on the policy implementation in the country. Purposive technique was applied in identifying the policy makers at DLTLD, National AIDS and STI Control Programme (NASCOP) and the National AIDS Control Council (NACC) as key informants in the study.

In gathering information for this report the following sample frame was used.

a) Personal interview with key informants at DLTLD and NASCOP.
b) HIV and TB care settings in national referral hospital, provincial and district, hospitals, mission hospitals and health clinics in Nairobi and Nyanza Provinces.

c) CSO working on TB and HIV/AIDS and representatives of affected communities in Kenya.

Table: 2.1 the table below shows the distribution of the sample:

Sample Number	Sample Description	Sample Size
Sample 1	Policy Makers	4
Sample 2	HIV Care Settings	12
Sample 3	TB Care Settings	12
Sample 4	Affected Community	7
Total		35

2.3 The Scope

The monitoring tools were administered in two provinces in Kenya that was Nairobi and Nyanza Provinces. These two have the highest burden of TB, HIV, and TB/HIV in Kenya.

The following six TB and HIV care settings were visited in both Nyanza and Nairobi and the responsible officers in charge of the clinics were interviewed:

Table 2.2: Sampled TB and HIV care settings

Nairobi Province	Nyanza Province
Kenyatta National Hospital (KNH)	Nyanza Provincial Hospital
Mbagathi District Hospital	Kisii District Hospital
Casino STC Nairobi	Homabay District Hospital
Coptic Mission Hospital	Migori District Hospital
Mater Mission Hospital	Chula – Imbo Health Centre Kisumu
AMREF	

2.4 Methodology Approach

Structured questionnaires developed by TAG/ICW monitoring and evaluation technical team were used to gather information for this report. The personal interviews were carried out by the researchers at the facilities and community settings visited.

2.5 Data analysis and presentation

The raw data collected from the field were cleaned and systematically organized for easy interpretation. They were arranged in different categories in terms of the four categories of respondents.

2.6 Limitations

The major constrain in this exercise was time and resources to carry out a more comprehensive assessment of Universal Access to TB and HIV care services in a larger geographic regions of the country and to involve a larger number of CSOs working on TB and HIV. However, the interviews undertaken did cover urban and rural areas.

Most respondents wanted an official introduction letter to introduce the researchers when collecting data on health matters especial. The process of obtaining approval consumed time during the monitoring tool administration. The actual data collection was undertaken by the National Empowerment Network of people living with HIV/AIDS in Kenya (NEPHAK) and the Network of men living with HIV/AIDS in Kenya (NETMA+) and both organizations are also part of the country UNGASS reporting process. The UNGASS Technical Working Group (TWG) did have some concerns as to why the NETMA+ and NEPHAK were involved in a parallel process of data collection. It was however understood that the 2 processes could complement each other and that this exercise was giving the necessary attention to TB/HIV issues.

SECTION THREE

3.0 FINDINGS

This section summarized the findings of this monitoring exercise and highlights the key findings. The findings are presented in different sections corresponding to the categories of the questionnaire.

I. Findings from HIV health facilities - Assessing the availability of services to decrease the burden of TB among people living with HIV.

The monitoring team visited 11 heath settings. All the visited health care facilities were providing both HIV and TB services within the facility but in deferent clinics, they in the following categories: One (1) National referral hospital, one (1) Provincial hospital, four (4) district hospitals, two (2) mission hospitals, one (1) NGO hospital, one (1) health center and one (1) local authority special treatment center.

I. A: TB Intensified Case Findings (ICF) in HIV treatment clinics.

All the respondents agreed that the HIV clinics have a policy on screening PLWHA for TB symptoms. Four respondents indicated that clients are screened whenever they come for their care and treatment services. Two respondents, Chula-imbo and KNH, indicated that PLWHA are screened either when they visit the facility for the first time, when they request to be tested for HIV or when they are initiated on ART. One respondent from (Casino STC) said that they screen new clients for clinical presentations and when they show symptoms suspected of TB. All the respondents agreed that they referred TB suspects for confirmation of TB diagnosis. All the respondents indicated that the TB diagnostic centers are within their facilities. Table 1.2 below shows the number of children and adults enrolled in HIV care settings and those referred and enrolled in TB care settings and the proportion of PLHIV on TB treatment at the visited care settings.

Table 1.2: Number of Children and Adults enrolled in TB Care (September – December 2009)

Health Facility	Number of Children and Adults enrolled in HIV care	Number of Children and Adults enrolled in TB care	Proportion of PLHIV on TB treatment	Province
Mater Hospital	228	36	15%	Nairobi
AMREF ART Clinic	313	157	50%	Nairobi
Casino STC (referral)	184	165	89%	Nairobi

Chula-Imbo	237	178	75%	Nyanza
Kisii District Hospital	348	124	35%	Nyanza
Kenyatta National Hospital	232	131	56%	Nyanza
Homa Bay District Hospital	482	230	47%	nyanza
Coptic Mission Hospital	307	69	22%	nairobi
Migori District Hospital	532	259	48%	Nyanza
Nyanza Provincial Hospital	620	378	60%	Nyanza
Mbagathi District Hospital	870	363	41%	Nairobi

The findings in the table: 1.2 above shows that Casino STC registered the highest proportion of PLHIV on TB treatment by 89% in the last quarter, this could be attributed to the fact the it's the only special treatment center for infectious diseases in Nairobi. Chula-Imbo registered 75% proportion of PLHIV on TB treatment while Mater and Coptic Mission hospitals registered the least proportion of 15% and 22% respectively and the rest of the facilities registered between 35% to 60%. The average mean proportion of PLHIV on TB treatment in the eleven health care settings visited was 49%.

On working with other public/private/NGO working in TB/HIV burden congregate settings on intensified TB case finding (ICF)

Nine out of the eleven facilities visited agreed that they engage with public/private and NGOs in ICF. One respondent (Chulaimbo) indicated that they collaborate with community based organizations, including post –test clubs in training and recruitment of TB Ambassadors of Hope to identify TB suspects in the community, in prisons and among people with HIV.

I .B: TB Treatment

Provision of TB treatment for PLWHA diagnosed with TB disease.

Nine out of the eleven respondents agreed that they provide TB treatment for PLWHA diagnosed with TB disease. One respondent (AMREF ART clinic) indicated that they do not provide TB treatment but make immediate referrals of TB suspects or patients after screening to other public health facilities.

The findings further demonstrate that the number of children living with HIV attending care services as very low compared to the of adults in all the TB and HIV care settings visited by less than 10% the number of adults. One respondent from Coptic mission hospital said that the fear of the unknown and issues associated to pediatric disclosure were two common reasons why most of the HIV+ parents were not willing to have their children tested for HIV. Generally, there are more adults living with HIV and affected by TB in Kenya.

TB treatment recorded in pre-ART/ART register.

Eight respondents agreed that TB treatment was recorded in the pre ART and ART register at their facilities. On the provision of treatment for drug-resistant TB, two respondents (Mater Hospital and AMREF ART Clinic) indicated that they do not provide treatment for drug resistant TB. Three hospitals (Mbagathi District Hospital, KNH, Nyanza PGH, Homa- Bay D.H) indicated that they provide treatment for drug–resistant TB. Mbagathi District Hospital in Nairobi is the main TB treatment facility in Nairobi taking care of over 2000 TB treatment cases, including some cases of MDR-TB. During this study, six respondents said that they refer drug-resistant case to Mbagathi District Hospital or the TB clinic at KNH and Moi referral Hospital in Eldoret. Migori and Kisii District Hospitals indicated that they refer drug-resistant cases to either Nyanza Provincial General Hospital or Homa-Bay District Hospital to TB clinic run by MSF.

I. C: Provision of Isoniazid Preventive Therapy (IPT)

Kenya as a country does not have a national policy to provide isoniazid preventive therapy (IPT) and IPT only available in few and special cases. Nevertheless, information on IPT is becoming increasingly available to people living with HIV in Kenya. Four respondents agreed that they provide PLWHA with information on IPT at the facilities, six facilities respondents indicated that they do not provide PLHIV with information on IPT. Two respondents (Chulaimbo and Homa-bay) agreed that they provide PLHIV who are latently infected with TB access to IPT as part of their package of care. Homa-Bay had 16 children and 30 adults on IPT as part of an ongoing IPT study. Chulaimbo had put 16 children and 28 adults on IPT in the last quarter of 2009 were also conducting a study on IPT the two studies are conducted by CDC. Seven respondents indicated that they do not provide IPT to PLWHA. One respondent (KNH) indicated that they provide IPT to patients who are at the highest risk of contacting TB especially those taking care of those with TB disease at households and are themselves HIV+. Respondent from KNH also indicated that there was a study going on in children and adults on IPT.

One health worker respondent reported that she had just been re-treated for TB for the third time and had been injecting herself every day with anti-TB drugs but still could not prescribe IPT to herself or her clients due to fear of mono resistant to INH. Seven respondents did not indicate a number of children and adults on IPT since they do not provide IPT to their clients.

I. D: Infection control measures in HIV care and congregated settings.

Nine respondents from the facilities visited indicated that they had TB infection control measures in HIV care and congregated settings. One respondents (Coptic) indicated that they do not have these measures in place-but they provide some of the listed infection control measures such as infection control posters (e.g. on cough hygiene) displayed in HIV care setting, training of HIV staff on infection control measures and that the sputum collection space is well ventilated. None of the eleven respondents used any mechanical tools to reduce TB infection such as fan and UV lamps.

Nine of the respondents agreed that they partner with public/private (PPM) and NGOs working in high TB/HIV-burden congregate settings to provide education on TB infection control. Most of the respondents indicated that they work with HIV support groups, schools, but not brothels, police or army barracks. One respondent (Coptic) indicated that they don't work in any of the congregate settings listed.

I. E: Support to health care workers in high TB/HIV setting who provide care to patients.

The following are the number of Health Care Workers (HCWs) that provide care to PLWHA in the last quarter July 1st to 30th September 2009 in the facilities visited facilities.

Table 3:2 Number of HCW working in the TB and HIV care settings visited:

Health Facility	**Number of HCW**	**Number of HCW who developed TB disease**	**percentages**
Kisii District Hospital	20	-	-
Coptic Hospital	150	-	-
Mater Mission Hospital	14	-	-
AMREF ART Clinic	14	-	-
Migori District Hospital	18	-	-
Casino STC	20	1	5%
Homa-Bay District Hospital	42	-	-
Chula-Imbo	68	2	2.9%
Kenyatta National Hospital	74	3	4.05%
Nyanza Provincial Hospital	54	-	-
Mgagathi District Hospital	48	-	-

Numbers of HCW who developed TB disease who provide care to PLWHA

From the findings only three respondents (KNH, Chula-Imbo and Casino STC registered TB cases in health care workers providing care for PLWHA. KNH had 3 cases (3/74 =4.05%), Chula-Imbo had 2 (2/68= 2.9%) and Casino had 1 relapse TB case. The rest of the 8 HIV clinic respondents did not register TB in HCW providing care to PLHWA within the last quarter of 2009.

TB Prevention measures/policies in place to protect health care workers who work with PLHWA.

Five respondents agreed that they provide regular and confidential TB screening for HCW working in HIV care settings. None of the respondents provided IPT to the HCW in their facilities. Six respondents agreed that they provide TB treatment for staff with confirmed diagnosis of TB disease and four respondents did not provide TB treatment to HCW but refer to other health care facilities because of high level stigma.

Nine respondents agreed that they provide training for health care workers on TB infection control, one respondent (Coptic) indicated that they do not provide training for HCW on infection control.

II. Findings from TB health care facilities and hospitals- Assessing the availability of services to decrease the burden of HIV among people living with TB.

The monitoring team visited 11 health care settings. All the visited health care facilities were providing both HIV and TB services within the facility but in deferent clinics, they in the following categories: one (1) national referral hospital, one (1) provincial hospital, and four (4) district hospitals, two (2) mission hospitals, one (1) NGO hospital, one (1) health center and one (1) local authority special treatment center in two provinces of Nyanza and Nairobi. The followings are findings from the assessment.

The team intended to establish how the TB/HIV collaborative policy has so far promoted Universal Access in TB care settings, ten respondents who are managing TB programs in their health facilities participated in the study.

II. A: HIV Testing and Counseling for TB patients

One respondent indicated that they do not provide HIV testing and counseling at their TB clinic. Nine respondents agreed that HIV testing and counseling are offered at their TB clinics. One respondent (KNH) indicated that HIV testing and counseling to TB patients were

done through referrals from VCT centers and hospitals outside the hospital, the respondents further indicated that all patients were referred to Diagnostics and Testing Centers (DTC).

On the charges for VCT services all the respondents agreed that the services were offered for free. One respondent indicated that the services are free but only after referral or request. It was established that the TB and HIV clinics are within the same facilities. All the respondents agreed that the TB register also captures information about the HIV status of the individual. Seven out of the ten respondents had referred over 75% of their TB cases for HIV follow testing and follow up, four respondents indicated that they had referred between 50 – 75% of their TB cases for HIV testing and counseling between 1st July to 30th September 2009.

II. B: Provision of HIV Prevention Method at TB the clinic.

Nine out of ten respondents agreed that there was provision for HIV prevention methods at the TB clinic. One respondent from (Mater Hospital) said they don't have such services in place, six respondents provided condoms, education programs, promoted safer sex practices, early diagnosis and treatment for STI, provided information on prevention of mother to child transmission (PMTC), and promoted positive living in PLHIV to address HIV risk amongst their TB patients. Four respondents said they do not provide promotion of positive living and partner testing for HIV infected patients.

II. C: Provision of Contrimaxazole Preventive Therapy (CPT)

One respondent (Mater Hospital) indicated that they do not provide CPT to HIV positive TB patient and instead they get prescription from their health care providers. The rest of the respondents indicated that they do provide CPT to HIV positive TB patients.

II. D: Provision of HIV care and support services at the TB care settings.

Eight out of the ten respondents agreed that they offer all the listed support services which include promotion of nutritional support and hygiene, TB/HIV and treatment education for home based care (HBC) providers, psychosocial support, treatment adherence, palliative care and follow – up care for opportunistic infectious. Two respondents (Coptic and Mater hospitals) said they only offer psychological support, treatment adherence and follow – up care for opportunistic infection.

II. E: Provision of ART for TB patients who are HIV positive.

The findings established that four out of the ten respondents did not have ART available in their TB clinics for TB patients who are HIV positive. Six respondents agreed that ART were

available to HIV positive TB patients at their TB clinics and also agreed that there is mechanism created between the HIV and TB program to provide ART to eligible HIV positive TB patients. Five of the respondents indicated that to be eligible for ART PLWHA needed to have a CD4 count of below 300. One respondent (Casino STC) indicated that they can accept up to 350 CD4 count depending on type of TB disease one has and other clinical presentation. Five respondents did not respond to this question but referred the question to HIV clinics. The findings therefore indicates that the providers seems follow the WHO guidelines for initiating ART in PLHWA with TB disease which states that these patients are eligible for ART regardless of their CD4 count.

III: Establishment of TB/HIV policy and its implementation (Questions asked to Policy Makers).

The study intended to establish the extent at which TB/HIV collaborative policy has enhanced planning and coordination between TB and HIV programmes in Kenya. The study went further to assess its implementation and effectiveness in reducing the burden of TB in people living with HIV/AIDS and reducing HIV burden in those infected with TB.

III. Existence of TB/HIV Collaborative Policy

Four policy makers participated in the study. The policy makers interviewed were top officials from the Division of Leprosy, Tuberculosis and Lung Diseases (DLTLD), National AIDS and STI Control Programme (NASCOP) and National AIDS Control Council (NACC) All the respondents agreed that the TB/HIV Collaborative Policy exists, but top official from the National AIDS Control Council (NACC) official agreed that they did not understand all the components of TB/HIV collaborative policy. For instance, two respondents agreed the IPT was being to offered to all PLWHA latently infected with TB, one respondent disagreed and the other one did not know whether it was being offered or not.

On the existence of mechanism to ensure policy implementation, all the interviewees agreed that the Joint Coordinating Board (JCB) has been established at national, provincial and at district levels. Only one respondent was able to confirm the existence of a communication strategy, joint planning, join resource mobilization, community involvement, joint operational research and joint approach to monitoring and evaluation.

On the number of HIV centers in the country or district, one respondent from NASCOP responded that there are 1,240 certified VCT centers in the country. Nyanza province has 17

health centers and 28 hospitals in Nyanza North that provide HIV services. One respondent from NACC referred this question to DLTLD and NASCOP. Three respondents agreed that there is regular screening for TB in HIV positive adult and children. Four respondents also agreed that IPT was not provided to all PLHWA latently infected with TB and children under five years.

All the respondents agreed that the strategy for addressing TB and HIV among vulnerable communities was in place. One respondent from NACC indicated that this strategy was one of the key indicators in Kenyan National AIDS and Strategic Plan (KNASP III).

Challenges in TB/HIV Policy Implementation

The findings established the following challenges in TB and HIV care settings in different programs.

National Policy Level NLTP/NACC

- Funding gaps for TB/HIV Collaborative activities in country.
- Improving Infrastructure (diagnosis TB)
- Integrating donor support e.g. PEPFAR and GF
- Human Resource training and development
- Information flow between the two programs at national level. Reporting format needs to be strengthened
- Integrating of NACC, NASCOP and DLTLD in planning and coordination
- Integrating of NACC, NASCOP and DLTLD in planning and coordination
- TB issues are not included under the Three-Ones Principle that coordinates funding, reporting, and evaluation.

Specific challenges in National TB Program

- TB does not have enough funding
- TB programs cannot address HIV/AIDS issues.
- Funding challenges
- Human resource constraints
- Emergence of Multi Drug Resistance TB
- Diagnostics facilities
- Getting TB patients to accept to be screened for HIV

Specific challenges in National HIV Program

- HIV program funding does not include TB issues.
- NACC role is purely coordination and not implementation
- Funding to HIV and reporting requirement are separate
- Increase in TB incidences in PLHIV is overwhelming HCW available
- Human resource
- Getting PLHIV to accept screening for TB.
- Getting TB programmes to report to NACC

As can be seen from the listed challenges, the main challenge facing TB/HIV collaboration in Kenya at the policy level is the fact that these two programmes are still coordinated and funded under different arrangements. In fact, HIV/AIDS programmes have more funding than TB programmes. Subsequently, monitoring, evaluation and reporting of these programmes are yet to be harmonized. TB/HIV Joint Coordinating committees exist in both provinces but programmes still work separately.

IV. PLWHA – TB Community perspective on availability of TB and HIV collaborative services in Kenya.

The study sought to establish the perspective of affected communities on the availability of the TB/HIV collaborative policy, its implementation and effectiveness in meeting the demands of people seeking HIV and TB services. Seven monitoring tools were distributed and collected from seven civil society organizations, including networks of people living with HIV and TB survivors in Kenya. The respondents included top officials of the organizations which included national networks, NGO and community based organizations (CBO). In addition, a TB survivor from the TB Patients Support Group in Kisumu was also interviewed for her perspective and experience on service provision in the clinic she attends.

<u>TB/HIV collaborative policy</u>

Five respondents agreed that the country had policy or guidelines for TB/HIV collaboration. The five are people had learnt about TB/HIV collaboration from previous trainings and/or related forums. Two respondents did not know about the existence of the TB/HIV policy or guidelines. The five CSOs who acknowledged the existence of the policy also agreed that all the listed components are in the policy or guideline. Five respondents don't know about the existence of mechanisms to ensure that the policy was implementation. Two respondents agreed that joint coordinating board/committee has been set up in some districts health facilities but they are not sure about the existence of the rest of the listed mechanisms.

Five respondents did not know how many HIV service centers existed in their country or districts. Two respondents knew the number of HIV centers that provide regular screening for TB in HIV-positive adults and children in their districts while four respondents did not know. All the seven respondents agreed that Kenya has a strategy for addressing TB and HIV among vulnerable communities especially PLWHA and children.

IV. II: TB/HIV UNIVERSAL ACCESS IN HIV CARE SETTINGS

A. Intensified case findings (ICF)

Six out of the seven respondent agreed that clinics they attend often screen for TB and this is an indication that these facilities had a policy ICF. One respondent did not know about ICF and none of the respondent knew how often screening for TB symptoms was to be done in the clinics where they get their HIV services.

Four respondents agreed that HIV positive patients suspected of having TB were referred to the TB clinics for confirmation of TB diagnosis. Three did not know. All the respondents indicated that TB diagnostics are carried out in the same health care facilities. Five respondents agreed that 51-75% of the HIV cases suspected for TB are referred to TB conformation. Two of the respondents said those who were referred were between 26-50%.

Five respondents indicated that they did not know whether the HIV clinics they attend work with public/private/NGOs that operate in TB/HIV burden congregate setting to conduct intensified case finding (ICF) amongst PLWHA. All the respondents agreed that the clinics address TB intensified case finding in prisons and HIV support groups were not aware of other congregate settings.

B. TB Treatment among PLWHA

Six respondents did not know if the HIV clinics provide first line TB treatment for HIV positive people with TB disease. One respondent agreed that the HIV centre provide TB treatment for HIV positive with TB treatment but not in the same place where ART is administered. All respondents indicated that it was not possible to know whether TB treatment was recorded on the one ART/ART register. Two respondents agreed that their clinics provide treatment for drug resistant TB. Five respondents did not know.

C: Provision of Isoniazid preventive therapy (IPT)

All the seven respondents reported that there is no provision of IPT in the HIV clinics they attend for PLWHA who are latently infected with TB as part of their package of care.

D: Infection control measures in HIV health care and congregate settings.

All the respondent said no HIV clinics they attend have infection control measures in place. If they are there, patients do not know or are not aware of them as they are not well documented.

IV.III. Assessing TB/HIV universal access in TB care settings

A. HIV Testing and Counseling for TB Patients

All seven respondents agreed that HIV testing and counseling were offered to TB patients in the clinics where they get their HIV services and the services are offered for free. The findings revealed that these services are integrated and offered within the same facility. Four of the respondents indicated the referred and followed up cases are over 75% since most of the patients getting the care services at the some facility. Three rated referral and follow-up cases at 51-75%. Three respondents agreed that all TB patients register also capture information about HIV status of the individual. Four respondents did not agree to this saying it was not possible for them to establish the content of the registers because the HCW did not allow them to see what has been written on it about them or any other client for reasons of confidentiality.

B. Provision of HIV prevention methods at the TB clinic

Six of the respondents agreed that their TB control clinics provided HIV prevention for TB patients. While one respondent indicated that only condoms are distributed to patients at the clinic. All the respondents indicated that mostly the clinics provided information and education materials and occasionally health talks by community health workers or expert patients on PMTCT and treatment adherence. They all agree that they were given referrals for opportunistic infections but sometimes they had to buy drugs to treat OIs which in most cases were out of reach due to their costs.

C. Provision of Cotrimoxazole Preventive Therapy (CPT)

All the respondents agreed that their TB clinics provide CPT to HIV positive people TB patients.

D. Provision of HIV Care and Support services at the TB care setting.

Three respondents agreed that all listed strategies were provided at the clinic. These included:

a. Promotion of nutrition support and hygiene
b. TB/HIV care and treatment education for home based care providers
c. Psychosocial support
d. Treatment adherence for both TB and HIV treatment and monitoring of adverse effects
e. Palliative care
f. Follow up care for opportunistic infections

While two respondents indicated that follow-up for opportunistic infections, nutritional information, sometimes little support in terms of food stuff was offered. The other two said that most of the list***ed*** strategies were being provided by the civil society organizations especially nutritional support, psychosocial support treatment literacy and palliative care.

E. Provision of ART for TB patients who are HIV positive

All the seven respondents agreed that ART was available for HIV positive patients at their clinics. Six respondents said the ART was started at below 200 CD4 count while one respondent said that Extra-pulmonary TB patients were being started as soon as possible even with CD4 over 300.

SECTION FOUR

V. A: RECOMMENDATION AND CONCLUSIONS

This section of the report highlights the key recommendations and conclusions based on the Kenyan team's assessment on the availability of TB/HIV universal access in HIV and TB care settings, the planning and coordination between TB and HIV programs and PLWHA-TB perspectives on availability of and HIV collaborative services in Kenya.

Kenya adopted the TB/HIV Collaborative policy recommended by the World Health Organization (WHO) of offering HIV testing and Counseling to all TB patients in 2005. However the implementation of this policy has not been well understood by those charged to implement it. There is an urgent need to re-orient all the key health policy makers on the importance of the policy to increase cohesion and commitment in its implementation.

The need for developments of a joint TB/HIV strategic plan for the country is evident to provide strategic direction on implementation, monitoring and evaluation of TB/HIV collaborative activities, besides separate current program specific strategic plans. All districts in Kenya should have functioning mechanisms that can coordinate TB/HIV activities more effectively; at the moment such a mechanism looks weak and therefore suggests lack of commitment by two main programs NTP and NACC seems to jeopardize success of its implementation.

There is need for well coordinated approach in exchange of key information from both HIV control program and TB control program in performing activities and collecting data of interest. The findings revealed only 40% of the facilities visited do have patient's information in both TB and HIV care and settings and 65% referred 50% - 75% HIV+ patients for TB confirmation, treatment and follow-up. Increasing information flow between the programs on patient's management will increase effectiveness in ensuring that patients receive optimal care from both programs and hence good treatment results. The joint TB/HIV national coordinating board should establish standard indicators on TB/HIV collaborative activities with clear reporting and recording systems or template like the community based programme (COBPAR) form used by National AIDS Control Council (NACC) in tracking the activities of community based organization implementing HIV activities.

Emphasis should be put to ensure that TB services are part of the HIV/AIDS services in clinics, community settings and that community based organization (CBOs) contribute to intensified case finding and TB infection control at community level.

The assessment has further shown that there is a great knowledge gap in people affected and infected by TB and HIV about TB/HIV collaborative policy and its implementation strategies, 89% of the respondents on community perspective variables said they that they don't have an idea about infection control measures put in place by the health care settings where they attend for health care services.

Education of TB patients and counseling them to test for HIV is an important strategy that can increase early case detection and infection control rapidly in the community. Most community members do not open up to the HCW at the clinic for fear of stigmatization which in turn creates an unnecessary barrier to accessing TB treatment.

It's therefore critical that treatment literacy programs and patients psychosocial support services be scale- up for both TB and HIV affected communities through training of more community health workers.

The new WHO guidelines for ART initiation amongst PLWH with TB state that these patients are eligible for ART regardless of their CD4s count. According to this report the providers seem to have differing understanding of this, 50% of the facilities visited in this assessment indicated eligibility for ART for PLHIV with TB as bellow 300 CD4 count which is not coherent with guidelines. It's critical that ART guidelines must be clarified and consistently applied in order to reduce pre-treatment mortality due to TB in PLHIV.

V. A. (i): CONCLUSIONS

The achievement of the desired treatment results articulated in the TB/HIV collaborative policy will depend on the provision of optimal care for HIV or TB patient, which requires knowing sensitive information about the patients. Care for TB patients will improve when TB care providers know patients' HIV status and can provide, or refer them for, appropriate preventive and treatment services. Similarly, the care of an HIV positive person may improve when HIV care providers are aware of his or her TB infection or disease status and can provide, or refer the patient for, appropriate TB treatment or prevention. This approach needs to be enhanced immediately and effectively by DLTLD and NACC programmes in Kenya in order to improve TB/HIV case management and reduce mortality and morbidity caused by TB/HIV co- infection in Kenya. While doing this, the capacity and participation of affected communities should also get sufficient attention.