

# **CIVIL SOCIETY UNGASS TB/HIV COUNTRY REPORT**

**KENYA**

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LIST OF ABBREVIATIONS .....	iv
SECTION ONE: INTRODUCTION .....	1
SECTION TWO: METHODOLOGY AND APPROACH.....	3
2.1. Data-Gathering Procedures.....	3
2.2. <i>Sampling Procedures</i> .....	3
2.3. <i>Scope</i> .....	4
2.4. <i>Methodology</i> .....	5
2.5. Data Analyses and Presentation.....	5
2.6. <i>Limitations</i> .....	5
SECTION THREE: FINDINGS.....	6
3.1. Findings from HIV Health Facilities: Assessing the Availability of Services for Decreasing the Burden of TB among People Living with HIV .....	6
3.1a. TB Intensified Case Finding in HIV Treatment Clinics .....	6
3.1b. TB Treatment .....	8
3.1b(i). Provision of Treatment for PLWHA Diagnosed with TB Disease .....	8
3.1b(ii). TB Treatment Recorded in the Pre-ART/ART Register .....	8
3.1c. Provision of Isoniazid Preventive Therapy .....	8
3.1d. Infection Control Measures in HIV Care and Congregate Settings .....	9
3.1e. Support to Health Care Workers in High-TB/HIV-Burden Settings who Provide Care to PLWHA.....	10
3.1e(i). Number of Health Care Workers Who Developed TB Disease While Providing Care to PLWHA.....	10
3.1e(ii). TB Prevention Measures/Policies in Place to Protect Health Care Workers Providing Care to PLWHA .....	11
3.2. Findings from TB Health Care Facilities and Hospitals: Assessing the Availability of Services for Decreasing the Burden of HIV among People Living with TB .....	11
3.2a. HIV Testing and Counseling for TB Patients .....	11
3.2b. Provision of HIV Prevention Methods at TB Clinics.....	12
3.2c. Provision of Cotrimaxazole Preventive Therapy .....	12
3.2d. Provision of HIV Care and Support Services in TB Care Settings.....	12
3.2e. Provision of ART for TB patients Who Are HIV-Positive.....	12
3.3. Establishment of TB/HIV Policy and Its Implementation: Questions Asked of Policy Makers .....	13
3.3a. The Existence of TB/HIV Collaborative Policy .....	13
3.3a(i). Challenges in TB/HIV Policy Implementation .....	14
3.4. PLWHA and TB Community Perspectives on the Availability of TB/HIV Collaborative Services in Kenya.....	15
3.4a. TB/HIV Collaborative Policy.....	15
3.4b. Assessing Universal Access to TB/HIV Treatment in HIV Care Settings.....	16
3.4b(i). Intensified Case Findings.....	16
3.4b(ii). TB Treatment among PLWHA .....	16
3.4b(iii). Provision of Isoniazid Preventive Therapy.....	17
3.4b(iv): Infection Control Measures in HIV Health Care and Congregate Settings.....	17
3.4c. Assessing Universal Access to TB/HIV Treatment in TB Care Settings.....	17
3.4c(ii). Provision of HIV Prevention Methods at TB Clinics .....	17
3.4c(iii). Provision of Cotrimoxazole Preventive Therapy .....	18
3.4c(iv). Provision of HIV Care and Support Services in TB Care Settings .....	18
3.4c(v). Provision of ART for TB Patients Who Are HIV-Positive.....	18

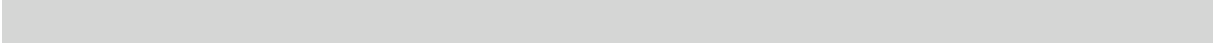
SECTION FOUR: RECOMMENDATIONS AND CONCLUSIONS.....	18
4.1. Recommendations .....	19
4.2. Conclusions.....	20
Appendix: Respondents .....	<b>Error! Bookmark not defined.</b>

Table 1 Distribution of the Samples .....	4
Table 2 Number of Health Care Workers in the TB and HIV Care Settings Visited.....	4
Table 3 Number of Health Care Workers in the TB and HIV Care Settings Visited.....	7
Table 4 Number of Health Care Workers in the TB and HIV Care Settings Visited.....	10

## LIST OF ABBREVIATIONS

ART	antiretroviral therapy
CBOs	community-based organizations
CPT	cotrimoxazole preventive therapy
CSOs	civil society organizations
DOTS	directly observed treatment short course
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease, Kenya
HCWs	health care workers
IPT	isoniazid preventive therapy
ICF	intensified case finding
ICW	International Community of Women Living with HIV/AIDS–East Africa
KNH	Kenyatta National Hospital
MDR-TB	multidrug-resistant tuberculosis
MoPHS	Ministry of Public Health and Sanitation, Kenya
NACP	National AIDS Control Programme, Kenya
NACC	National AIDS Control Council, Kenya
NASCOP	National AIDS and STI Control Programme, Kenya
NEPHAK	National Network of People Living with HIV/AIDS in Kenya
NETMA+	Network of Men Living with HIV/AIDS in Kenya
NGOs	nongovernmental organizations
NLTP	National Leprosy and Tuberculosis Programme, Kenya
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission of HIV
PPM	public-private mix
PLWHA	people living with HIV/AIDS
STC	special treatment clinic
TAG	Treatment Action Group
TB	tuberculosis
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	voluntary counseling and testing (for HIV)





## **SECTION ONE: INTRODUCTION**

Tuberculosis (TB) continues to be a public health and development problem in Kenya. The resurgence of TB in the country has been attributed to the high and rising number of HIV/AIDS cases. According to the 2009 report *Global Tuberculosis Control* from the World Health Organization (WHO), Kenya had more than 132,000 new TB cases and an incidence rate of 142 new sputum smear-positive cases per 100,000 people

(WHO 2009). Kenya's National Division of Leprosy, Tuberculosis and Lung Disease began to implement the WHO-recommended directly observed treatment short course (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 the WHO's target of 70 percent; it rose to 72 percent in 2007. The DOTS treatment success rate also met the WHO's target of 85 percent in 2007 (USAID 2009). Despite its successful DOTS program, the WHO estimates there were around 2,000 cases of multidrug-resistant tuberculosis (MDR-TB) in Kenya in 2007, while only 4.1 percent of the estimated cases were diagnosed and the patients notified about having MDR-TB. Kenya has a policy supporting multidrug-resistant tuberculosis (MDR-TB) diagnosis and treatment, and since 2008 the country conducts routine MDR-TB surveillance (USAID 2009).

Kenya is the first country in sub-Saharan Africa to have achieved the global TB targets for both case detection and treatment success, and the country treats an increasing number of TB patients each year. However, widespread coinfection with HIV (in close to 48 percent of new TB patients) makes TB diagnosis and treatment difficult. While the number of new TB cases appears to be declining, the number of patients requiring retreatment has increased. To better address TB/HIV coinfection, the government placed the National Leprosy and Tuberculosis Program (NLTP), newly renamed as the Division of Leprosy, Tuberculosis and Lung Disease (DLTLD), and the National AIDS Control Program (NACP) in the same division within 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 MoPHS, the DLTLD, and increased funding for TB control. The DLTLD implements TB/HIV treatment services, community-based DOTS, and public-private mix (PPM) DOTS, as well as activities to address MDR-TB (USAID 2009).

Kenya's HIV/AIDS policy has evolved over the years. By 2004, the MoPHS 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. The 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 the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, 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 higher, as the current recording and reporting system does not capture patients who start ART after the third month of TB treatment (WHO 2009).

The past United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS (UNGASS) reports from Kenya have not provided sufficient information about the current situation of TB in HIV populations. The current research and report is an attempt for civil society organizations (CSOs) to take center stage in ensuring that national responses are strengthened through the creation and implementation of TB/HIV collaborative policies.



## **SECTION TWO: METHODOLOGY AND APPROACH**

This report has been developed from information gathered through a qualitative monitoring effort focused on the implementation of TB/HIV collaborative policy. This policy focuses on strategies to increase collaborative surveillance, planning, and evaluation activities between Kenya's TB and HIV programs, reduce the burden of TB in people living with HIV/AIDS (PLWHA), and 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 predetermined instrument was developed to guide the data-gathering process. The instrument was developed by the International Community of Women living with HIV/AIDS–East Africa (ICW) and Treatment Action Group (TAG); it had different sections and was meant to identify the policy and implementation successes and gaps in TB/HIV collaborative activities in key health institutions, TB care settings, and HIV care settings, and to establish the perspectives of TB/HIV affected community on the availability of TB and HIV services in various health facilities in Kenya. A total of 35 questionnaires were administered to HIV clinics, TB clinics, policy makers, and people infected/affected by TB/HIV. The findings were then analyzed with a view toward establishing the existence of the policy and the degree of its implementation.

### ***2.2. Sampling Procedures***

Simple random sampling and purposive technique were used to select respondents in TB and HIV care settings to assess the degree of universal access to TB and HIV collaborative activities and CSOs to get their perspectives on policy implementation in the country.

Purposive technique was applied in identifying the policy makers at the DLTLTD, the National AIDS and STI Control Programme (NASCO), 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 interviews with key informants at the DLTLTD and NASCO.

- b) HIV and TB care settings in the national referral hospital, provincial and district hospitals, mission hospitals, and health clinics in Nairobi and Nyanza Provinces.
- c) CSOs working on TB and HIV/AIDS and representatives of affected communities in Kenya.

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 Communities	7
Total		35

**Table 1 Distribution of the Samples**

### **2.3. Scope**

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

Table 2.2 shows the 11 TB and HIV care settings that were visited in Nairobi and Nyanza. In each setting the officers in charge were interviewed.

Nairobi Province	Nyanza Province
American Medical and Research Foundation (AMREF) ART Clinic	Chula-Imbo Health Centre, Kisumu
Mater Mission Hospital	Homa Bay District Hospital
Casino Special Treatment Clinic	Kisii District Hospital
Mbagathi District Hospital	Migori District Hospital
Coptic Mission Hospital	Nyanza Provincial General Hospital
Kenyatta National Hospital (KNH)	

**Table 2 Number of Health Care Workers in the TB and HIV Care Settings Visited**

## **2.4. Methodology**

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

## **2.5. Data Analyses 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 constraints in this exercise were time and resources to carry out a more comprehensive assessment of universal access to TB and HIV care services in 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 both urban and rural areas.

Most respondents wanted an official letter of introduction from the researchers when they were collecting data on special health matters. The process of obtaining approval was time-consuming during the monitoring. 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 did have some concerns as to why NEPHAK and NETMA+ were involved in a parallel process of data collection. It was understood, however, that the two processes could complement each other and that this exercise was giving necessary attention to TB and HIV issues.

## SECTION THREE: FINDINGS

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

### **3.1. Findings from HIV Health Facilities: Assessing the Availability of Services for Decreasing the Burden of TB among People Living with HIV**

The monitoring team visited 11 health care settings. Each health care facility was providing both HIV and TB services, but in different clinics> The 11 facilities fall into the following categories: 1 national referral hospital, 1 provincial hospital, 4 district hospitals, 2 mission hospitals, 1 NGO hospital, 1 health center, and 1 local authority special treatment clinic (STC).

#### **3.1a. TB Intensified Case Finding in HIV Treatment Clinics**

All respondents noted that the HIV clinics have a policy on screening PLWHA for TB symptoms. Four respondents indicated that clients are screened whenever they come for care and treatment services. Two respondents, from the Chula-imbo Health Centre and the 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 the Casino STC) said that new clients are screened for clinical presentations of TB and when they show symptoms indicative of TB. All respondents noted that they referred suspected TB cases for confirmation of diagnosis. All respondents indicated that there are TB diagnostic centers within their facilities. Table 3.1 shows the number of children and adults enrolled in HIV care settings, those enrolled in TB care settings, and the proportion of PLWHA on TB treatment at the visited care settings.

<b>Health Facility</b>	<b>Number of Children and Adults Enrolled in HIV Care</b>	<b>Number of Children and Adults Enrolled in TB Care</b>	<b>Proportion of PLWHA on TB Treatment</b>
AMREF ART Clinic	313	157	50%
Casino STC (referral)	184	165	89%

Chula-Imbo Health Centre	237	178	75%
Coptic Mission Hospital	307	69	22%
Homa Bay District Hospital	482	230	47%
Kenyatta National Hospital	232	131	56%
Kisii District Hospital	348	124	35%
Mater Mission Hospital	228	36	15%
Mbagathi District Hospital	870	363	41%
Migori District Hospital	532	259	48%
Nyanza Provincial General Hospital	620	378	60%

**Table 3 Number of Health Care Workers in the TB and HIV Care Settings Visited**

The table shows that the Casino STC registered the highest proportion of PLWHA on TB treatment (89%) in the most recent quarter; this could be attributed to the fact that Casino is the only special treatment clinic for infectious diseases in Nairobi. Chula-Imbo Health Centre registered 75% of PLWHA on TB treatment while the Mater and Coptic Mission hospitals registered the lowest proportions with 15% and 22%, respectively. The rest of the facilities registered between 35% and 60%. The average proportion of PLWHA on TB treatment in the 11 health care settings visited was 49%.

**3.1a(i). On Working with Other Public/Private/Nongovernmental Organizations Working in TB/HIV Congregate Settings on Intensified TB Case Finding**

Respondents from 9 out of the 11 facilities visited explained that they engage with public, private, and nongovernmental organizations in intensified case finding (ICF). One respondent (from Chula-Imbo Health Centre) indicated that the health facility collaborates with community-based organizations (CBOs), including posttest clubs, in the training and recruitment of TB “ambassadors of hope” to identify those potentially infected with TB in the community, in prisons, and among people with HIV.

### **3.1b. TB Treatment**

#### **3.1b(i). Provision of Treatment for PLWHA Diagnosed with TB Disease**

Respondents from 9 out of the 11 facilities explained that they provide TB treatment for PLWHA diagnosed with TB disease. One respondent (from the AMREF ART Clinic) indicated that the facility does not provide TB treatment but makes immediate referrals of TB patients or those suspected of having TB to other public health facilities.

The findings further demonstrate that the number of HIV-positive children attending HIV care clinics is very low compared to the number of adults in the TB and HIV care settings visited. One respondent (from the Coptic Mission Hospital) said that the fear of the unknown and issues associated to pediatric disclosure were two common reasons why most HIV-positive parents were not willing to have their children tested for HIV. Generally, there are more adults than children living with HIV and affected by TB in Kenya.

#### **3.1b(ii). TB Treatment Recorded in the Pre-ART/ART Register**

Eight respondents noted 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 (from Mater Mission Hospital and the AMREF ART Clinic) indicated that they do not provide treatment for drug-resistant TB. Four hospitals (KNH, Mbagathi District Hospital, Nyanza Provincial General Hospital, Homa Bay District Hospital) 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 2,000 TB cases, including some cases of MDR-TB. During this study, six respondents said that they refer drug-resistant case to Mbagathi District Hospital, the TB clinic at the KNH, or the Moi Referral Hospital in Eldoret. The Migori and Kisii District Hospitals indicated that they refer drug-resistant cases to either Nyanza Provincial General Hospital, Homa Bay District Hospital, or the TB clinic run by Médecins Sans Frontières/Doctors without Borders.

### **3.1c. Provision of Isoniazid Preventive Therapy**

Kenya as a country does not have a national policy to provide isoniazid preventive therapy (IPT), and such therapy is only available in few and special cases. Nevertheless, information on IPT is becoming increasingly available to PLWHA in Kenya. Four respondents noted that PLWHA are provided with information on IPT at the facilities; six respondents indicated that their facilities do not provide PLWHA with information on IPT. Two respondents (from

Chula-Imbo and Homa Bay) noted that they provide PLWHA who are latently infected with TB access to IPT as part of their course of care. Homa Bay had 16 children and 30 adults on IPT as part of an ongoing IPT study. Chula-Imbo had put 16 children and 28 adults on IPT in the last quarter of 2009 and was also conducting a study on IPT. The study is being conducted by the U.S. Centers for Disease Control and Prevention. Seven respondents indicated that their facilities do not provide IPT to PLWHA. One respondent, from the KNH, indicated that the hospital provides IPT to patients who are at the highest risk of contacting TB, especially those who are themselves HIV-positive and taking care of others with TB disease in their households. The respondent from the KNH also indicated that there was an ongoing study in IPT for children and adults.

One health worker respondent reported that she had just been retreated 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 monoresistance to isoniazid. Seven respondents did not indicate a number of children and adults on IPT since they do not provide IPT to their clients.

### **3.1d. 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 in congregated settings. One respondent, from the Coptic Mission Hospital, indicated that the facility does not have these measures in place, but that it provides some of the recommended infection control measures, such as posters on cough hygiene displayed in HIV care settings, training of HIV staff on infection control, and a sputum collection space that is well ventilated. None of the 11 respondents used any mechanical tools to reduce TB infection such as fans or UV lamps.

Nine of the respondents noted that they partner with public, private, and nongovernmental organizations 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 and schools, but not brothels or police or army barracks. One respondent from the Coptic Mission Hospital indicated that its health care workers don't work in any of these settings.

### 3.1e. Support to Health Care Workers in High-TB/HIV-Burden Settings who Provide Care to PLWHA

Table 3.2 shows the number of health care workers who provided care to PLWHA in the most recent quarter (July 1–September 30, 2009) in the facilities visited.

Health Facility	Number of Health Care Workers	Number of Health Care Workers Who Developed TB Disease	Percentages
AMREF ART Clinic	14	—	—
Casino STC	20	1	5%
Chula-Imbo Health Centre	68	2	2.9%
Coptic Mission Hospital	150	—	—
Homa- Bay District Hospital	42	—	—
Kenyatta National Hospital	74	3	4.05%
Kisii District Hospital	20	—	—
Mater Mission Hospital	14	—	—
Mgagathi District Hospital	48	—	—
Migori District Hospital	18	—	—
Nyanza Provincial Hospital	54	—	—

**Table 4 Number of Health Care Workers in the TB and HIV Care Settings Visited**

#### 3.1e(i). Number of Health Care Workers Who Developed TB Disease While Providing Care to PLWHA

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



### **3.1e(ii).TB Prevention Measures/Policies in Place to Protect Health Care Workers**

#### **Providing Care to PLHWA**

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

Nine respondents noted that their facilities provide training for HCWs on TB infection control, while one respondent (from Coptic Mission Hospital) indicated that the facility does not provide such training.

### **3.2. Findings from TB Health Care Facilities and Hospitals: Assessing the Availability of Services for Decreasing the Burden of HIV among People Living with TB**

All 11 of the health care facilities visited were providing both HIV and TB services, but in different clinics within the facilities.

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

#### **3.2a. HIV Testing and Counseling for TB Patients**

One respondent indicated that the TB clinic at which he/she worked did not provide HIV testing and counseling. Nine respondents noted that HIV testing and counseling are offered at their TB clinics. One respondent (from KNH) indicated that HIV testing and counseling to TB patients were done through referrals from voluntary counseling and testing (VCT) HIV centers and hospitals outside KNH; the respondents further indicated that all patients were referred to diagnostic and testing centers.

On the cost of VCT services, all the respondents agreed that these 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 explained 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

testing and follow up, and four respondents had referred between 50 and 75% of their TB cases for HIV testing and counseling between July 1 and September 30, 2009.

### **3.2b. Provision of HIV Prevention Methods at TB Clinics**

Nine out of eleven respondents noted that there was provision for HIV prevention methods within the TB clinics. One respondent (from Mater Mission Hospital) explained that they don't have such services in place; six respondents said their facilities provided condoms and education programs; promoted safer sex practices and early diagnosis and treatment for sexually transmitted illnesses; provided information on prevention of mother-to-child transmission (PMTCT) of HIV; and promoted positive living in PLWHA to reduce stigma, address the need for PLWHA taking care of themselves and their partners and also encourage others who are at risk for HIV risk to know their status. Four respondents said that their facilities do not provide promotion of positive living or partner testing for HIV-positive patients.

### **3.2c. Provision of Cotrimoxazole Preventive Therapy**

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

### **3.2d. Provision of HIV Care and Support Services in TB Care Settings**

Eight out of the eleven respondents noted 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 providers, psychosocial support, treatment adherence support, palliative care, and follow-up care for opportunistic infections. Two respondents (from the Coptic and Mater Mission Hospitals) said they only offer psychological support, treatment adherence, and follow-up care for opportunistic infections.

### **3.2e. Provision of ART for TB patients Who Are HIV-Positive**

The findings established that four out of the eleven respondents did not have ART available in their TB clinics for patients who are HIV positive. Six respondents explained that ART was available to HIV-positive TB patients at their clinics and also noted that there is mechanism that has been created between the HIV and TB programs 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, from the Casino

STC, indicated that Casino will accept PLWHA with a CD4 count of up to 350 depending on the type of TB disease they may have and other clinical presentations. Five respondents did not respond to this question but suggested that the question of the CD4 eligibility criteria for access ARTs would be better answered by the HIV clinics. The findings therefore indicate that the providers do not seem to consistently follow the WHO guidelines for initiating ART in PLHWA with TB disease, which state that these patients are eligible for ART regardless of their CD4 count.

### ***3.3. Establishment of TB/HIV Policy and Its Implementation: Questions Asked of Policy Makers***

This portion of the study sought to establish the extent at which TB/HIV collaborative policy has enhanced planning and coordination between TB and HIV programs in Kenya, and, further, to assess its implementation and effectiveness in reducing the burden of TB in PLWHA and reducing HIV burden in those infected with TB.

#### **3.3a. The Existence of TB/HIV Collaborative Policy**

Four policy makers participated in the study. The policy makers interviewed were top officials from the Kenyan government's Division of Leprosy, Tuberculosis and Lung Diseases (DLTLD), its National AIDS and STI Control Programme (NAS COP), and its National AIDS Control Council (NACC). All the respondents concurred that TB/HIV collaborative policy exists, but top officials from the NACC explained that they did not understand all the components of such policy. For instance, two respondents noted that IPT was being offered to all PLWHA latently infected with TB, while another respondent disagreed and another did not know whether it was being offered or not.

On the existence of mechanism to ensure policy implementation, all the interviewees noted that a joint coordinating board has been established that is made up of policy leaders at the national, provincial, and district levels. Only one respondent was able to confirm the existence of a communication strategy, joint planning, joint resource mobilization, community involvement, joint operational research, and a 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 that provide HIV services. One respondent from the NACC referred this question to the DLTLD and NASCOP. Three respondents noted that there is regular screening for TB in HIV-positive adults and children. Four respondents also noted that IPT was not provided to all PLHWA latently infected with TB or to children under five years of age.

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

### **3.3a(i). 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 the country.
- Improving infrastructure (diagnosis of TB).
- Integrating donor support (e.g., PEPFAR and the Global Fund)
- Human resource training and development.
- Information flow between the two programs at the national level. Reporting format needs to be strengthened.
- Integrating of the NACC, NASCOP, and DLTLD in planning and coordination.
- TB issues not being included under the three ones principle that coordinates funding, reporting, and evaluation.

#### *Specific Challenges in the National TB Program*

- TB programs do not have enough funding.
- TB programs cannot address HIV/AIDS issues.
- Human resource constraints.
- The emergence of MDR-TB.
- Shortage of diagnostic facilities.
- Getting TB patients to accept screening for HIV.

### *Specific Challenges in the National HIV Program*

- HIV program funding does not include TB issues.
- The role of the NACC is purely one of coordination and not of implementation.
- Funding for HIV programs and reporting requirements are separate
- Increase in TB incidence in PLWHA is overwhelming available HCWs.
- Human resource constraints.
- Getting PLWHA to accept screening for TB.
- Getting TB programs to report to the NACC.

As can be seen from the challenges listed, the main challenge facing TB/HIV policy collaboration in Kenya is the fact that the TB and HIV/AIDS programs are still coordinated and funded under different programs. In fact, HIV/AIDS programs receive more funding than do TB programs. Subsequently, monitoring, evaluation, and reporting for these programs has yet to be harmonized. TB/HIV joint coordinating committees exist in both provinces, but the TB and HIV/AIDS programs still operate independent of each other.

### **3.4. PLWHA and TB Community Perspectives on the Availability of TB/HIV Collaborative Services in Kenya**

This aspect of the study sought to establish the perspective of affected communities on the availability of TB/HIV collaborative policy and 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 PLWHA and TB survivors in Kenya. The respondents included top officials of the organizations, which included national networks, NGOs, CBOs. In addition, a TB survivor from the TB Patients Support Group in Kisumu was also interviewed for her perspective and experience on service provisions in the clinic she has used.

#### **3.4a. TB/HIV Collaborative Policy**

Five respondents noted that the country had policy or guidelines for TB/HIV collaborative policy. The five had learned about TB/HIV collaboration from previous trainings and/or related forums. Two respondents did not know about the existence of the collaborative policy or its guidelines. The five CSOs that acknowledged the existence of the policy also concurred that all the listed components are in the policy or its guidelines. Five respondents didn't know about the existence of mechanisms to ensure that the policy was implemented. Two

respondents noted that a joint coordinating board/committee has been set up in some health districts but were not aware of how well these joint coordinating committees were functioning.

Five respondents did not know how many HIV service centers existed in the country or in their 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 noted that Kenya has a strategy for addressing TB and HIV among vulnerable communities—especially PLWHA and children.

### **3.4b. Assessing Universal Access to TB/HIV Treatment in HIV Care Settings**

#### **3.4b(i). Intensified Case Findings**

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

Four respondents noted that HIV-positive patients suspected of having TB were referred to TB clinics for diagnostic confirmation; three respondents were not aware of this. All the respondents indicated that TB diagnostics are carried out in the same health care facilities that house the HIV clinics. Five respondents noted that 51–75% of the HIV cases suspected for TB are referred for diagnostic confirmation. Two of the respondents said those the proportion of people referred was between 26% and 50%.

Five respondents indicated that they did not know whether the HIV clinics they frequent work with public/private/nongovernmental organizations that operate in TB/HIV burden congregate settings to conduct ICF amongst PLWHA. All the respondents noted that the clinics address TB intensified case finding in prisons and HIV support groups, but were not aware of other congregate settings.

#### **3.4b(ii). TB Treatment among PLWHA**

Six respondents did not know if the HIV clinics provide first-line treatment for HIV-positive people with TB disease. One respondent explained that the HIV center provides TB treatment

for HIV positive people but not in the same place where ART is administered. All respondents indicated that they did not know whether TB treatment was recorded on the ART registers. Two respondents noted that their clinics provide treatment for drug-resistant TB, while five respondents did not know if their clinics provided such treatment.

### **3.4b(iii). Provision of Isoniazid Preventive Therapy**

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

### **3.4b(iv): Infection Control Measures in HIV Health Care and Congregate Settings**

All respondents noted that none of the HIV clinics they frequent have infection control measures in place. If such measures are in place, patients are not aware of them, as they are not well documented.

## **3.4c. Assessing Universal Access to TB/HIV Treatment in TB Care Settings**

### **3.4c(i). HIV Testing and Counseling for TB Patients**

All seven respondents noted that HIV testing and counseling were offered to TB patients in the clinics where they get their HIV services, and that such testing and counseling is offered for free. The findings reveal that these services are integrated and offered within the same facility. Four of the respondents indicated that over 75% of the TB cases referred for HIV testing got tested as they were being referred to HIV testing sites within the health center. Three TB clinics stated that they about 51–75% of the TB cases referred got HIV tested. Three respondents reported that TB patients register also capture information about the HIV status of the individual. Four respondents did not know whether the TB registers captured HIV information of the patients as the HCWs did not allow them to see the contents of the TB register for reasons of confidentiality.

### **3.4c(ii). Provision of HIV Prevention Methods at TB Clinics**

Six of the respondents explained that the TB clinics they frequent also provide HIV prevention for TB patients. One respondent indicated that only condoms are distributed to patients at the clinic he or she frequents. All respondents indicated that, for the most part, clinics provided informational and educational materials on HIV prevention, and occasionally health talks by community health workers or expert patients on PMTCT and HIV treatment adherence. They all agreed that they were given referrals for opportunistic infections but that

sometimes they had to buy their own drugs to treat these infections and that in most cases such drugs were out of reach due to cost.

### **3.4c(iii). Provision of Cotrimoxazole Preventive Therapy**

All respondents noted that the TB clinics they frequent provide CPT to HIV-positive TB patients.

### **3.4c(iv). Provision of HIV Care and Support Services in TB Care Settings**

Three respondents noted that all the following support services were provided at the clinic:

- Promotion of nutritional support and hygiene.
- TB/HIV care and treatment education for home-based care providers.
- Psychosocial support.
- Adherence information for both TB and HIV treatment and monitoring of adverse effects.
- Palliative care.
- Follow-up care for opportunistic infections.

Two respondents reported that TB care clinics offered follow-up for opportunistic infections, information on nutrition, and sometimes also provided a small amount food. Two others said that most of the listed HIV support strategies were being provided by CSOs—especially nutritional support, psychosocial support, treatment literacy, and palliative care.

### **3.4c(v). Provision of ART for TB Patients Who Are HIV-Positive**

Six respondents noted that ART was started at a CD4 count of under 200, while one respondent said that extrapulmonary TB patients were being started as soon as possible, even with CD4 counts of over 300.

## **SECTION FOUR: RECOMMENDATIONS AND CONCLUSIONS**



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

#### **4.1. Recommendations**

In 2005, Kenya adopted the TB/HIV collaborative policy recommended by the World Health Organization of offering HIV testing and counseling to all TB patients. However, the implementation of this policy has not been well understood by those charged to implement it. There is an urgent need to reorient all key health policy makers on the importance of the policy in order to increase cohesion and commitment in its implementation.

The need for development of a joint TB/HIV strategic plan for the country is evident in order to provide strategic direction on implementation, monitoring, and evaluation of TB/HIV collaborative activities. These must be in addition to current (and separate) program-specific strategic plans. All districts in Kenya should have functioning mechanisms that can coordinate TB/HIV activities more effectively; at the moment any such mechanisms that exist look weak, and therefore suggest lack of commitment by the two main programs, the NTLP and the NACC. This would seem to jeopardize the success of the implementation of any joint TB/HIV plan.

There is need for a well-coordinated approach to the exchange of key information between the HIV control program and the TB control program. The findings reveal that only 40% of the facilities visited had full information about a patient's TB and HIV status. Increasing the information flow between the programs will increase effectiveness in ensuring that patients receive optimal care from both programs and thus good treatment results. The TB/HIV national coordinating board should establish standard indicators on collaborative activities with clear reporting and recording systems or templates.

TB services should be part of HIV/AIDS services in clinics and community settings, and CBOs should be supported to contribute to TB intensified case finding and infection control at the community level.

The assessment has further shown that there is a great knowledge gap in people affected by and infected with TB and HIV about collaborative policy and its implementation strategies. Eighty nine percent of the respondents from the communities infected/ affected with TB and HIV were not aware of infection control measures in the clinics they frequent.

Education of TB patients and encouraging them to get tested for HIV is an important strategy that can greatly increase early case detection and infection control in the community. Most community members do not open up to health care workers at the clinics they frequent for fear of stigmatization; this in turn creates an unnecessary barrier to accessing TB treatment.

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

The new WHO guidelines for ART initiation among PLWH with TB state that these patients are eligible for ART regardless of their CD4 counts. According to the data gathered in the present report, Kenyan health care providers seem to have a differing understanding of this: 50% of the facilities visited in this assessment indicated eligibility for ART for PLWHA with TB who had CD4 counts lower than 300, which is not coherent with the WHO's guidelines. It's critical that ART guidelines be clarified and consistently applied.

## **4.2. Conclusions**

The full implementation of a TB/HIV collaborative policy in Kenya will lead to optimal care for patients with HIV, TB, or both. However, this requires that both service providers know the HIV and TB statuses of their patients. Care for TB patients will improve when care providers know patients' HIV status and can provide or refer them for appropriate preventive and treatment services. Similarly, the care of PLWHA will improve when HIV care providers are aware of their TB infection or disease statuses and can provide—or refer the patient for—appropriate TB treatment or prevention. This approach needs to be enhanced immediately and effectively by the DLTLDD and the NACC in order to improve case management and reduce mortality and morbidity caused by TB/HIV co infection. While doing this, the capacity and participation of affected communities should also get sufficient attention.



