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# KENYAN CONCERNS ABOUT RISING MDR-TB REFLECT REGIONAL PUBLIC HEALTH CHALLENGE

Kenya has made enormous strides in its efforts to tackle tuberculosis amongst its population, improving diagnosis and treatment to such an extent that prevalence has dropped from 335 to 299 cases per 100,000 people between 2006 and 2012. But the continuing insecurity in the region backed by the weakness of the health infrastructure in neighboring countries have maintained the flow of refugees into Kenya, and into the national health system in search of treatment and care.

Multi-drug resistant TB (MDR-TB) is of particular concern. Those who flee their homes can at times carry only the clothes on their backs — not the drugs they need to continue or complete a treatment regimen. Of the 550 patients currently being treated for MDR-TB in Kenya, 87 (15%) are in Dadaab on Kenya's eastern border with Somalia: the world's largest refugee settlement, home to more than 500,000 people.

Kenya has achieved a drop in new cases of TB due to detection rates that exceed WHO's target of 70%, according to Dr Jackson Kioko, director of the TB unit of the Ministry of Health. This success, however, belies the eight new cases of MDR-TB recorded each month in Dadaab, says his colleague, Dr Maurene Kamene.

"In a country that has been at war for more than 20 years, the population is always on the move," Kamene said. "There is no quality control for TB medications, and furthermore, many have begun treatments that they did not finish; this has created a lot of resistance."

Some $32 million was approved in January by the Board of the Global Fund — which has shouldered much of the financial burden for TB treatment in Somalia — to, among other things, initiate the roll-out of treatment for MDR-TB to begin to address the disease prevalence of 5.2% among new cases and 40.7%

among retreatment cases (see article here).

But while the Somali population is moving across the border into Kenya, the funds are not, which Dr Bernard Langat, in charge of planning policy and research at the National TB , Leprosy and Lung Disease Unit at the Ministry of Health said will place undue strain on its health system and its budget.

“It’s adding a burden to our Kenyan situation,” added Dr Kioko. “The quantification of medication is based on the Kenyan population, not on the refugees figures.”

And while Global Fund resources are paying 89% of the budget for Somalia’s TB response, the proportion is significantly smaller for Kenya’s proportionally greater need. Kenya’s national TB program estimates needs at some $244 million for controlling the disease; its allocation from the Global Fund for the period 2014-217 stands at just $45 million.

As it stands, $1.8 million of the estimated $12.7 million needed to respond to MDR-TB in Kenya was contributed between 2013-2015.

Financial concerns aside, even procuring the right quantity of medicine is a challenge. Even citizens of countries that are not in crisis turn to Kenya for treatment relief for MDR-TB, relying on its experience in treatment of the illness and the comparatively low cost of the eight months of injections: some $2,500 on average.

Western neighbor Uganda only began systematic treatment of MDR-TB in 2012 — representing 1.4% of new cases reported in 2011. To the south in Tanzania, MDR-TB estimates were 1.1% of cases reported in 2011, and treatment was initiated for 1,000 new cases of MDR-TB the following year. Costs in both these countries can be as much as 100 times the cost for the same drugs in Kenya.

But it’s among the Somali refugee population in Kenya that MDR-TB is flourishing, according to Lucy Chesire, executive director of the local NGO TB-Action. “Thirty percent of MDR-TB [patients] are refugees,” she told Aidspan. “We are basically importing MDR-TB. From a human rights perspective, we cannot deny them services. But monitoring, contact investigation and sensitization are the priority.”

The response: regional, decentralized and integrated with HIV

Dr Joseph Sitienei, director of the department of prevention of transmissible disease at Kenya’s Health Ministry, considers that surveillance, detection and awareness cannot stop at national borders.

“We need an approach that transcends borders,” he told Aidspan. “East Africa should sign a protocol so that all countries follow the same treatment program [for TB]. If someone falls sick in Rwanda or Uganda, and didn’t carry with him enough doses, he now runs the risk of not being able to find [the same medicine] and to interrupt his therapy.”

Those populations that are highly mobile — be they bus or truck drivers, economic or political migrants or nomadic pastoralists — pose a highly complex problem for therapeutic response, said Sitieni, noting that the “resistant TB belt follows the highway from [coastal Kenya’s port city of] Mombasa to Uganda”.

Kenya will finish revising its new National Strategic Plan for TB by the end of June, paying special attention to improved access to treatment and better identification of vulnerable populations. It is likely that workplans envisioned under the NSP will draw on the planned decentralization of services outlined in the constitution promulgated in 2013. This should allow for more targeted placement of health services in communities to be nearer to patients.

“We need to use the county structure put in place by the new devolution in order to identify TB cases at

the local level, to improve diagnostics, and to better reach marginalized populations who have limited access to TB services," said Dr Kioko.

Aligning the TB strategy with devolution is smart thinking, agreed Lucy Chesire. However, she cautioned, "TB is always perceived as a vertical program. You will see a district health manager not developing a budget for TB because he knows the government has already taken care of it. It really needs to be embraced by local governments, especially in the hardest-hit regions, so that they can determine their financing priorities."

A meeting held 22-27 April in the western city of Kisumu aimed to carry this message to civil society and local government stakeholders from around the country. The meeting, which brought together the national TB/HIV ICC secretariat, sought to open the Fund's country dialogue process and identify areas requiring joint TB/HIV planning, in line with the Fund requirement that Kenya submit a joint HIV/TB proposal due to high co-morbidity of the two diseases.

How to better incorporate cross-cutting issues of health and community systems strengthening, human rights and gender into the concept note, which should be submitted in the first quarter of 2015, were also discussed.

Although there are concerns among stakeholders in the TB community that integration with HIV could mean subordinating priorities to the better-resourced HIV community, Dr Kioko said that it is only when true integration is achieved that the real work to combat TB and MDR-TB can be done. Citing 2011 figures, Dr Kamene said that co-morbidity of infection is estimated at 39% for TB and HIV in Kenya; among patients with MDR-TB, co-infection incidence is 27%.

"There are many advantages: it is cheaper for the patient, less time is spent, efficiency is increased, but this a question of mindset," said Dr Kioko. "When you want to change a system, there is always resistance, people are afraid to lose their jobs, to lose resources."

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