Gender Responsive Health Systems in TB Programming in Kenya

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Context

The Kenya TB prevalence survey (2016) demonstrated the urgency to address the gender-specific challenges in TB detection, diagnosis, and treatment-seeking. The gap in male patient-centred care with early diagnosis and systematic screening as a population at high risk was glaring.

This was after the Survey indicated that Kenya has 40% of persons with TB who are still missing as they have not been diagnosed nor notified, majority of whom were men of productive age (25-34 years), and are mostly urban dwellers. The prevalence of TB among men was twice that in women. Also, males within this age group had poor health seeking behaviour with majority visiting a facility only when symptoms were severe. Cultural norms discouraging vulnerability and weakness further deterred men from seeking healthcare. Unfortunately, discussions on gender tend to focus primarily on women, overlooking the specific challenges faced by men in accessing healthcare services (UNAIDS 2017 blind spot)

Moreover, the prevalence of TB among working-age males has adverse consequences for workplaces, leading to a loss of skills and experience, disruptions in production processes, and reduced overall productivity (ILO). Workers also largely bear the costs associated with seeking healthcare, impacting their dependents economically.

This initiative was carried out in the period between September 2017 and March 2018, where thirteen corporate organizations were reached responding to the END TB strategy pillar one that focuses on patient centred care with early diagnosis and systematic screening of populations at high risk(END TB strategy) There was a need to develop a people centred, community based and gender responsive health services, based on human rights (UNHLM-TB).

CHS endeavored to implement the USAID vision on ensuring reliable links between the public and private sectors, including communities, to lead to stronger health systems.

Activity Description

This activity took a collaborative approach and workplace identification process in the intervention. There was the engagement with the County Health Management Teams (CHMT) in identifying private non health business sector within 12 industrial priority counties. The selection criteria were based on prioritizing companies (corporates) with larger male workforce, any known TB cases within the listed corporates, as well as previous engagements with the respective County Public Health or TB Coordinators.

A County entry and sensitization meeting targeting the prioritized health management teams (CHMT) were conducted to get a buy in on the PPM Model on Corporate Engagement. This was followed by entry meetings conducted in the identified corporates, to also get a buy-in of the Corporate Engagement Model from the senior management of the corporates, and a plan to roll out the implementation process in the respective workplaces. These assisted in guiding on the existing workplace policies and structures such as the occupational, Safety & Health –OSH, Human Resource, HIV & AIDS, and Wellness, for leverage in the implementation of this Model.

The intervention also sort to collaborate with the Kenya Private Sector Consortium Against AIDS to identify target corporates, engage senior managements, and integrate TB interventions in the existing HIV-AIDS workplace programs. The consortium included workplace wellness program implementers, workers and employers' associations, the International Labour Organization (ILO), and the Ministry of Health's National AIDS Control Council (NACC).

- The Consortium platform provided guidance on identifying large corporates, particularly those within their wellness programming networks that had not yet integrated TB programming
- Targeted corporates included heavy industrial and agricultural companies, manufacturing companies, and long-distance transport companies
- Engagement with the identified corporates was facilitated through the employers' federation and workers' union platforms.
- Discussions were held with senior managements of the corporates, mobilized workers, and involved the County, National Tuberculosis Program (NTP), and USAID TB ARC teams to support the TB intervention
- Ongoing follow-up was conducted through existing steering committees in each corporate platform
- A Rapid Analysis tool was utilized to conduct a basic TB status checklist in each corporate, providing a baseline for planning tailored interventions on a case-by-case basis.

In the workplaces, the TB activities included;

- Conducting TB sensitizations and awareness sessions for targeted corporate employers and employees
- Identifying steering committees and training of peer educators or champions to sustain health promotion efforts within workplaces
- Offering voluntary TB symptomatic screening for employees within identified workplaces
- Collecting sputum samples for GeneXpert testing and made appropriate referrals for chest X-rays if TB symptoms were present
- Ensuring linkage to care for all individuals diagnosed with TB and facilitating prompt initiation of treatment
- Sensitizing clinicians in corporates' clinics on TB and providing guidelines to enhance their skills in TB identification, treatment, and referral mechanisms
- Empowering clinicians to sustain TB integration efforts in their respective workplaces.

Activity Impact

The seven (7) months pilot activity strengthened cross-sector coordination in identification and engagement of the prioritized private non health industrial sector with large workforces. This was through the engagement of Ministry of Health's National TB Program, the private sector consortium of HIV service providers at workplaces and the County health management leadership.

Private sector world of work integration: Sensitizations on TB in relation to business and economics were conducted among private non-health sector employers targeting senior management for buy in and support, while reaching employees for uptake of TB services at workplaces.

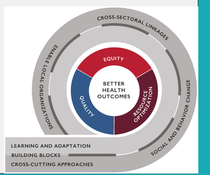
Males reached with TB service: The activity targeted and prioritized industrial counties which were also among the ones considered to have high burden of TB and had many industries with large male population of productive age (populations at risk of TB). This included taking the mobile TB services to the specific workplaces and engaging existing structures in the respective workplaces.

New technology in TB diagnosis was utilized in these activities: TB symptomatic screening and chest X-Rays were conducted for all employees within their workplaces, while diagnostic services through GeneXpert testing were conducted for those identified as presumptive for TB.

The Health Systems Actors were sensitized on delivering differentiated TB services to the industry workers as linkage to care was done for all those diagnosed with TB, to the nearest facility. This included fast tracking the male workers seeking TB services and allowing for different facility opening and closing times.

TB Services Accessibility: The activity brought the TB services closer to the males and leveraged on existing workplace policy platforms to integrate TB response at workplace such as the Occupational Safety and Health, Human resource, wellness program the workers/employers' platforms, among others.

Policy Influence: In Corporate structures adopted TB at workplace programming as a good fit that made business sense. The activity implementation findings informed the Ministry of Health's National TB Program towards development of the first national Workplace Policy on TBas well as inform the Multi-sectoral Accountability Framework



Evidence

Through this activity, the 13 corporates were reached and 4,208 workers were screened for TB. 39% of the workers did not take up the TB screening services provided at their respective workplaces. 32% (1349) were presumptive for TB, of which 65% were males. In total, 5% (26) were identified to have TB, one being a case of extra pulmonary TB, of which 73% were males while 27% were females. The 23(18%) TB suggestive X-Rays were among the abnormal X-Rays and were all subjected to a molecular test.

Figure 1: The Activity Implementation model

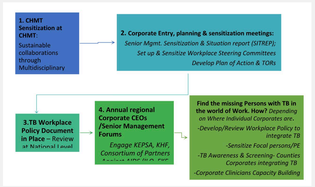


Figure 2: Data Results from the implementation of the Activity:

Indicators	Total	Proportion	Male	Female
Workload	6846			
Screened for TB	4208	61%	2482	1631
X rays done	1603		962	641
Normal xray	1472			
Abnormal xray	129			
TB suggestive	23			
Total presumptives	1349	32%	876	473
Total investigated	648	48%	449	171
Clinically diagnosed	15			
Bact confirmed	11			
Total diagnosed	26	4%	19	7

Figure 3: Activity's impact : Scale up of Workplace Engagement - Acknowledgement by Mombasa County on the relevance of TB sensitization in the workplace

Figure 4: Activity Influence on Policy: NTP Kenya developed and launched the first National Workplace Policy on TB, co-signed as Tripartite by FKE, Ministry of Labour & Ministry of Health

Facilitators

The Activity referenced the guidelines and steps recommended from the following:

- WHO – Stop TB guidelines for TB Programming in the workplaces https://stoptb.org/assets/documents/getinvolved/psc/TBinWorkplace_WHO_stopTBPartnership.pdf
- Planning and Implementation - A Step by Step Guide Integrating TB Into HIV/AIDS Workplace Programs by ILO https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_220383.pdf
- WHO Recommendations on TB Control in the Workplace https://apps.who.int/iris/bitstream/handle/10665/206461/B3683.pdf?sequence=1&isAllowed=y
- Great Partnerships with the Ministry of Health's National TB Program, the respective County Government's Departments of Health,
- There existed the Kenya Private Sector Consortium against Aids platform who included the workplace wellness program implementers among them the International Labour Organization (ILO), the Central Organization of Trade Unions (COTU), the Federation of Kenya Employers (FKE), the Kenya's Office of the President's National AIDS Control Council, The Swedish Workplace HIV-AIDS Programme (SHWAP), the Long Distance Truck Drivers Health Services Program.

Challenges

- Some workplaces management were hesitant to integrate TB programming at their respective workplaces due to the fact that they had existing health schemes whereby their workers and dependents were already receiving health benefits as incentives via a self-insured in-house medical scheme.
- The activity was largely donor funded and a few workplaces developed a sense of dependence to accessing free health services making it difficult to contribute to future interventions.

Lessons Learned

- Gender responsive health systems can work and be strengthened when a collaborative approach in engaging different sectors is consulted and meaningfully engaged by the Health Departments at national and sub-national levels.
- Engagement with private business sector is fruitful and sustainable, when the collaborative approach through governance, and cross-sector coordination with the world of work, the national and county government is optimized for buy in and support.
- All workplaces can be reached through a Workplace Policy on TB which can be rolled out through a tripartite agreement with the workers or employers' federation, or through inter-Ministerial partnership involving the Ministry of Labour and Social Protection and the Ministry of Health.