All-Party Parliamentary Group
On Global Tuberculosis

Parliamentarians' delegation on tuberculosis - Kenya

August/ September 2010

Delegation Report

action
Advocacy to Control TB Internationally

RESULTS
the power to end poverty

Contents

Abbreviations

ACTION	Advocacy to Control TB Internationally
AMREF	African Medical and Research Foundation
APPG	All-Party Parliamentary Group on Global Tuberculosis
ART	Antiretroviral Therapy
ARVs	Antiretroviral (drugs)
CCM	Country Coordinating Mechanism
CSO	Civil Society Organisation
DFID	UK Department for International Development
DOT	Directly Observed Treatment
GFATM	Global Fund to Fight AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
KEMSA	Kenya Medical Supplies Agency
MDGs	Millennium Development Goals
MDR-TB	Multiple Drug Resistant Tuberculosis
MNC	Multi-National Corporation
MoH	Ministry of Health
MSF	Médecins Sans Frontières (Doctors Without Borders)
NGO	Non Governmental Organisation
NTP	National Tuberculosis Control Programme
PEPFAR	President's Emergency Plan for Aid Relief
PLWHA	People Living With HIV / AIDS
PPP	Public Private Partnership
SWAp	Sector Wide Approach

Acknowledgements

The APPG on Global TB and RESULTS UK would like to thank all of the organisations and individuals who helped make the delegation possible. We would also like to particularly thank ACTION Kenya partners from Kenya AIDS NGO Consortium (KANCO) and AMREF who assisted with the delegation.

Photographs used in this report were taken by Mike Smith and Aparna Barua.

About the delegation

RESULTS, the ACTION Project and the APPG on Global TB

RESULTS is a national grassroots advocacy organisation committed to creating the political will to end global poverty and needless suffering. RESULTS leads parliamentary delegations to educate decision makers about the challenges associated with global poverty – but also on the impact of solutions.

The Advocacy to Control Tuberculosis Internationally (ACTION) project is an international partnership of advocates working to mobilise resources to treat and prevent the spread of tuberculosis (TB). ACTION's underlying premise is that more rapid progress can be made against the global TB epidemic by building increased support for resources for effective TB control among key policymakers and other opinion leaders in both high TB burden countries and donor countries. The project is currently funded by the Bill & Melinda Gates Foundation and other donors.

The All-Party Parliamentary Group on Global Tuberculosis is a cross-party group of MPs and Peers established in response to concern for the growing scale and impact of the TB epidemic and to reinforce the UK's commitment to halting and reversing the incidence of TB worldwide.

About tuberculosis

Tuberculosis is a preventable and curable disease which kills around 4500 people every day. Despite its global scale and impact, TB has a relatively low profile compared to the other major infectious diseases such as HIV and malaria. Each year, 1.8 million die from TB, even though it costs only around $20 to treat. Most are adults in the prime of life who leave behind school-age children and a tremendous void in their community.

About tuberculosis in Kenya

Tuberculosis is a major public health problem in Kenya. The country is ranked 13th among the 22 high TB burden countries which collectively contribute about 80% of the global TB cases. The TB case notification rate has increased more than tenfold since the early 1990s. The absolute number of TB cases notified increased from less than 50 per 100,000 in 1990 to 329 per 100,000 populations in 2008. A total of 110,251 TB cases were notified in 2008 of which 45% were dually infected with HIV. The high increase in TB notification rate is attributed primarily to HIV co-infection. Other factors include high poverty levels and rapid growth of the urban poor population.

The section of the population most affected by TB are those in the income generating age group between the ages of 15 and 54 years of age who are severely hampered by the disease during their most economically productive years. TB therefore contributes to an increase in poverty levels.

Despite this, Kenya is the first country in sub-Saharan Africa to have achieved the global targets for

both case detection and treatment success. Collaboration between TB and HIV services are now widely implemented and multidrug resistant TB (MDR-TB) treatment is available.

Visit programme

The delegation took place between 29th August – 3rd September, 2010 and was funded by RESULTS UK as part of their work on the ACTION *(Advocacy to Control TB Internationally)* Project (www.action.org).

Monday 30th August

- Visit to the MDR-TB treatment facilities at Kenyatta National Hospital
- Visit to the AMREF-run health centre in Kibera Slum, Nairobi
- Visit to the HIV post-test club group in Kibera Slum, Nairobi
- Meeting with members of the Global Fund Country Coordinating Mechanism
- Meeting with Dr Joseph Sitienei, Head of the National Division of Leprosy, Tuberculosis and Lung Disease

Tuesday 31st August

- Visit to the Nyanza Provincial Hospital
- Field visit to TB patients receiving community-based treatment in their homes

Wednesday 1st September

- Visit to the AMREF Maanisha HIV/TB project in Homa Bay, including the Star of the Lake Community Based Organisation
- Visit to the MSF-run MDR-TB isolation treatment unit in Homa Bay

Thursday 2nd September

- Meeting with Prof P. Anyang' Nyong'o, Minister for Medical Services
- Meeting with members of the Departmental Committee on Health of the Kenya National Assembly
- Meeting with Jean-Marrion Aitken, Senior Health and HIV Advisor, DFID
- Meeting with Mark Bor, Permanent Secretary, Ministry of Public Health and Sanitation
- Meeting with Michael Mills, Lead Economist and HD Leader, World Bank

Members of the delegation

Andrew George, MP for St Ives
Andrew George MP chairs the UK All Party Parliamentary Group on Global Tuberculosis.

Virendra Sharma, MP for Ealing Southall
Virendra Sharma MP is the vice-chair of the APPG TB.

Aparna Barua
Project Associate, ACTION Project, RESULTS UK

Mike Smith
Coordinator, All Party Parliamentary Group on Global Tuberculosis

Purpose of the delegation

The purpose of the delegation was to learn more about how Kenya is addressing major health challenges, specifically TB and HIV, and the impact of the UK Government's support to Kenya through different bilateral and multilateral channels.

By visiting a range of programmes devised to overcome the challenges of TB control and by speaking to patients, health workers and decision makers, delegates gained a broader understanding of the impact that TB has on the lives of individuals, communities and the country as a whole, as well as the actions that are needed to improve control of the disease. Delegates were also given insight into the increasing challenges presented by co-infection of TB with HIV, as well as the emergence of drug-resistant strains of the disease.

This visit follows a previous RESULTS UK parliamentary delegation to Kenya in 2005. This delegation was attended by John Barrett MP, Andrew George MP, Nick Herbert MP and Julie Morgan MP. On this occasion the delegation visited sites in Nairobi, Nyanza Province and Eldoret and met with representatives from the National TB and Leprosy Programme, DFID Kenya, Kisii District Hospital (Nyanza province), Rachuonyo District Hospital, AMREF Kenya, the Moi Teaching and Referral Hospital, the Kenyan Ministry of Health, and Community Based Organisations.

A similar report was produced following the 2005 delegation. This report noted that some progress was being made, but also identified several barriers to controlling TB in Kenya:

- Lack of money
- Delays in money granted by multilateral organisations reaching the ground
- Prolonged decision-making and complicated bureaucracy caused by centralisation of government and health systems
- Shortage of qualified staff to deliver TB treatment to the whole population
- Inadequate infrastructure and equipment
- Lack of awareness among communities about how to identify TB and how to seek treatment
- TB not being prioritised by the Kenyan Government, Ministry of Health or certain bilateral donors

2010 Delegation findings

1) Diagnosis and Treatment

Treatment

It is clear that progress has been made in the availability of TB and HIV treatments in Kenya since the last RESULTS UK parliamentarians' delegation in 2005. It is particularly encouraging that access to drugs, including antiretroviral treatments (ARTs), seems to have increased significantly. For example, in the Kibera Health Centre run by AMREF there are plentiful supplies of ARTs and TB drugs funded by PEPFAR and the Kenyan Ministry of Health respectively. Improvements have also been made in collaboration between TB and HIV services. The delegation learned that 88% of TB patients are now able to access HIV treatments. The distribution of drugs through KEMSA (Kenya Medical Supplies Agency) has improved, and Kenya was the first sub-Saharan African country to reach the WHO TB target of 85% of people diagnosed with TB accessing treatment.

…too few sites diagnosising HIV and TB are able to also deliver TB and HIV treatments.

Overall, access to and dependable delivery of drugs to the front line has significantly improved over the past five years; though some of this is largely the result of aid agencies setting up entire parallel delivery programmes for some conditions/ programmes, e.g. PEPFAR for the delivery of anti-retroviral treatments. Kenya will soon need to take ownership of the management of these programmes if the health system is to develop in a sustainable manner.

Andrew George MP and Virendra Sharma MP with AMREF employees outside the Kibera Health Centre, Nairobi

Even so, the delegation heard reports that this is not uniformly the case. Despite progress in recent years, integration of TB and HIV treatment services remain inadequate and are typically run in parallel rather than in a combined setting. In addition, too few sites diagnosing HIV and TB are able

to also deliver TB and HIV treatments together. The long term nature of TB and HIV treatments make adherence difficult and this is exacerbated when treatments are administered in different locations. A greater effort should be made to combine TB and HIV diagnosis and treatment facilities.

While access to drugs in the areas visited was readily available, the delegation heard reports that this is not uniformly the case. During one meeting, the delegation was informed that only 37% of HIV patients are accessing ARTs. The access to ARTs appears to be geographically patchy with, for example, a high concentration of resources available in Nyanza province (where the HIV burden is particularly high) but far fewer in other parts of the country.

Diagnosis

Policy makers, experts and practitioners the delegation met with generally agreed that diagnosis of TB, especially MDR-TB, needs to improve. It is particularly concerning that not all HIV clinics screen patients for TB despite a policy that clinics should screen their patients for the disease. The delegation's site visit to the AMREF programme in Homa Bay reinforced the message that there remains a pressing need to integrate testing for TB and HIV.

In addition to better integration of testing, diagnosis facilities themselves need to be improved. The group was informed that in some hospitals the x-ray machines used to diagnose patients date from the 1960s. Limitations in diagnostic capacity also mean that services are unable to pursue intensive TB case finding in urban settings, prisons and military camps where tuberculosis is most prevalent.

Kenyan health services estimate a shortage of 26,000 nurses.

Improving diagnostic capacity and practice is of particular concern regarding MDR-TB. So far surveillance of drug resistance is only happening in one laboratory, although eight laboratories are needed to cover a country with the population size of Kenya. This lack of capacity means there are likely to be many more cases of undiagnosed MDR-TB in Kenya, posing a serious infection risk to the public. These issues are discussed further in the 'Multidrug-Resistant Tuberculosis' section of this report.

Health workers

There is a concerning shortage of healthcare workers in Kenya. Despite having recruited over 4,000 additional nurses in the last financial year, Kenyan health services still estimate a shortage of 26,000 nurses.

The delegation was not able to clarify the reason behind the health worker shortage. Many people the group spoke with criticised the human resource shortage on the 'poaching' of staff by developed countries' health services. Despite high numbers of unemployed health care workers, they argued that the best and most experienced workers were moving to health services abroad. However, criticisms were also levelled at the Kenyan government for not sufficiently prioritising health and not investing a higher percentage of national expenditure on health services. The delegation heard that many trained health workers remain unemployed or are employed outside the health sector. In the Nyanza Province, the group were told that the district hospital only has 50% of the staff it needs.

This staff shortage also includes laboratory technicians needed to diagnose TB and other diseases. The government currently spends 5 – 6% of its budget on health, despite signing up to the Abuja 2001 target of 15% of total government expenditure to be allocated to health.

Diagnosis and treatment recommendations

- Greater effort is needed to ensure HIV screening and treatment services include TB services as standard and vice-versa.
- Access to drugs should be made available on a uniform basis across the country.
- Diagnostic facilities, including laboratories, urgently need to be upgraded and expanded.
- Shortages of health care workers are a major concern. It is unclear whether these are working in the UK, but the perception is that they are. More needs to be done to support Kenya to retain its health workers and to ensure a sufficient budget is available to expand numbers.

2) Multidrug-Resistant Tuberculosis

The increasing number of cases of MDR-TB is a major health concern in Kenya. While numbers are still relatively low at 1.9% (WHO, Global Tuberculosis Control 2009 Report) the number of cases are steadily increasing and many patients are not receiving appropriate treatment. The fragile infrastructure to diagnose, treat and prevent infection of MDR-TB is worrying. Concern over the rise of MDR-TB is exacerbated by the resource implications of treating the disease. While resources to treat existing levels of MDR-TB infection are already stretched, should the number of cases rise further, treatment costs could become prohibitively expensive.

Diagnosis

One area of concern is that some frontline staff seem to be not sufficiently aware of MDR-TB and the protocols for testing and treating MDR-TB. The delegation was informed that any patient who does not respond to first-line TB drugs should be tested for MDR-TB. However, during a field visit near Kisumu in Nyanza Province the group met a patient who had been treated with standard drugs three times, was still displaying symptoms, but was refused an MDR-TB test. The delegation was not able to verify how widespread this problem is, but anecdotal evidence suggested that this example is not an isolated case.

There is only one laboratory available for diagnosis of MDR-TB. Eight laboratories are needed to cover a country the size of Kenya.

Limited human resources and laboratory capacity to diagnose MDR-TB is also a concern. There is only one laboratory available for diagnosis of MDR-TB. Eight laboratories are needed to cover a country the size of Kenya. However, the delegation was pleased to learn that the World Bank is investing $63.66 million in a regional laboratory network which will greatly expand capacity to diagnose MDR-TB across east Africa.

Andrew George MP and Virendra Sharma MP visiting the MDR TB treatment centre at Kenyatta National Hospital

Treatment

The delegation received differing reports from different individuals about the level of treatment available for MDR-TB. These ranged between 75 and 90%, meaning that between 10 and 25% of MDR-TB infections remain untreated. The cost of treating one patient is 2-3 million KSH (around £20,000) and therefore a significant strain on financial resources. This additional cost of treating MDR-TB patients raises the concern that MDR-TB treatments will not be available to those who need them if funding is unable to keep pace with rising rates of multidrug-resistant infections.

Infection control

As discussed earlier, only one laboratory is available for surveillance and diagnosis of drug resistance, rather than the eight laboratories needed to cover the country. It is therefore likely that many cases of MDR-TB go undiagnosed, increasing the exposure to and risk of spreading MDR-TB.

To prevent the spread of infection, MDR-TB patients should typically be treated in isolation units or at home via community based treatment programmes. The number of isolation facilities in Kenya is inadequate at present with only three facilities available in the entire country. At Kenyatta National Hospital the isolation unit is unfinished and infectious patients are treated in tents, travelling to and from appointments by public transport. Clearly this system of treatment poses a risk of infection to the public.

Community-based treatment provides another option for treating MDR-TB patients and minimising the risk of spreading the disease. In Nyanza Province General Hospital, the delegation heard how the Centre for Disease Control and Prevention (CDC) has funded community-based treatment which allows patients to take treatment at home. This is extremely important as it prevents MDR-TB patients from using public transport to reach treatment facilities risking the transmission of MDR-TB to fellow passengers. However, across the country provision of community-based treatment is irregular and limited by the shortage of heath care workers.

Future developments

Most Kenyan decision makers, experts and practitioners the group met with view tackling MDR-TB as a health priority. The recognition of this problem has yielded some progress. The delegation heard that the government aims to increase the number of people accessing treatment and put all of the country's MDR-TB patients on treatment within two months of diagnosis. The success of this, of course, depends on adequate financing and how effectively policies can be implemented by frontline staff treating patients on the ground.

The earlier mentioned World Bank investment in a new East African Laboratory Network, which will greatly expand MDR-TB diagnosis capacity, is also extremely welcome. However, more isolation units and health care workers administering home-based treatment will also be needed to limit the spread of MDR-TB, and greater funding will be needed for treatment once these cases have been successfully diagnosed.

MDR-TB recommendations

- The delegation fears MDR-TB may be on the verge of becoming an epidemic and should be one of Kenya's top priorities over the next 24 months.
- All appropriate diagnostic and treatment facilities should be urgently funded and put in place.
- It is vitally important that access to swift and accurate diagnosis for suspected MDR-TB cases is improved as soon as possible. The World Bank programme to upgrade laboratory capacity across East Africa is therefore very welcome.
- Protocols for the basis on which MDR-TB tests are given need to be more effectively disseminated to frontline clinicians.

3) Sector-Wide Approaches to Health System Support

The Sector-Wide Approach (SWAp) emerged as a means for improving the effectiveness of aid delivery in health and other sectors more than 20 years ago. While there are several technical definitions of SWAps, the World Bank's Operations Policy and Country Services Vice Presidency has described SWAps as "an approach to a locally-owned program for a coherent sector in a comprehensive and coordinated manner, moving toward the use of country systems. SWAps represent a … shift in the focus, relationship and behaviour of donors and governments. They involve high levels of donor and country coordination to achieve program goals, and can be financed through parallel financing, pooled financing, general budget support, or a combination."[1]

Stakeholder opinion

Opinions were divided among stakeholders the delegation met with regarding the effectiveness of implementing SWAps in Kenya. This mostly stems from differing assessments of the reliability of the Kenyan government to effectively manage SWAp support. The general approach of strengthening health system capacity was supported by most with some reservations.

The World Bank in Kenya is enthusiastic about using SWAps as a tool to support health programmes. In spite of previous unsuccessful SWAp programmes, the Bank recently approved $100 million over four years for health system strengthening. The Bank recognised that previous SWAps in the country, particularly around education, had been unsuccessful.

The delegation heard that the World Bank generally felt SWAps were the best approach to ensure long-term development of the health infrastructure of the country. By working through the government in Kenya, SWAps should strengthen the government's systems, financial management and auditing – rather than bypassing government structures.

Other organisations, such as DFID, are more wary, pursuing a SWAp style approach to health but channelling funding through development organisations rather than the central government. This is primarily due to concerns over the ability of the Kenyan government to use the funding effectively. Particular concerns about the Kenyan SWAps emerged following the 2007/2008 post-election violence. These concerns have pushed partners such as DFID away from pursuing SWAps in Kenya for the present time.

The delegation also head wider criticisms of SWAps, particularly in relation to the impact on diseases such as TB. The point was made to the group that a focus on SWAps alone risked resulting in lower profile diseases, such as TB, being neglected. Zambia was cited as an example of this. Having infrastructure and staff already in place before the SWAp is implemented is also an important

[1] Vaillancourt D, Do Health Sector-Wide Approaches Achieve Results: Emerging Evidence and Lessons from Six Countries, IEG Working Paper Series, 2009/4 [accessed online at http://siteresources.worldbank.org/EXTWBASSHEANUTPOP/Resources/wp4.pdf on 23/11/10.]

prerequisite for the success of a SWAp.

Sector-Wide Approaches recommendations

- On balance, the delegation supports bolstering the SWAps approach to address health priorities in Kenya.
- The delegation broadly agrees with the SWAps approach in principle and particularly welcomes greater emphasis on long run health capacity strengthening.
- There is a general need to build up the long-term capacity of the Ministry of Health in Kenya at the same time as reassuring donors and the Kenyan taxpayers in respect of probity and accountability.

4) The Global Fund in Kenya

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a funding mechanism to combat these three major infectious killer diseases. The GFATM sources donations from donor governments and other organisations, such as MNCs and philanthropic foundations, and then disperses these to country programmes which bid for funding. At the country level, grant proposals are submitted by the Country Coordinating Mechanism (CCM) made up of government, civil society and private business representatives. CCMs also oversee implementation once grants have been made. In Kenya, the CCM contains seven government representatives, five CSO representatives, two private sector representatives, three faith-based organisation representatives and three representatives from development partners. The Global Fund accounts for two thirds of all international funding to fight TB.

The delegation has several concerns about the way the Global Fund model operates in Kenya. These issues centre on the CCM, the long-term health capacity created by the Fund's programmes and the lengthy process for dispersing funds. The delegation was informed that 45% of the money given to Kenya has not reached the ground and the GFATM rates Kenya as 110 of 120 in terms of its performance.

Kenyan Country Coordinating Mechanism

The CCM in Kenya has had several well documented concerns raised about it previously. Of specific concern to the delegation is the apparent lack of leadership within the CCM and the lack of coordination of the CCM with the Kenyan Government. Representatives of the current CCM membership acknowledged that there were problems with the way the CCM operates. Recent restructuring, including a halving of the size of the CCM from 30 – 12 members, was due to conclude Oct/Nov 2010. A lack of communication between the CCM and implementing agencies is also a major concern.

Stakeholders told the group that being a member of the CCM involves a large time commitment, meaning that important stakeholders are often reluctant to get involved.

Leadership issues within the CCM cause problems for the way the mechanism functions in Kenya. The CCM model means that there is no Global Fund head office representation in the country. Stakeholders told the group that being a member of the CCM involves a large time commitment, meaning that important stakeholders are often reluctant to get involved. Not having any in-country representation can also make it difficult to resolve disputes – for example, it is often unclear who actually speaks on behalf of the Fund.

The view of the MP delegation was that the natural leadership role within the CCM should lie with the Ministry of Health, which chairs the mechanism. The Ministry of Health should also be best placed to take an overarching view to grant proposals and the monitoring of implementation.

Building government capacity

The delegation also heard the opinion that the GFATM reinforces a dependency of the country on foreign support, and that this support is often unpredictable making planning and development of the country's health services difficult.

Repeat funding often depends on successful results from the initial phase of a programme. This results-linked funding applies huge pressure to deliver tangible results from the first phase meaning that the Global Fund's grants are less likely to be channelled through an often weak government system, but rather through other organisations with an established capacity and track record. This happens not because of corruption but the slow processes associated with government health systems which, almost by definition, lack capacity. This approach will often save more lives in the immediate term (and therefore secure second-phase funding), but not strengthen the long-term health system infrastructure of the country. It can therefore also reduce strategic and long-term thinking within the Ministry of Health.

Dispersal of funds

The operation of the Global Fund in Kenya often results in delays in disbursing funds. Delegates also heard concerns that the barriers to access funds are set too high. Delays in receiving funds can mean that projects fail entirely because resources cannot be used on time. It can also result in the cost of projects increasing significantly as projects drag on.

Virendra Sharma MP visiting the uncompleted isolation ward at Kenyatta National Hospital

One example of this is the badly needed isolation ward in Kenyatta National Hospital. The project has fallen behind schedule and it is uncertain whether funding will be available to complete the work. Initial funding for the project was provided by the GFATM, but underestimates and inflation meant that this proved insufficient to finish the ward. With the project incomplete, costs continued to rise and accessing funding (from the Global Fund and other sources) to finish the project has become increasingly difficult. While these delays persist, MDR-TB patients continue to be treated in tents, travelling on public transport to receive their treatment.

Global Fund achievements

The feedback the group received regarding the GFATM was not unanimously negative. Several stakeholders said that money from the Global Fund was much needed and that if the Fund wasn't available then, for example, the MDR-TB isolation facility in the Kenyatta National Hospital would not even have started construction. Similarly, at the Nyanza Provincial General Hospital many of the drugs used are provided by the GFATM.

Global Fund in Kenya Recommendations

- Global Fund communication and support arrangements in the country, particularly within the Country Coordinating Mechanism, need to be urgently reviewed.
- The process of dispersing funding needs to be reviewed to ensure that funding reaches those it is intended for and projects are completed.

5) The Kenyan Government and Tuberculosis

Health spending

Several stakeholders the delegation met with raised the concern that the Kenyan government is not investing sufficiently in health. The government has committed to spend 15% of the budget on health, but current levels of spending are around 5 – 6%. These concerns were compounded by the notion that Kenya relies too heavily on donor funds, particularly for ART drugs. While the group did not have time to follow up these concerns, it is worth noting that domestic efforts to increase health funding may be needed to complement external efforts.

Structure and coordination of health services

The delegation also heard concerns from stakeholders about the division of the Ministry of Health into a Ministry of Public Health and a Ministry of Health Services. TB policy straddles these two departments. Clearly, this raises issues about the coordination of policy, which can be difficult within one department let alone across two separate ministries.

Kenyan civil society

Kenyan civil society and media appear strong and effective in both articulating health concerns and implementing policies.

Andrew George MP and Virendra Sharma MP visiting the Star of the Lake CBO in Homa Bay

Two of the programmes the delegation visited, both run by AMREF –the post-test club in Kibera and the Star of the Lake CBO in Kisumu – play a critical role in implementation of policy. The Star of the Lake project, which is run by AMREF with DFID and SIDA funding, is starting to move towards self-funding providing long-term self-sufficient community capacity to support health programmes. The

delegation was impressed by this model and recommend greater funding to expand the number and capacity of community-based projects where appropriate.

Kenyan government recommendations

- The government should keep the level of domestic health spending under review with a view to domestic financing of health systems as needed.
- Funding agencies should develop the role of civil society organisations – not only for delivery of projects but also for scrutiny and for ensuring proper accountability.
- Greater and better coordination of all agencies, donor countries and bodies with the support of the Global Fund and the World Bank are needed.

Summary of recommendations

Diagnosis and treatment recommendations

- Greater effort is needed to ensure HIV screening and treatment services also have TB services provided as standard and vice-versa.
- Access to drugs should be made available on a uniform basis across the country.
- Diagnostic facilities, including laboratories, urgently need to be upgraded and expanded.
- More needs to be done to support Kenya to retain its health workers and to ensure a sufficient budget is available to expand numbers.

MDR-TB Recommendations

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Sector-Wide Approaches Recommendations

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For further information about the APPG on Global Tuberculosis please contact the APPG's Secretariat at:

RESULTS UK
2nd Floor, 13 Maddox Street
London
W1S 2QG

Tel: 0207 4998238
Email: mike.smith@results.org.uk