

The Challenges of TB in Africa



**Report of UK Parliamentary Delegation
Rwanda and Kenya
September 2006**

Produced by **RESULTS UK**

Purpose of the Trip

RESULTS UK is a partner in the Advocacy to Control TB Internationally (ACTION) Project. Through the collaborative advocacy activities of partners and experts in donor and high burden countries, the ACTION project aims to generate greater financial support and political commitment to the control of TB worldwide.

The purpose of the delegation to Rwanda and Kenya in September 2006 was to help raise awareness of the severity of the TB and TB/HIV epidemics in these two countries and across the developing world, and to develop TB 'champions' amongst UK policy-makers and civil society. Members of Parliament and grassroots activists were given the opportunity to see the impact of these diseases first-hand by visiting a range of TB and HIV programmes and by speaking with representatives from National Governments, The Global Fund to fight AIDS, TB and Malaria, patients and health workers.

Why Rwanda and Kenya?

Rwanda has the eleventh highest rate of TB in Africa.¹ Rwanda's recovery since the political and social upheaval of the early 1990s has been remarkable. The country is investing heavily in health and education and is regarded as an international success story in its approach to tackling infectious diseases. Despite strong political will and financial support from the Global Fund to Fight AIDS, TB and Malaria, Rwanda is still blighted by TB and HIV.

Kenya has the sixth highest rate of TB in Africa. It also ranks tenth out of the twenty-two countries in the world with the highest TB burden. Less than half of all TB cases are being detected in Kenya, reflecting a continued lack of political and financial investment in tackling the problem. Success is being made in collaborating TB and HIV services across Kenya with increasing numbers of TB patients being offered testing for TB and vice versa.

Delegates



Members of UK delegation (left to right) **Sheila Davie**, National Director, RESULTS UK, **Michael Connarty MP** (Labour, Falkirk East), **Richard Bacon MP** (Conservative, South Norfolk), **Annette Brooke MP** (Liberal Democrat, Mid Dorset and North Poole), **Julie Morgan MP** (Labour, Cardiff North), **Gloria Godfrey**, (RESULTS grassroots advocate, Leamington Spa), **William Ross**, (RESULTS grassroots advocate, Linlithgow), **Helen Davis**, (RESULTS grassroots advocate, Poole). Not in photo: **Louise Holly**, Project Manager, RESULTS UK

¹ Data on TB rates is extracted from the recently released WHO TB Report 2006.

Delegation Report

A narrative account will be given of the delegation's activities and findings in chronological order. Overall conclusions and actions to take forward will be recorded at the end of the report.

DAY ONE: Sunday 3 September

The delegation arrived in Kigali to a warm welcome from the Rwandan Ministry of Health and representatives from the Rwandan Country Co-ordinating Mechanism (CCM) who submit proposals to, and oversee implementation of grants from, the Global Fund to Fight AIDS, TB and Malaria.

A detailed briefing was given to the UK delegation on the scale of Rwanda's TB, HIV/AIDS and malaria epidemics plus the activities and impact of the Global Fund to Fight AIDS, TB and Malaria (Global Fund) across the country.

General information about Rwanda

Ms Caroline Kayonga, Permanent Secretary of the Ministry of Health and Dr Agnes Binagwaho, Director of National AIDS Co-ordinating Committee outlined the Government's role in treating HIV/AIDS, TB and malaria.

To fully appreciate the challenges faced in addressing infectious diseases and other issues, the UK delegation was told that it is important to first understand Rwanda's unique history. More than one million people were killed in the genocide of 1994 including many skilled healthcare personnel. Important infrastructure was damaged and the general population left to manage the unimaginable psycho-social affects of the atrocities.

The population of Rwanda is a young one (67% under 25) with more than 1.25 million orphans. Over half (55%) of people live below the poverty level and average life expectancy is just 49 years.

The Government of Rwanda is focused on providing strong leadership and a clear vision for the eradication of poverty and the fulfilment of Millennium Development Goals in the

country. It plays a critical leadership role in the fight against infectious diseases and is committed to rebuilding a new Rwandan society based on principles of equity and harmonisation. The Government is striving to fully utilise regional mechanisms to fight diseases with bordering countries e.g. the Great Lakes Initiative against HIV/AIDS, recognising that its own success relies heavily on that of its neighbours.



Briefing Meeting (Photo courtesy of Michael Connarty MP)

Global Fund

The Global Fund is currently supporting six projects in Rwanda which have all played an important role in the fight against the three pandemics. They cover HIV prevention, improvement of the care for people living with HIV, the management of opportunistic infections including TB, in addition to malaria control and health system strengthening. [See Appendix 1 for further details.] Around 52% of the budget for HIV, TB and malaria programmes comes from the Global Fund, the World Bank and other external donors. Although most funding is external, we were told that programmes are very much country and community – driven.

As the principle recipient of Global Fund grants, the Ministry of Health sub-grants money to 147 health facilities and clinics across Rwanda. The value of these grants is currently \$173 million (2003-2010). All programmes are results-based and must follow strict rules of transparency.

The Global Fund is heralded as a three-year success story. It has given hope to Rwanda and has been flexible enough to respond to the country's particular needs.

TB in Rwanda

The UK delegation was told that TB control is not separated from other health issues since it affects the same patients and involves the same health workers and infrastructure. TB has already established itself as an opportunistic infection along with HIV in national and regional health policies.

Dr Michel Gasana, the National TB Programme Manager, presented his views on the Rwandan TB control programme:

In spite of high BCG immunisation coverage, Rwanda is still faced with a sizeable TB problem. To address this, the Government has invested a great deal of time and resources into early screening programmes and education initiatives which aim to reduce stigma and promote good health and hygiene.

TB rates are on the increase in Rwanda. It is unclear if this is the result of improved case detection rates. No baseline figure existed in previous years against which to measure progress.

There are currently 161 health facilities that screen and provide treatment for TB nationally. All of these facilities follow the World Health Organization's recommended strategy for controlling TB, known as 'DOTS'. Thanks to support from the Global Fund and Global Drug Facility, there are currently no shortages of quality drugs for TB or Multi-Drug Resistant forms of TB in Rwanda.

The main objectives of the National TB Programme are:

1. To improve TB **case detection rates**. Only 50% of TB cases are currently being detected, falling far short of the international target of 70%.
2. To improve **treatment success rates**. More than 82% of identified cases are being treated

successfully, almost reaching the international target of 85%.

3. To fully integrate **TB and HIV** services. More than one-third of TB patients are HIV-positive. TB services are therefore an excellent entry point for HIV testing and treatment and vice-versa. The number of TB patients taking an HIV test is on the increase: 70% of TB patients now accept HIV tests (June 2006 figures) of which 45% tested positive. Of these, 30% were put on Anti-Retroviral treatment (ARVs) and 40% on co-trimoxazole prophylaxis.

4. To manage **multi-drug resistant TB** (MDR-TB). The National TB Programme aims to detect all cases of TB as early as possible and to treat effectively in order to prevent further cases of drug resistance. It is estimated that around 4% of TB cases are MDR-TB. Fifty-eight cases of MDR-TB have been detected in the past 12 months. With the support of the Global Fund, many of these patients have been transferred to a special ward in Butare where they remain in isolation until they are no longer infectious.

Main Challenges for the Rwandan TB Programme

The two main challenges faced by the National TB Control Programme are to: a) **increase case detection** rates through community involvement, increased screening for TB among HIV patients and improved paediatric detection; b) improve **management of MDR-TB** cases through reducing treatment costs and providing better nutritional and social support for patients to minimise side effects and increase treatment success rates.

HIV/AIDS and Malaria

The Government of Rwanda is quietly confident that the rate of HIV/AIDS is now on the decline. The problem of malaria however, is still great and will not be reduced until environmental causes are addressed. Please refer to Appendix 2 for further details of presentations given on HIV/AIDS and malaria.

The relationship between HIV/AIDS and other diseases including TB and malaria was widely

acknowledged. The Government of Rwanda is regarded as a role model for successful harmonisation and integration of programmes across the health sector and development sectors in general.

DAY TWO: Monday 4 September

Treatment and Research AIDS Centre, Kigali

The delegation's first site visit was the Treatment and Research AIDS Centre (TRAC) clinic in central Kigali. TRAC, which is located within the Ministry of Health, was created to conduct national HIV/AIDS surveillance and provide technical assistance to the public and private sectors in the prevention, testing and clinical treatment of HIV/AIDS in Rwanda. In addition, TRAC is responsible for national planning, policy development, training and curriculum development for clinical programmes. In undertaking all of its activities, TRAC applies state-of-the-art information technology and new approaches to HIV/AIDS planning, treatment, technical assistance and research.

This clinic provides ARV treatment for 2,161 patients of which 51% are women and 14% are children. The clinic strives to get all patients who need them on ARVs within two weeks of diagnosis. It also provides HIV testing and counselling as well as a range of educational services including nutritional support for children and HIV education for teachers.

A major challenge, faced by many clinics, is the growing number of patients seeking testing and treatment for HIV and TB. Staff at many clinics across Africa already struggle to deal with the number of people requiring care, and health workers at TRAC told the delegation that they feared what impact this disproportionate staff/patient ratio will have on the sustainability of ARV delivery in the future.



Patients waiting for treatment at TRAC Clinic (Annette Brooke MP)

The realities of this problem were evident to the delegation who witnessed more than one hundred people waiting at the clinic for outpatient services. Some were waiting for ARV treatment, some for HIV tests and others waiting to see a doctor. Patients often travel a great distance to the clinic and can wait for many hours before being seen.

TB and HIV services are well integrated at TRAC. There are 5-6 standard questions that patients are all asked to try and help staff detect TB. If patients have one or more symptoms they are then tested for TB. Fortunately, the clinic is very close to a TB laboratory and referral hospital meaning that patients can receive treatment for both TB and HIV together.

Centre Hospitalier Universitaire de Kigali (CHUK)

The second visit of the day was to the Centre Hospitalier Universitaire de Kigali (CHUK), a referral hospital offering inpatient treatment for TB and HIV. The hospital, which served 12,628 inpatients and 95,323 outpatients in 2005, is supported by the Global Fund. There are currently 800 people on ARV drugs and the Global Fund has also enabled the purchase of TB and malaria drugs plus nutritional supplements for HIV patients. Global Fund grants have also paid for staff and their training as well as vehicles for home visits and laboratory equipment.

The delegation visited the inpatient ward of the hospital where patients are treated for a range of conditions. Although patients with MDR-TB are treated in a separate isolation ward, patients with TB and other infectious diseases were often found sharing a ward or a bed with other ill patients. As a result of high numbers of staff contracting infections in the past, all staff (and the delegation) are now recommended to wear masks when entering the ward.



Richard Bacon, Annette Brooke, Julie Morgan and Michael Connarty with hospital staff (Sheila Davie)

National Reference Laboratory

The delegation then visited the Kigali National Reference Laboratory which performs more than 500 HIV, CD4 and blood tests per day for people all across Rwanda. A separate TB and malaria laboratory funded by the Global Fund now provides the modern and sophisticated equipment needed to test for TB and drug resistance.



Testing for TB (Sheila Davie)

Kacyiru Health Centre

In the afternoon, the delegation was invited to visit a local health centre in Kacyiru on the outskirts of Kigali.

Dr Claude, head of the clinic, explained that all members of the community – which in this area happened to include the local police force – are involved in the management of the facility in order to ensure local ownership. A tour was given of the small inpatient ward which on that day only accommodated one patient. Like at CHUK, when greater numbers of patients are in need of treatment, the ward can become extremely overcrowded and the risk of cross-infection between patients is great.

The delegation also visited the clinic's small laboratory which carries out testing for TB, malaria, HIV and other conditions. Equipment here was found to be extremely basic in contrast to that seen at the National Reference Laboratory.

Other facilities available at Kacyiru include a voluntary counselling and testing (VCT) clinic, a pre- and antenatal clinic and a range of facilities for people living with HIV/AIDS. After local people have registered for VCT and met certain other conditions such as encouraging other members of their family to also receive VCT then they are eligible to join a support group and become involved in an income-generation scheme. The delegation had the opportunity to meet a number of women involved in this scheme who help to support their families through the production and sale of woven and beaded goods.



Members of Income Generation Scheme (Gloria Godfrey)

Shyorongi Health Centre

Shyorongi health centre is a rural clinic outside Kigali which is run by Sister Josepha Uwumuremyi and supported with money from the Global Fund. The centre serves 10,000 people a year with around 30 people a day receiving VCT and 15-20 additional people walking in each day for consultations on a range of other conditions.

This rural centre lies at the top of one of the many hills in Rwanda – an additional obstacle when sick and having to walk many miles to a clinic for treatment.



View from Shrorongi Health Centre, Patients walk in from as far as the eye can see (Sheila Davie)

The delegation were introduced to a group of people who had all come together to watch an educational video about health as part of a group counselling session which takes place before individual testing and counselling.

HIV counselling is available for anyone over the age of eight. The delegation was shown personal records of one HIV-positive child and was informed that each child must have a personal 'tuteur' or carer to support them through their treatment. As in Kacyiru, family members of a person with HIV are also strongly encouraged to be tested. The centre provides a range of additional activities to support people living with HIV including a well attended nutritional programme led by Sister Cecile Uwizeyemaliya in the centre's vegetable garden. The Clinic has also been treating TB for many years and currently treats six TB patients at the clinic. Staff were confident that there are many more undetected TB patients in the vicinity of the Clinic that need treatment

and recognised that there were still many obstacles that need to be overcome to deliver TB treatment to all that need it.



Community Health Workers at Shyorongi (Helen Davis)

Community Health Workers

One proven method of increasing TB detection rates in countries like Rwanda is to enrol members of the community to go out and search for people displaying symptoms. At Shyorongi, the delegation met three community health workers who play an extremely important role in outreaching to the local population and encouraging people and their families to use the clinic.

Around 16,000 community health workers are currently working for the Ministry of Health in Rwanda. For the most part, they are volunteers and well respected members of the community, elected into the position. They are not paid but can be offered incentives like radios and bicycles. The main aim of community health workers is to build links between local communities and health facilities, educating peers on health related issues and encouraging them to seek testing and treatment where necessary.

In countries across Africa, community health workers also have a role to play in supporting the delivery of treatment for illnesses such as TB, particularly for patients who are unable to travel to clinics. Where limited finances hinder the recruitment and training of nurses and doctors, community health workers can increasingly help to manage growing demand.

The second day of the delegation ended with a reception at the residence of the British Ambassador to Rwanda, Jeremy Macadie, where the delegates had the opportunity to network with representatives from the Department for International Development, EU, UN, World Bank and International Monetary Fund. Also in attendance were representatives from the Governments of the United States, Germany and The Netherlands. International NGOs working in Rwanda including Care International and VSO were also present.

DAY THREE – Tuesday 5 September (Rwanda)

Gisozi Genocide Memorial, Kigali

The delegation was invited to visit the Gisozi Genocide Memorial Centre in Kigali to learn more about the events that so heavily affect all aspects of Rwandan society. The delegation was privileged to be accompanied by Dr. Innocent Nyarahirira, the Minister in charge of HIV and other epidemics, as they toured the museum and laid a wreath on the site of an unmarked grave. The graves consist of concrete crypts three metres deep, each filled from floor to ceiling with coffins. The coffins rarely contain the remains of an individual victim, and can contain the remains of up to 50 victims. The whole site is the burial place for 250,000 victims of the genocide.

Meeting at the Rwandan Parliament

Before leaving Rwanda, the UK delegation was invited to meet with members of the Rwandan Parliament's Social Affairs Committee. Four of the six deputies that make up the Committee – including the Chair Hon. Hamidou Omar MP and Vice Chair Hon. Dr. Ezechias Rwabuhiri MP – were present. Dr Agnes Bingawaho from the National Aids Coordination Committee and Dr. Thomas from the Global Fund CCM also attended the meeting.

The Department of Social Affairs grew out of the atrocities of the 1994 genocide; it is made up of 6 deputies from 3 different political parties. The department is strongly driven by principle of national unity which is extremely important in shaping the future of their country.

Hamidou Omar and Ezechias Rwabuhiri informed the UK delegation that one third of their budget is spent on health and education and acknowledged the British Government for being one of the largest contributors. Extreme poverty in Rwanda means that the Government is constantly forced to make hard choices in terms of what their priorities are and how their budget is spent. Further information was given on the structure of the Rwandan Parliament and can be found in Appendix 3.



Delegation with Members of Rwandan Parliament (Michael Connarty MP)

On the subject of TB and HIV control, the Committee members said that they believe that Rwanda is on the right path. They acknowledge that HIV has taken over as the primary health issue, but now there is a concerted effort to tackle and coordinate the treatment of the three major pandemics. This integration will help increase the detection of TB and the implementation of DOTS TB programmes across the country.

Agnes Binagwaho commented that it is not part of Rwandan culture to share or talk about problems or health issues. There is a real need to fight 'auto-stigma' among people living with HIV/AIDS to feel like strong and valuable members of the community. This stigma still prevents many people from coming forward for HIV testing. On the positive side, it was acknowledged that there is much less stigma over HIV in Rwanda than in many other African countries and no real stigma is attached to TB.

Michael Connarty asked the committee how prevention of TB transmission is dealt with in Rwanda. Dr Agnes Binagwaho reinforced the importance of education in preventing the spread of TB. She said that coughing is a very common symptom of poverty so people don't necessarily think that it could be related to TB. Community workers are appointed to educate people to isolate themselves until they are no longer infectious. Education on TB is also part of HIV counselling. The Ministry of Health is working hard to improve general awareness about TB and thus improve case detection and treatment success rates. Messaging through schools and billboards is already common and national TB day events take place each year. A special media campaign through weekly TV and radio programmes on TB is currently being planned.

At the close of the meeting Dr. Ezechias Rwabuhiri MP asked the delegation how they saw the future of the Global Fund. Julie Morgan replied on behalf of the UK delegation and stated that they *"were fully supportive and would go back and advocate for the Global Fund"* on their return to the UK.

DAY THREE – Tuesday 5 September (Kenya)

Having arrived in Nairobi, the UK delegation invited Dr. Jeremiah Chakaya, adviser to, and formally head of, the Kenyan National TB Control Programme to deliver a presentation on TB in Kenya.

Overview of the TB Problem in Kenya

Before 1990, there were less than 10,000 cases of TB in Kenya per annum. Kenya then saw a sharp increase in TB rates and by 2005 the number of cases had risen 10-fold to over 100,000. **It is now estimated that up to 500 people die from TB each day in Kenya.** The current case detection rate in Kenya is slightly below 50% meaning that more than half of TB patients are not being detected and therefore probably infecting many others. Like Rwanda, Kenya is therefore falling far short of the global case detection target of 70%. The treatment success target of 85% is only narrowly being missed at around 82%.

TB affects the most productive age group, with serious consequences for the Kenyan economy. Dr. Chakaya noted that although HIV rates are much higher among women in Kenya, TB affects notably more males than females. One possible explanation for this could be that Kenyan men are more commonly engaged in social activities, e.g. visiting bars that would make them more susceptible to TB infection.

For many years the Kenyan National Leprosy and TB Programme (NLTP) had insufficient information on **TB/HIV**. Revised TB case recording tools with TB/HIV indicators were introduced in July 2005 and now records show that around 60% of TB patients are being tested for HIV. 56% of those TB patients tested for HIV have been found to be positive and one-third of those with HIV have been put on anti-retroviral treatment.

Dr. Chakaya reaffirmed the close relationship between TB and **poverty**. Even if HIV was eradicated in Kenya, he argued, TB would continue to impact upon the population for as long as poverty remains endemic. TB, HIV and poverty must all be addressed together.



The delegation discuss the health worker crisis with Kenyan health workers (Louise Holly)

Whilst the Kenyan Government has been trying to improve general health systems by abolishing user fees for example, efforts to keep wage bills – and inflation – to a minimum is resulting in a large proportion of diagnostic facilities closing down due to insufficient technicians to carry out testing for TB and other diseases. Although the International

Monetary Fund (IMF) no longer imposes strict rules on the Kenyan Government to limit the number of health care workers past policies and perceptions of 'best practice' are deeply engrained.

The Ministry of Health calculates that there is a deficit of 19,000 **health workers** in Kenya (2003). To help fill this shortfall, increasing numbers of community health workers are being engaged and trained to identify patients, collect sputum samples and help patients complete their course of TB treatment. However, the potential of successful community-based programmes such as those being rolled out in Kisumu District (Western Kenya) is being seriously compromised by a lack of trained laboratory staff to test the sputum samples being collected.

Main Challenges for the Kenyan TB Programme

In order to dramatically increase case detection rates, the following challenges need to be overcome:

- a) Insufficient laboratory capacity to diagnose TB;
- b) Shortage of technical assistance to scale up detection and treatment at local level;
- c) An estimated annual funding gap of over \$25million;
- d) Lack of political will at National Government level to increase public awareness about TB or to make fighting TB a priority.

DAY FOUR – Wednesday 6 September

Meeting at Office of the Provincial Medical Officer

The delegation was invited to meet with Dr. Sam Macharia, the Provincial Medical Officer (PMO) for the Nairobi Province.

Dr. Macharia explained that three million people live in Nairobi Province – comprising roughly 10% of the Kenyan population but carrying 20% of the country's TB burden. The Province also has the second highest HIV burden after Kisumu with more than half of TB patients also being co-infected with HIV.

The population of Nairobi, like many large cities, is transient and diverse. The fluctuating, urban population presents additional challenges for early case detection and treatment completion. Extreme poverty and overcrowding is a catalyst for the spread of TB. Dr. Macharia informed the delegation that the Kenyan Health Authorities are extremely worried about the growing prevalence of **MDR-TB**, fearing that drug resistant strains would be transmitted as easily throughout the province with devastating effects.

Karasani Clinic

The Karasani Clinic in Eastern Nairobi has seven small treatment rooms in which it cares for around 200 patients a day. The clinic also holds daily educational talks on health issues including TB and HIV/AIDS. TB and HIV services are being fully integrated with all TB patients being offered HIV testing and counselling and vice versa.

The delegation had the opportunity to meet one patient, a student, who had attended the clinic to receive TB treatment. Every TB patient has their own complete supply of TB drugs – provided by the Global Drug Facility – which are stored by the clinic. Staff at the clinic explained that the clinic does not have enough room to store the drugs on the premises and that much time and effort is wasted in travelling between the store room and dispensary where patients are observed taking their treatment.

St. Francis' Dispensary

The Order of the Little Sisters of St. Francis allowed the delegation to tour its facilities which were built to provide medical care to the poorest and most vulnerable of Nairobi's inhabitants, particularly those on less than \$2 a day. The dispensary is currently being expanded to become a fully functional hospital and is looking for further funding for additional infrastructure, equipment and staff. Like in many health facilities across Kenya, all TB patients at St. Francis are encouraged to take an HIV test and are provided with constant counselling to ensure that they understand their condition, the type of treatment they have been prescribed and the importance of adhering to their treatment regime.

Because defaulting rates in Nairobi are so high, patients at St. Francis are encouraged to find a treatment sponsor who can support them and collect drugs if the patient is too sick to come to the clinic themselves. Staff said that they still lose many TB patients who, when they become very ill (largely as a result of TB/HIV co-infection), return to their rural homes to die without informing the clinic. It costs less to transport a living person than a corpse, the delegation was told.



Annette Brooke & Michael Connarty with Sisters from St. Francis (Julie Morgan MP)

The Arrival of MDR-TB

St. Francis had 147 TB patients on its records when the delegation visited. Earlier that week, their first suspected case of multi-drug resistant (MDR) TB had also been discovered. After months of treatment, the patient was still not getting better and sputum samples were coming back positive. Staff at St. Francis were extremely concerned for the patient because they have no supplies of second-line drugs at the clinic and they are too expensive to purchase (drugs for one patient cost approximately £2,000.) Applications for MDR-TB drugs can be made by the NLTP through the Green Light Committee (which provides highly subsidised, good quality MDR-TB drugs) but the process is very slow and would probably be completed too late for their patient.

Kahawa Health Facility

On the edge of Soweto slum in Eastern Nairobi, the Kahawa Health Facility run by Sister Rosa of St. Joseph's serves 80-90 of Nairobi's poorest residents every day. The small facility had 181 HIV-positive and 32 TB patients registered and receiving treatment. Sister Rosa remarked that the facility's biggest challenge is being able to provide patients with food along with their medication. In addition to being necessary for overall health and well-being, nutritious food is needed to reduce side effects caused by the drugs that patients receive for conditions such as TB. In order to obtain food, Sister Rosa and her staff sometimes go to the airport and beg for food to take back to the facility.

The only income generated by the facility comes from the dispensary. Payment is equivalent to just 25p per person and this is often waived if a patient is too poor to pay the fee. This low income often leaves the facility with insufficient funds to pay staff wages. Sister Rosa depends on the generous nature of her staff who may work for months without pay. Construction of the facility was started in 1997 with funding from a Spanish organisation but to date only the lower floor of the building has been completed. Kahawa Health Facility aspires to provide a 'Complete Care Service' which would enable them to provide ARVs and a reliable supply of food for patients. At present, there is no money available for such scaling-up.

At Kahawa, the delegation had the privilege of being able to visit the homes of a few of the individuals who are benefiting from the TB services provided by the facility.

Case study: Grace

Grace is 32 years old with two sons (aged 15 and 18). She has been left extremely weakened by both TB and HIV and is dependent on her aunt for care since her mother died last year. With the support of her aunt, Grace will continue her course of TB drugs and multivitamins for another six months. This is her second time on TB treatment, having previously defaulted before finishing her full course of drugs. Grace discovered that she was HIV-positive in April but thinks that

she could have been carrying the infection for many years. She is on course to start ARV treatment in a few weeks time and is expected to regain her strength again very quickly, which was difficult to imagine given her current, frail state. At present, Grace is far too weak to travel down the road to the Kahawa health facility, but in order to register for ARV treatment it is necessary for her to go there in person. Her family will therefore have to hire a bicycle to transport her.



Julie Morgan with Grace and her aunt (Julie Morgan MP)

Case study: Nancy

Nancy is 31 years old and lives with her husband and two sons. Nancy is HIV positive as is her three year old son Njoroge. She is currently on ARV treatment but since Kahawa Health Facility does not yet have ARVs Nancy has to walk two kilometres in order to catch a bus to the nearest ARV clinic. The bus costs 40 Kenyan Shillings (30p) – half of her family’s average daily income. Nancy has recently come out of hospital in Nairobi where she had to have an emergency operation to remove an abdominal obstruction. She was awaiting test results that might confirm whether it was cancer or extra-pulmonary TB.

Nancy has incurred a considerable bill of 3,000 Shillings (£22) for her one month’s stay in hospital which she cannot pay as she still too ill to work. Initially, the hospital would not discharge her until staff at Kahawa came forward and offered to pay 200 Shillings of her bill.



Nancy and her son (Annette Brooke MP)

Nancy is incredibly worried about how to pay off her bill plus the additional travel costs needed for her to collect ARVs for herself and Njoroge. The local health official who accompanied the delegates to Nancy’s house is trying to arrange for her hospital fees to be waived.

Cost Barriers TB drugs and basic sputum testing are provided free of charge in Kenya. The cost of more complex diagnostic services such as x-rays and transportation to and from hospital are however, a major barrier to individuals living on or below the poverty line. Clinics such as those visited by the delegation try to subsidise their patients where possible but themselves have very limited resources.

The financial burden of TB is experienced by both the patients who have the disease and the clinics that provide treatment. Although drugs may be free, facilities offering TB testing and treatment receive no government subsidies to support the salaries or training of the personnel who deliver the TB drugs or carry out sputum testing. All of the facilities visited in Kenya relied heavily on staff who are willing to work without knowing if or when they will get paid. Sister Clare from St. Francis’ commented: ***“When donors give drugs, they should also think about who is going to deliver them and provide additional support for the health workers.”***

DAY FIVE – Thursday 7 September

Briefing at AMREF Kenya Country Office

The delegation met with Mette Kjaer, Country Director for AMREF Kenya, who gave an overview of AMREF's work in Kenya and across Africa.

AMREF (African Medical and Research Foundation) currently operates over 40 projects in several African countries including Kenya, Tanzania, Uganda, South Africa, Ethiopia, Southern Sudan and Somalia. Training programmes are also provided across the continent. AMREF's key objectives are to facilitate health services for vulnerable groups and to bridge the gap between communities and the delivery of health care. This is achieved through working closely with other organisations to implement health-related programmes that will empower communities and give them a sense of ownership.

AMREF has two successful projects in Kenya and they are hopeful that the model used in delivering healthcare in an informal settlement in urban Nairobi can be replicated in rural communities.

Kibera Community Based Health Care Project

Following the briefing at the AMREF Kenya office, a visit was arranged to a Community Based Health Care Project in Kibera, one of the largest 'slums' in sub-Saharan Africa with an estimated population of between 850,000 and one million.

Despite being an enormous population centre, the informal settlement in Kibera receives no formal municipal services such as water, sanitation or health care services. As in other slum areas, extreme poverty is widespread in Kibera exacerbating the impact of poverty-related diseases such as TB. Most residents are employed in the informal sector or in low paid jobs in the city.

The AMREF Community Based Health care project (CBHC) project was started in 1998. The project aims to improve the health status of the population of Kibera Laini Saba's 50,000 residents through a community based Primary

Health Care (PHC) project functioning from a clinic in Laini Saba. The general strategy is one of promoting community participation and ownership in partnership with the Ministry of Health, which will eventually take over long-term support of the project in 2008/9.



Richard Bacon with AMREF staff in Kibera (Sheila Davie)

The Kibera Community Health Centre provides free ARVs and TB treatment. AMREF have been working with partners to dispel the myth that ARVs can only be delivered by doctors. The clinic has successfully trained clinical officers and community workers to deliver ARV treatment, a model which AMREF hopes to roll out across Africa.

The Kibera TB programme, which is being implemented in collaboration with Malteser Germany, aims to support the National Tuberculosis programme of Kenya to enhance accessibility and improve case findings and treatment of tuberculosis in the urban slum. At the time of visit, the clinic was treating 326 TB patients.

In contrast to clinics visited the previous day, the Kibera clinic receives support in the form of health workers seconded from the Ministry of Health. Many of the staff placed in Kibera however, see the move as a form of punishment and thus morale and motivation is low. The delegation was informed that the Ministry of Health – with the support of DFID – had recently completed a mapping exercise of Kenya to identify where staff are most needed.

Press Briefing and Roundtable Meeting

Dr Festus Ilako, AMREF's Head of Programmes in Kenya and Sheila Davie, National Director, RESULTS UK joined UK MPs Richard Bacon, Annette Brooke, Michael Connarty and Julie Morgan in a briefing for the Kenyan press.

Dr Ilako highlighted the scale of the TB and TB/HIV epidemics in Kenya and talked about the work that AMREF is doing in Kibera to tackle the diseases. The four British MPs shared their reflections of the trip and called for an emergency response to the TB crisis in Kenya and across Africa.

The press briefing resulted in considerable national press and radio coverage. See appendix four for further details.

Following the press briefing a roundtable meeting, organised by RESULTS with considerable support from the Kenya AIDS NGOs Consortium (KANCO), was held to discuss the challenges of addressing the TB and TB/HIV epidemics in Kenya.



Roundtable meeting on the challenges of TB in Kenya (Louise Holly)

The meeting was attended by representatives from a broad range of organisations including the NLTP, WHO, DFID and NGOs working on TB control in Kenya. Members of the Kenyan Parliament were invited to attend the meeting but unfortunately none were able to do so. Discussion was focused on the level of progress made in tackling tuberculosis in Kenya one year on from the declaration of a

TB emergency in Africa and the main barriers that must still be overcome.

Dr Joseph Sitienei, the National TB Programme Manager, reiterated the reliance of the Programme on the support of external donors. He stressed that the supply of TB drugs is particularly vulnerable.

The NLTP is in the process of evaluating its human resource needs on a facility by facility basis but is already aware of a particular shortage of laboratory technicians. The delegation was told that Kenya does in fact have sufficient trained staff but there is not enough money to pay their salaries. The representative from Merlin added that some facilities also have insufficient diagnostic equipment.

The UK Department for International Development (DFID) is undertaking a human resource mapping exercise which will include an evaluation of the balance of personnel currently working within the Ministry of Health compared with those working on the ground. Dr Chakaya noted that it is important to assess the needs of facilities on an individual basis rather than assuming that each needs the same number or type of personnel.

When the discussion turned to the declaration of a **TB Emergency in Africa** in August 2005, Alan Ragi from KANCO remarked that no one in Kenya really knows that TB has been declared an emergency.

The representative from WHO Kenya explained to the UK delegates that the continent-wide declaration of an emergency was made following a 10 year increase in the number of new TB cases and stagnation of treatment success rates. He agreed that policymakers and the public need to be convinced that TB is indeed an emergency in Kenya.

Even the provision of free TB treatment and sputum testing is not bringing more people into the national TB programme. Further action is needed to scale up community level support for TB control and to encourage politicians and the media to "talk TB".

With regards to **political will** in Kenya, nothing is being done to deliberately push TB off the agenda, but little is being done to prioritise it either. In the 12 months since TB was declared an emergency in Africa, there has been little movement politically. The NTLP has already drafted an emergency action plan to respond to the declaration but it cannot be implemented until the President of Kenya publicly declares TB a national emergency. It was suggested by participants of the roundtable that the move is being delayed because HIV/AIDS has not yet even been declared a national emergency and because such declarations demand a financial commitment from the Kenyan Government. Festus Ilako from AMREF suggested that the President should address and respond to the joint TB and HIV emergencies together.

Simon Bland, Head of DFID Kenya, acknowledged that his department have not been prioritising TB within their health portfolio or investing enough in TB. He commented that looking at numbers alone; TB doesn't appear to be as much of an issue as HIV or malaria. He therefore asked how the problem of TB should be messaged to get it higher on the political agenda, particularly in the run up to the next set of elections.

It was suggested that the scale of the problem needs to be reasserted – if 500 people were to die each day in bus crashes, the Government would not accept it.

At the close of the meeting, Dr Chakaya said that he hoped that the UK MPs would all go on to become TB advocates and ensure that the UK continues to play a key role in global TB control, especially by increasing their support for the Global Fund to Fight AIDS, TB and Malaria and the Global Drug Facility.

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On the final day of the delegation, some members of the delegation visited the Jamii Bora Trust – a microfinance institution based in Nairobi. A separate report of this visit is available.



Delegates with staff and clients of the Jamii Bora Trust (Helen Davis)

Summary and Next Steps

The continent of Africa has been widely recognised as the battleground upon which the battle against TB will be won or lost. Fuelled by the HIV/AIDS epidemic, TB rates in sub-Saharan Africa are increasing by approximately 4% per year – enough to increase the global TB rate by 1% per year and potentially prevent the Millennium Development Goal target to “halt and reverse the incidence of” TB by 2015 being met.

Both Rwanda and Kenya are close to reaching the Stop TB Partnership’s international target for treatment success rates (85%) but both countries report that they are only detecting about half of their estimated TB cases thus falling short of the 70% target.

The UK delegation’s visit to Kenya and Rwanda demonstrated that whilst being very different in terms of their geography, history and government, etc, both countries share a similar set of challenges in their fight against TB and TB/HIV co-infection.

The main barriers to scaling up effective TB control in Rwanda and Kenya were found to be:

- **Lack of resources** – both National TB programmes expressed an urgent need for additional investment in TB control at national and local levels. Both programmes have funding gaps that could be filled by increased financing through both governmental and non-governmental channels.
- Greater investment in **advocacy**, communication and social mobilisation is also needed – particularly in Kenya – to increase active case finding and therefore case detection rates.
- In addition to money, more well-trained **human resources** are needed on the ground to diagnose TB, prescribe drugs and to support patients through their treatment.
- In Kenya, the delegation heard that there was a lack of **political will** from the Government to declare TB a national emergency and to respond accordingly.
- A further scaling up of **TB/HIV** collaborative activities is needed across Africa. Given the

high rates of co-infection in both countries, TB and HIV programmes need to work more closely together to identify and treat more patients for both diseases.

- The threat of **MDR-TB** and now **XDR-TB** is growing in both Rwanda and Kenya. Technical support and additional resources for complex diagnosis and expensive second-line drugs are needed to improve management of existing cases.

Next steps for the UK delegation

- To use information and experience gained from the delegation to raise the profile of the TB emergency in Africa in Parliament, DFID, the media and our communities.
- To advocate for the UK and other donors to increase investment in TB control through bilateral and multilateral channels.
- To help support the Global Fund to Fight AIDS, TB and Malaria by highlighting the positive impact it is having in Rwanda and exploring ways to help ensure the Fund is a success in Kenya.
- To encourage the WHO and African Governments to develop a roadmap for an international response to the declaration of a TB Emergency in Africa and to support African countries in developing and financing national emergency action plans.
- To maintain communication with the National TB Programmes in Rwanda and Kenya as well as other organisations and individuals that supported the delegation in order to identify further roles that UK Parliamentary or grassroots delegates can play in supporting their efforts to control TB.
- To support the work of the newly established All-Party Parliamentary Group (APPG) on Global TB, a cross-party group of MPs and Peers which is committed to making global TB control a political priority for the UK Government. The APPG is chaired by Julie Morgan and MPs Andrew George and Nick Herbert. Richard Bacon, Annette Brooke and Michael Connarty are also now members of the APPG.

Appendices

Appendix 1 – The Global Fund in Rwanda

Six projects are being currently funded by the Global Fund in Rwanda:

1. **Integrated VCT Project (Round 1)** – to improve access to voluntary counselling and testing (VCT) services, improve access to prevention of mother to child HIV transmission (PMTCT) services and proper care for opportunistic and sexually transmitted infections as well as TB control.
2. **Decentralisation of care for people living with HIV/AIDS (Round 3)** – to increase access to quality care and access to ARV treatment, by a decentralisation of their prescription, distribution and patient follow up.
3. **Controlling malaria in Rwanda (Round 3)** – aimed to reduce by 25% the morbidity and mortality attributed to malaria in the three years of the project, particularly among pregnant women and children under 5 years.
4. **Strengthening tuberculosis control in Rwanda (Round 4)** – to support efforts to achieve MDG targets on TB with a focus on increasing case detection rates to 70% and treatment success rates to 85% by 2009. Includes specific case detection targets for women.
5. **Strengthening malaria control in Rwanda (Round 5)** – to build upon the round three grant by increasing availability of Artemisinin Based Combination therapy (ACT) and increasing the availability and utilisation of insecticide treated nets for children under 5, pregnant women and people living with HIV/AIDS.
6. **Assuring access to quality care (Round 5)** – strengthening health systems so to improve the quality of care and to improve financial access to health care for the poor and vulnerable groups.

Appendix 2 – HIV/AIDS and Malaria in Rwanda

HIV/AIDS

Rwanda's first Global Fund grant in Round 1 was for an integrated voluntary counselling and testing (VCTI) project. This project exceeded its targets. Average HIV prevalence in Rwanda is now 3% (3.6%=women and 2.8%=men). Almost half of all people living with HIV are found in the capital, Kigali where average prevalence is around 5%. Today there are 26,000 people on ARV treatment. There are 94 centres across Rwanda that deliver ARVs in both urban and rural settings. There are now just two parts of Rwanda not served by a centre, due to lack of infrastructure. There are also around 400 testing centres in Rwanda of which half also test for TB.

Responsibility for effectively funding the HIV programmes is kept at local (decentralised) level. The delegation was told that this helps to make local government more responsible and transparent.

Malaria

Representatives of the National Malaria Programme informed the delegation that they are working to achieve three primary objectives:

1. To reduce fatalities due to malaria by 50%.
2. To ensure that at least 60% of pregnant women and all children under 5 years old sleep under insecticide-treated bed nets.
3. To address all outbreaks of malaria within two weeks.

The Programme noted a recent success in advocating changes to national policy which now recommends the use of combined therapies to treat malaria rather than monotherapies that can lead to drug resistance. Furthermore, it was announced that later that same week, 1.4 million long lasting bednets were to be distributed across Rwanda alongside a national measles vaccination campaign, adding to the 750,000 nets already distributed.

It remains a challenge for the National Malaria Programme to sustain a focus on preventing malaria among pregnant women and under-5s whilst also recognising the need to protect other vulnerable groups. The Programme acknowledged that the problem of malaria will not be reduced until the environmental causes are addressed. Significant investment is needed to scale up interventions that break the cycle of malaria transmission, particularly the development of hormone treatment which kills mosquito larvae when sprayed on stagnant water. Weather stations are also needed to predict malaria outbreaks.

Appendix 3 – the Rwandan Parliament

Further information about the structure of the Rwandan Parliament was shared with the delegation:

Following the UN brokered ceasefire a constitution was adopted by the Parliament, following a referendum. The main objective was to fight the genocide and govern through the principle of power sharing. The constitution now states that there must be a balance in Parliament comprising the different ethnic groups and gender. With regard to gender, there must be at least 30% of women in key decision making roles. The current Parliament has 48% of women, making it one of the most representative Parliaments in Africa.

The Rwandan Parliament is a bicarmel (2 chambers), with 26 senators and 80 Deputies (from the 8 political parties). The Deputies are elected from a national list and not geographical constituencies like the UK. There are 2 deputies representing youth and 24 representing women (all elected by other women and representing all regions of Rwanda). The Parliament operates 11 committees comprising: political, budget/economy, agriculture, social affairs, foreign affairs, human rights, unity and reconciliation, gender, petitions, education and scientific research, security. A number of different networks exist, made up of both Senators and Deputies, which include population and reproductive health (which includes HIV); the Women's network is considered to be the most powerful network.

There are different mechanisms in place to measure the effectiveness of the Government, and Parliament can call upon Ministers to give evidence. There is an office of the General Auditor set up in 1998 which reports to the Parliament. The auditor's report is extremely detailed, describing exactly how the money has been spent and how that compares with the original budget. This does however, lead to a heavy burden on reporting and providing documentation for all initiatives.

The Government of Rwanda reports back to its external donors regularly, for example, with DFID through the Government audits, internal auditors and external audit bureau. Other assessments are made on whether the money is being spent effectively i.e. if targets are being met. MPs can go out into the field and at grassroots level (e.g. from

the women's council) to see if what was planned has been implemented. Macroeconomic indicators are also another useful tool to measure effectiveness. The Office of the Ombudsman has broad powers to help alleviate corruption and financial mismanagement.

Appendix 4 – Media Generated by the Delegation

As a result of the press briefing in Nairobi, the following media was published/broadcast:

Date, Headlines & Publication

- 06 September (2006) '**Delegation to Africa will see Results**' Southampton Daily Echo
- 07 September (2006) '**MP on Trip to study deadly TB**', Falkirk Today
- 08 September (2006) '**UK MPs moved by plight of Kibera dwellers**', Kenya Times
- 08 September (2006) '**Declare TB a disaster, MPs urge**' The East African Standard, Nairobi
- 08 September (2006) '**HIV/AIDS fund: British MPs call for openness**', The People, Nairobi
- (No date) Press release '**Michael Connarty MP Unearthing Africa's TB Emergency**' Michael Connarty MP – epolitix website
- 08 September (2006) '**Kenya: Declare TB an Emergency, British MPs Urge State**, allafrica.com
- October Edition (2006), Article by Annette Brooke MP on delegation, The Clarion
- October Edition (2006), Article by Helen Davis '**TB in Rwanda/Kenya**' in 'Tidings' – Magazine of Salterns Road Methodist Church (Grassroots activist on delegation)
- October Edition (2006), Article by Helen Davis '**TB in Rwanda/Kenya**' in 'Noah's News' – Magazine of Oakdale Methodist Church (Grassroots activist on delegation)
- 08 September (2006), Article by William Ross '**My Harrowing Overseas Visit – William (71) in bid to raise disease awareness**', Linlithgow Journal & Gazette (Grassroots activist on delegation)
- 08 September (2006) '**MP on Africa TB Mission**', Linlithgow Journal & Gazette
- 27 September (2006) '**Make poverty history with action to beat diseases**' Western Mail, Wales
- 06 October (2006) '**Tackling TB worldwide**', Liberal Democrat News

William Ross also produced a short DVD film of the delegation's time in Rwanda & Kenya