Your Ref: TBA **Our Ref:** **Date:** 6 November 2017

The Cabinet Secretary,
Ministry of Health,
Afya House, Cathedral Road,
P.O. Box 30016–00100,
Nairobi, Kenya.

Dear Dr Cleopa Mailu,

RE: Global Ministerial Conference on Ending TB (Moscow, 16-17 November 2017) and UN High-Level Meeting on Tuberculosis (2018)

On behalf of the undersigned civil society organisations and community groups committed to the fight to end tuberculosis (TB) in Kenya, we are writing to encourage you and the Kenyan government to:

1. Attend the *Global Ministerial Conference on Ending TB in the Sustainable Development Era* on 16–17 November 2017 in Moscow, Russian Federation. We are particularly concerned that you may no longer be attending the Conference. This is the first ever global ministerial meeting on TB and hence a strategic moment to articulate innovative strategies for the TB response in Kenya and in the region. Kenya is among the 22 high burden TB countries in the world and your attendance would be an affirmation of high-level commitment towards eradicating TB by the Kenyan Government. A Ministerial Declaration will be signed at the Conference, containing bold commitments by countries to accelerate action to end TB and meet the milestones towards the 2030 Sustainable Development Goals (SDGs). The Ministerial Conference will also inform the UN General Assembly High-Level Meeting on TB in 2018 to be attended by Heads of State. Since you're also scheduled to speak on a panel titiled "Stepped-up TB/HIV response" at the Ministerial Conference we urge you to attend and speak at the panel. We express our disappointment that you cancelled a briefing meeting scheduled between yourself, and Kenyan TB civil society representatives on 24th October 2017.
2. Engage in the planning and lead up to the first-ever UN High-Level Meeting (UN HLM) on TB in 2018 and ensure a high-level delegation attends to demonstrate Kenya's prioritization and commitment towards ending TB;
3. Commit to increasing Kenya's annual investment in TB research and development (R&D) to USD 800 000[i] per year and
4. Commit to providing high quality, evidence-based TB services, including the best available tests, prevention, and treatment, and to ensuring protection of human rights.

We laud the National Tuberculosis, Leprosy, and Lung Disease Program (NTLD-P) for conducting the first National TB Prevalence survey post-independence. The survey revealed that Kenya has an estimated 138 105[ii] incident cases of TB each year and the annual report in 2016 indicated that 0.7% of new TB cases are drug-resistant[iii]. From the survey it emerged that the prevalence of TB in Kenya is almost double the World Health Organization (WHO) 2014 estimate [ii]! It is atrocious and alarming that 29 000 Kenyans die of TB each year [vi] despite TB being preventable and curable. The recent National TB Prevalence survey also indicates that Kenya is missing to diagnose 40% of all TB cases [ii]. It is appalling that only 59% of pulmonary TB cases are bacteriologically confirmed cases and only 10% of Kenyans have access to rapid diagnostic testing at the time of diagnosis[iv], which confirms the underutilization of GeneXpert. The low number (22 out of 368) of MDR/RR-TB cases tested for resistance to second-line drugs [iv.] alludes to the underutilization of drug susceptibility testing (DST) through culture. It is deplorable that majority of the MDR/RR-TB patients are not tested further for drug resistance profiling through liquid culture to adequately determine the most appropriate and effective treatment regimen for patients to be rapidly initiated onto treatment. This issue also leads to inadequate forecasting for drug procurement. Despite Kenya having recently implemented the new shortened treatment regimen, patients still have limited access to new life saving, more tolerable DR-TB drug medicines; only six and four patients were initiated on bedaquiline and delamanid this year[v], respectively. Kenya must commit to increasing access to new and repurposed DR-TB drugs to all patients eligible for these DR-TB drugs. In a recently alarming revelation by the WHO, Kenya has now transitioned into a high MDR-TB country, the Government must prioritize to diagnose and treat DR-TB cases effectively[vi].

Since its introduction in 2014, isoniazid preventive therapy (IPT) roll out has been limited in Kenya, with only 3.6% and 10% of eligible adults and children who received IPT in 2015 **Error! Bookmark not defined.**. Kenya needs to at least achieve the goal of putting 90% of adults and children respectively onto IPT as targeted by the NTLP.

Cross-sector solutions are necessary to adequately address these issues. We are committed to working together to leverage the unprecedented opportunities presented by the Ministerial Conference and UN HLM on TB to mobilize the political will and action necessary to achieve the ambitious targets set out in the End TB Strategy.

We still appeal to you to attend the Ministerial Conference in Moscow in November and to work to raise the understanding of and response to the challenges we face in TB among other government officials, including the Ministries copied to this letter. Engagement at the highest levels of the Kenyan government between now and the UN HLM on TB in 2018 is critically important to ensuring that meeting outcomes are translated into the urgent investments and actions needed.

Despite the two billion people infected globally, and the 10 million people that fall ill with TB each year, TB R&D remains severely neglected and increasingly dependent on donor funding. To catalyze the development of breakthrough TB diagnostic, treatment, and preventive technologies and strategies necessary to eliminate TB, there is an urgent need for new and increased investments in research.

We call on you and the Kenyan government to commit to investing USD 800 000 in TB R&D each year between now and 2020. Further, a portion of committed funding should be applied through a coordinated global TB research platform to be proposed at the Ministerial Conference in Moscow and discussed in detail at the UN HLM on TB. Funding should come with provisions to ensure that knowledge generated is publicly available, and products developed are affordable, available, and accessible. By stepping up and setting this important example, Kenya can help the global TB community challenge the governments of other countries to do the same.

Attached to this letter is a checklist of necessary TB technologies and interventions. We call on you to ensure the availability of these diagnostic, treatment, and preventive technologies and interventions within TB and other health programs in Kenya. We also encourage you to work with regulators, legislators and civil society to create legal and regulatory environments conducive to the implementation of this list and the included technologies. The impact of the Ministerial Conference on TB and the first-ever UN HLM on TB will only be as large as the ambitions of the governments participating therein; we are counting on you to use these opportunities to affect change sorely overdue in the fight against TB.

We will be in contact again soon to arrange a follow up meeting to discuss the outcomes of the Ministerial Conference on TB and actions necessary to ensure the implementation of commitments made in Moscow. To further discuss any of the points raised in this correspondence in the meantime, please direct your response to Khairunisa Suleiman (Khairunisa.suleiman@gmail.com, +254 727 289 223).

Respectfully submitted

Stop TB Partnership Kenya
Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN)
Women Fighting AIDS in Kenya (WOFAK)
Health NGOs Network (HENNET)
National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK)
Global TB Community Advisory Board (TBCAB)
Global Coalition of TB Activists (GCTA)
Talaku Community Organisation
Pamoja TB Group

NATIONAL TB CHECK LIST

TB testing is widely available, and free of charge, including:

[ ] Digital chest x-ray to screen for TB
[ ] Xpert MTB/RIF as the initial TB test for all
[ ] HIV testing offered to all patients diagnosed with TB
[ ] Molecular line probe assay for TB diagnosed rifampicin-resistant by Xpert MTB/RIF
[ ] Liquid culture for further drug-susceptibility testing and treatment monitoring
[ ] TB testing offered to all patients diagnosed with HIV
[ ] In high TB/HIV burden settings: TB-LAM testing for all presenting to health care with advanced HIV (CD4<100 cells/mm^3) or danger signs

TB treatment programs provide quality-assured treatment, based on drug susceptibility, free of charge, and in regular supply, including:

[ ] Daily fixed-dose combinations to adults and children with drug-sensitive TB
[ ] The shortened regimen for multidrug-resistant TB to all eligible adults and children
[ ] Optimized regimens, including bedaquiline, delamanid, linezolid, and/or clofazimine, to adults and children ineligible for the shortened regimen
[ ] Pre-approval access to new drugs for adults and children with few remaining treatment options or intolerance to available drugs
[ ] Antiretroviral therapy for all people with TB and HIV
[ ] Necessary medicines and supplements to support taking therapy, such as anti-emetics, anti-pain medicines, and vitamin B6
[ ] Linkage to nutritional support for those who need it
[ ] Risk and side effect monitoring at baseline and at indicated intervals once on treatment, including liver function tests, audiometry, vision testing, ECGs, mental health effects (including depression, psychosis), nerve damage
[ ] Decentralized treatment for drug-resistant TB, without routine compulsory hospitalization
[ ] Protections for patients' livelihoods, including housing, employment, and schooling
[ ] An environment conducive to patient needs and treatment success, including accessible clinic hours and/or community based care

TB prevention programs provide:

[ ] Bacillus Calmette–Guérin (BCG) vaccine at birth to HIV-negative babies
[ ] Contact tracing and active case finding
[ ] Routine screening for high-risk populations (e.g. children, people living with HIV, prisoners, etc.)
[ ] Preventive therapy to all eligible according to WHO guidelines, especially people with HIV and children age 5 and under

[ ] Regular supply of high quality versions of recommended regimens (6 or 9 months of daily isoniazid and B6—with cotrimoxazole for people with HIV; 3 months of weekly isoniazid plus rifapentine, and B6; 3 or 4 months of daily isoniazid plus rifampicin, and B6; 3 or 4 months of daily rifampicin alone)

[ ] Infection control, including properly designed facilities, N95 respirators for healthcare workers, and information for patients and caregivers about how to prevent the spread of TB

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

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

[v] GDF_BDQ_Rpt_31-May-2017

[vi] WHO Global TB Report 2017; https://reliefweb.int/sites/reliefweb.int/files/resources/9789241565516-eng.pdf

CC:

Amb. (Dr.) Amina C. Mohamed, EGH, CAV
Cabinet Secretary for Foreign Affairs and International Trade
Old Treasury Building,
Harambee Avenue
P.O. Box 30551 -00100 G.P.O
Nairobi, Kenya

Mr. Henry K. Rotich
Cabinet Secretary for the National Treasury
The National Treasury,
P.O. Box 30007-00100,
Nairobi, Kenya.

H.E Josphat Koli Nanok,
Chair, Council of Governors,
Delta Corner, 2nd Floor,
P.O Box 40401,
Nairobi.

Dr. Rudolf Richard Eggers,
Country Representative,
WHO, Kenya,
4th Floor ACK Garden House,
P.O. Box 45335,
Nairobi.

Dr. Maureen Kamene
Head, National Tuberculosis, Leprosy, and Lung Disease Program (NTLD-P)
1st Floor, Afya Annex
Kenyatta National Hospital Grounds

Hon. Stephen Mule,
MP, Matungulu Constituency, and Chair of the African Parliamentary TB caucus