Kenya is a high TB, TB/HIV co-infection and now MDR-TB burden country, which does not diagnose an alarming 40% of all TB cases. Even with the country-wide introduction of GeneXpert MTB/RIF in 2013, there is limited access to new TB diagnostic tools; only 10% of people diagnosed for TB have access to rapid TB diagnostics at the time of diagnosis[i]. Kenya has an estimated TB incidence of 138 105 cases per year[ii] and 0.7% of these cases are drug resistant (DR-TB) cases[iii]. However, only 6% of the RR-TB/MDR-TB cases were tested further for resistance to all second line drugs through culture in 2015[i]. The limited drug susceptibility testing (DST) of RR/MDR-TB patients results in the under-diagnosis of DR-TB patients and limits the placement of DR-TB patients on the most appropriate and effective TB treatment regimens. The NLTP recently introduced the new shortened DR-TB treatment regimen, however there is limited access to the new and more tolerable drugs; bedaquiline and delamanid. Only six and four patients were initiated onto bedaquiline and delamanid in 2017[iv]. Since Kenya has recently been listed as a high MDR-TB country[v], the Government must prioritize to diagnose and treat DR-TB cases effectively. The limited collaboration between the national TB and HIV programs is evident in the lack of implementation of TB LAM; a TB diagnostic tool specifically for PLHIV with low CD4 counts or very sick. The WHO recommended LAM use since 2015 but Kenya has not implemented the tool, yet TB LAM is registered in Kenya.

TB is an opportunistic disease, which disproportionately affects those with suppressed immune systems such as those living with HIV. TB prevention in PLHIV is achievable however, Isoniazid preventive therapy (IPT) roll out in Kenya has been very poor and only 3.6% and 10% of eligible adults and children respectively received IPT in 2015. The NTLP is falling far behind its target of putting 90% of adults and children respectively onto IPT [iii.]

On 18 October 2017, representatives of civil society organizations and communities living with and affected by TB in Kenya held a brainstorming meeting on the upcoming High Level Meetings on Tuberculosis (TB). The CSOs and Communities expressed their excitement about the upcoming United Nations High-Level Meeting on TB (UNHLM) in 2018 and the WHO Global Ministerial Conference to End TB in November 2017. The UNHLM and WHO Ministerial Conference present unprecedented and critical opportunities to have TB made a key health priority item. These meetings will heighten awareness of the social and economic impact caused by TB and the need for urgent global attention to end TB as a public health threat by 2030. The Civil society and Communities remain key stakeholders in the process of advocacy, and in holding leaders accountable to their commitments. The Civil Society in Kenya seeks to be part of the processes in the lead up to the two High Level Meetings. This will provide an opportunity for collaboration with the Government and other

stakeholders for an all-inclusive process. The approach will ensure feedback from both ends and collaboration even beyond the High Level Meetings. In this view, the CSOs make the following *initial* recommendations to the Kenyan Delegation to the Ministerial Conference in Moscow.

1. That the Kenyan Government, respecting Article 10 Principle on Public Participation and ensuring inclusion of all stakeholders in the process develops a structured forum for engaging civil society organizations and Communities ahead of the UNHLM and the Moscow Ministerial Conference. Relatedly, the Kenyan government should include CSOs and Communities as equal partners in the Kenyan Government Delegation to both Meetings.
2. That the Kenyan Government commits and advances the need for promotion, protection and respect for human rights in measures developed to end TB. That Government commits to integrate and fund TB programmes to achieve this goal. That the NLTP finalises and implements the isolation policy and social protection policy for TB patients before the end of December 2017. That the NTLP releases the official number of deaths attributed to TB based on the national prevalence survey and data for annual reports.
3. That the Kenyan Government commits and advocates for the fast tracking the adoption of innovations in TB management, including increased scale up of GeneXpert Ultra and line probe assay (LPA). Ensuring that **all** RR-TB patients are tested for LPA and all MDR-TB patients are tested for second line drug susceptibility using liquid culture. The Government should distribute placement of GeneXpert Ultra instruments and LPA according to the burden of TB disease in all the 47 counties. The Kenyan Government must quickly increase uptake of the new drugs bedaquiline and delamanid by initiating more DR-TB patients on treatment regimens containing these two new drugs. That the NTLP swiftly integrate LAM use in TB diagnosis for PLHIV and finalise policy on LAM use by end of November 2017. The process of uptake of innovative technologies, while respecting human rights, should be speeded up to save more lives.
4. That the Kenyan Government commits and advances the adoption of a multi-sectoral approach in the TB response. The various government sectors and private health sector should be accountable to the Ministry of Health on TB data, and work with Counties in collaborations with civil society organisations, private sector and key affected communities. The Government should commit for the convening of a national inter-ministerial commission on TB composed of TB units in all Ministries.
5. The Kenyan Government commits and advances the agenda for universal health coverage for all, to ensure that patients with TB have access to quality services as well as social protection against the catastrophic costs and impact of the disease.
6. The Kenyan Government commits and advocates for an increase in both domestic and international financing for TB management, research, innovation and development. That

Government increases additional domestic funding to fill the funding gap of USD 24 million annually towards addressing TB in the country [i]. That the Kenyan Government allocate USD 800 000 per year for TB R&D until the year 2020[vi].

7. That Government commits to prioritization of interventions that lead to increased case finding, identification of TB key populations, increased cure rates, and related indicators that determine the country's progress towards ending TB.
8. CSOs are concerned about the low levels of awareness regarding Antimicrobial Resistance (AMR), which directly impacts on the development of Drug Resistant TB (MDR-TB). The strain is expensive to treat both to the Government and to the patient. To reduce AMR, CSOs recommend robust campaigns by the Government in collaboration with civil society to create public awareness and reduce the burden of AMR to the country.
9. The Government commits to the development of a well-defined M&E system that disaggregates data along all social economic indicators (age, sex and economic status) that can inform interventions that comply with gender and other socio-economic indicators. The process should also allow active engagement, monitoring, reporting and audit by CSO as well as other key stakeholders.
10. The Government commits to ensuring access and availability of point of care child-friendly diagnostics for all children who need it. It should also ensure access to sustainable TB prevention and care for all, especially children and vulnerable populations.

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[i] https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=KE&outtype=pdf

[ii] Kenya TB prevalence survey, Ministry of Health, Kenya, 2016

[iii] Draft Annual Report, National Tuberculosis, Leprosy and Lung Disease Program, Ministry of Health, Kenya, 2016

[iv] GDF_BDQ_Rpt_31-May-2017

[v] GDF_BDQ_Rpt_31-May-2017

[vi] https://docs.google.com/spreadsheets/d/1YmOGkUEPPRm9AmcZO37hais7yi-mdL9vsSTnMRoDueg/edit#gid=1950221757