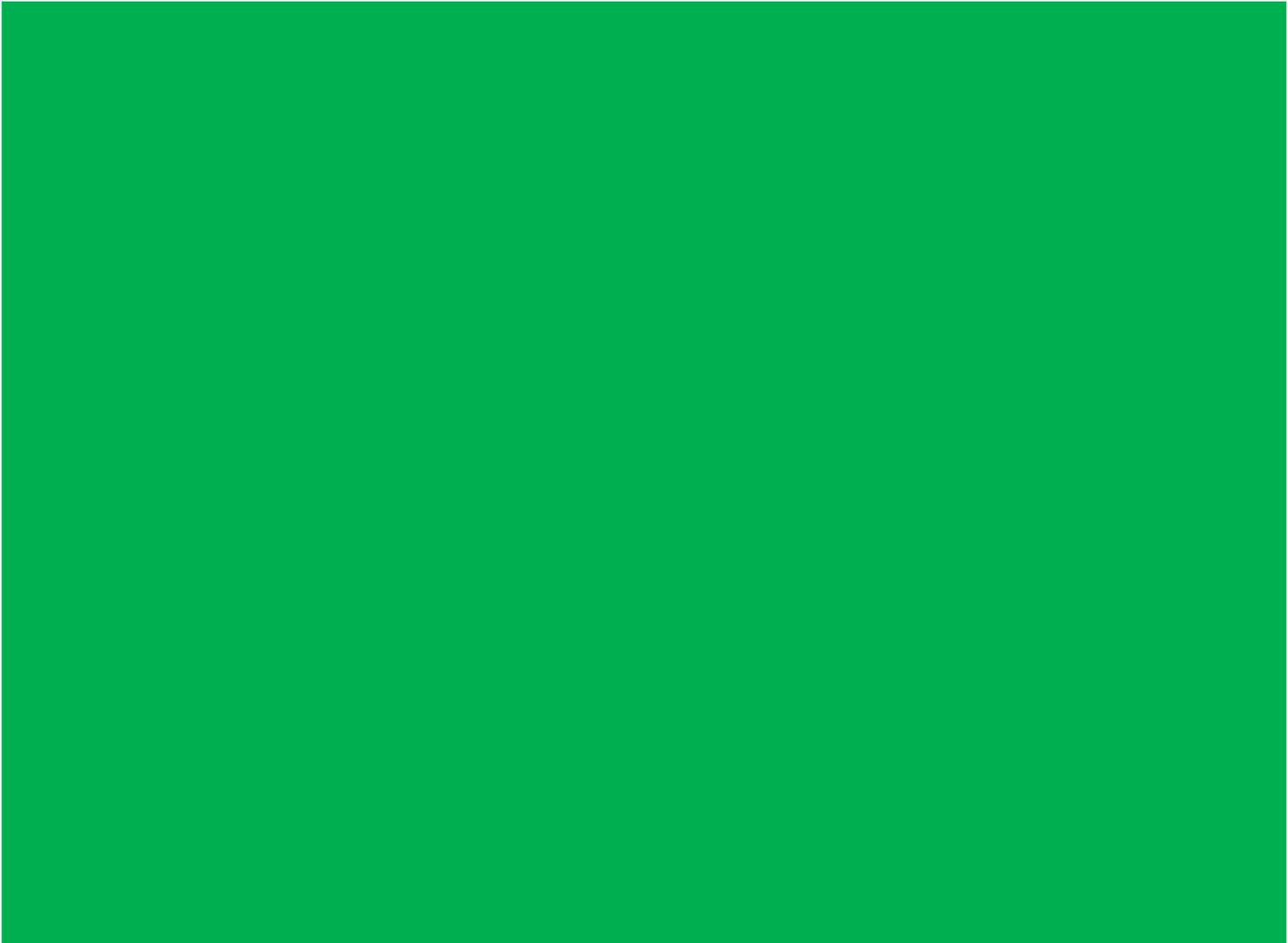




# **TB KP PRIORITIZATION & RAPID ASSESSMENT REPORT**





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## **TB Key Population Prioritization and Rapid Assessment Report - NIGERIA**

### **Executive Summary**

The Stop TB Partnership, the World Health Organization (WHO) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GTFM) are collaborating on projects to find and treat an additional 1.5 million people with tuberculosis (TB) who are currently missed by health systems. Under GTFM TB Strategic Initiative (SI), the Stop TB Partnership will work with national TB programmes and partners in Nigeria, providing technical support through a combination of innovative approaches, tools and best practices to identify and remove barriers in the context of TB with a particular focus on key populations and vulnerable groups.

Under the SI, the Stop TB Partnership is continuing to pursue the paradigm shift that is articulated in the Global Plan to End TB. This paradigm shift, in alignment with the End TB Strategy and the Global Fund Investing to End Epidemics places enhanced focus on people-centered care and community driven responses, as well as key populations and gender sensitive programming. To support this area of work the Stop TB Partnership, in addition to other areas of work, and in collaboration with partners, defined TB key populations in the Global Plan to End TB, developed Key Population Briefs, and developed Community, Rights and Gender (CRG) tools for Impact.

In the absence of official statistics, the best prioritization approach is a multi-stakeholder one, which a diverse group of stakeholders from TB government officials, NGOs to members of key populations triangulated information between any available official statistics and the collective expertise of the stakeholders in the room. The key populations directly and indirectly through NGOs working with or advocating for them were involved in the prioritization process. This gave room for some of the key populations to become relevant and subsequent involvement of the KPs in the planning for services for them will lead to programs that would address any barriers these key populations are faced with when accessing health services.

Removing these barriers will increase the chance of not only finding these population sub-groups previously missed by TB services, but of equal importance, getting them to initiate treatment as early as possible and stay on treatment to prevent further transmission. The KP report was used to identify the wider and unreached key populations in the context of TB in Nigeria. It suggested recommendations to address areas of concern and to enhance country level knowledge and focus on marginalized and vulnerable populations. The tools were further supported by a tool assisting community monitoring for accountability and one to assess TB stigma.

This assessment was done by the country team trained recently in Addis Ababa. Through this high-level commitment and coordination, the Stop TB Partnership hopes that national TB responses can be strengthened, the barriers preventing the missing TB people accessing TB services will be removed, and that together we ultimately end TB.

## **Background**

The Global Plan to End TB 2016-2020 focuses on the needs of key populations recognizing that the world has a collective responsibility to protect vulnerable people from TB, to provide them with a cure and to involve them as key stakeholders in the fight against the disease. The Global Plan defines ‘key populations’ as people who are vulnerable, underserved or at-risk of TB infection and illness.

The UN Sustainable Development Goals (Global Goals) and the End TB Strategy aim to end tuberculosis (TB) within a generation and boldly challenge the global health community to demonstrate greater urgency and ambition. People across the world are aligning behind this global movement to end TB once and for all. The paradigm shift in TB response as stated in the Global Plan made it clear that without a dramatic change in how we respond to the disease, these targets will not be achieved in 150 years, let alone by 2030. The number of people becoming ill with TB each year has declined by just 1.5% annually over the past 15 years. This rate of decline is unacceptably slow for a

preventable, curable disease, and must increase dramatically by 2020 to put the world on track to end TB. Moreover, TB has now the unenviable title of being the world's leading cause of death from an infectious disease. In addition, TB continues to be the leading killer of people with HIV, responsible for one in three HIV-related deaths. We should not, and must not, accept this.

Through our inaction, TB has mutated into drug-resistant forms that are exceedingly difficult and expensive to diagnose and treat. Drug resistant TB is an ongoing global crisis, described by some as "airborne cancer". Unfortunately, this is widely overlooked by governments, despite the fact that it is overwhelming national health systems and budgets. There are efforts that are grossly insufficient in meeting the targets. Clearly seen in the communities, factors to address in order to achieve the 2030 target require all lot of proactiveness by the leaders. Increased political will and improved health seeking behaviour of the community members.

In Nigeria, the NTBLCP called for a major rethinking of the approaches the programme is using to control TB in Nigeria. The mid-term review of the national strategic plan for TB 2010 – 2015 underscored one key performance challenge that has the highest priority in this new NSP-TB: case notification. The prevalence survey results reinforced the need to strengthen case finding and diagnostic capacity to bring down the backlog of prevalent cases and prevent ongoing transmission and mortality. Many national strategies and assessments have enumerated the key health systems weaknesses that must be addressed to improve health programme performance.

This NSP-TB presents an ambitious agenda for rapid scale-up of services to achieve universal access to TB prevention, diagnosis and treatment, with an emphasis on quality, accountability, linkages between the different levels of the health system and partnerships that leverage the resources and efforts of other disease programmes and initiatives to have a greater impact for TB control. While basic TB services will be expanded to cover all the country, the NTBLCP analyzed existing epidemiological and performance data and has prioritized geographic regions for intensified

interventions to increase case-finding in 13 states and the FCT, representing an estimated 50% of the missing cases in Nigeria.

The analysis was conducted based on burden of HIV, current case notification rates and current population coverage of TB diagnostic and treatment services. Priority was given to states with a high burden of TB, a large gap in actual versus expected case notification and low coverage of services, based on a weighted ranking. FCT was added because of the high concentration of key affected populations within the FCT area. Much as this is commendable, the states have not done categorically and survey to know the key populations and then program effectively.

The intensified intervention package include community outreach for demand creation; active case-finding in key affected populations; public-public- and public-private mix strategies to engage key care providers in case-finding activities; scale-up of rapid diagnostic technologies; and expansion of treatment capacity to meet the increased need. States targeted for this intensified package of services include Akwa Ibom, Anambra, Bauchi, Borno, Imo, Jigawa, Kaduna, Kano, Katsina, Lagos, Oyo, Rivers and Sokoto as well as the FCT.

### **Assessment Objectives**

- ✓ To accelerate country's effort towards End TB goal by improving case finding among population sub-groups who are faced with significantly higher TB risks/more exposures (e.g., 5-10 times more vulnerable) and less likely to be reached by government TB services compared to the general population (more marginalized due to legal, human rights, gender and economic barriers to accessing government services).
- ✓ To capture those population sub-groups who are considered "hidden" (i.e., no, or very little, official TB statistics) and have not yet been reached by government TB services.
- ✓ To maximize the specific contexts and different degrees of resource limitations faced by different countries.

- ✓ To identify the most vulnerable and marginalized sub-groups to help increase the country's efficiency in finding missing TB cases.

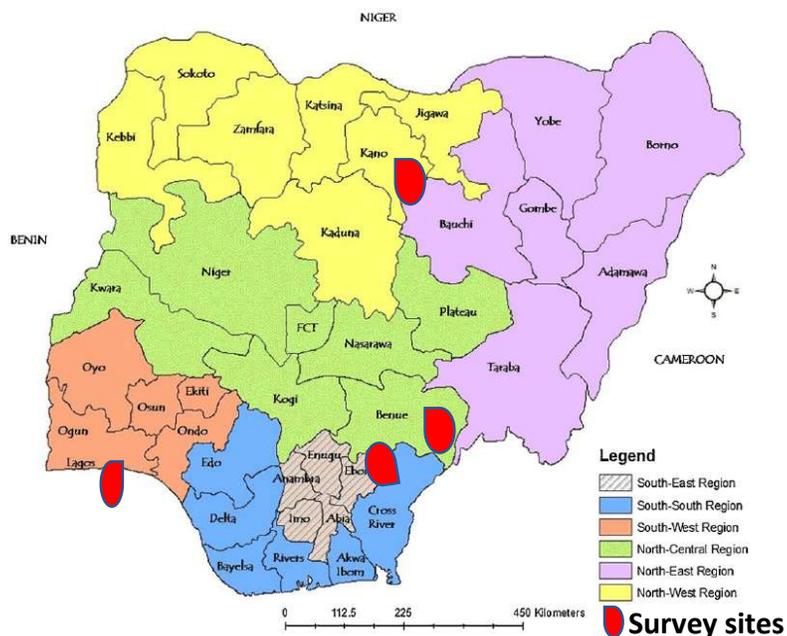
### Scope

The scope of the TB Key Population and

Rapid Assessment followed a desk review of national documents as well as covered

both Global and national plans to stop TB. It covered the rural and urban areas of Nigeria with specific focus on the 4 selected states. The states covered were Lagos, Cross River, Kano and Benue. The assessment examines the situation of key populations, the challenges, the state specific key populations, government services for them and their risk factors to mention a few. The respondents were mainly TB Patients, TB survivors, Health workers working on TB, Civil Society Organizations working on TB, Community leaders, Government and Political leaders, Control officers, Prisoners, and community people. It also examined the impact of government intervention on the TB Patients, TB survivors, their families and people who are also vulnerable to the disease.

The assessment will involve qualitative analysis using key informant interviews and focus group discussions in 4 geo-political zones in Nigeria. (1) South-West-Lagos; (2) South-East-Enugu; (3) North-Central-Abuja; and (4) North-West-Kano. However, after meeting with the USAID in Nigeria and aligning with the country program, the above states were agreed on: Kano - NorthWest, Lagos – SouthWest, Benue – NorthCentral and Cross River – SouthSouth.



## **Site Visits**

The assessment visited the selected TB treatment sites in the States observed and got independent perspectives on the processes involved in accessing TB diagnosis, treatment and care. The sites visited put into consideration in each state the groups (key populations most hit with the disease).

## **Focus Group Discussions (FGDs)**

These comprised members of the populations and the community members. Focus groups comprised diverse sectors of the population who fulfilled the eligibilities. Questions focused on opinions and experiences about other key population members and NOT about the participant themselves. When asking personal questions about participants themselves, these were asked in an in-depth interview.

Each FGD had a maximum of 12 participants drawn from the earlier identified groups from the guidelines. FGD with male representatives of TB patient groups or TB patients in an identified TB treatment centre in the State (Urban or Rural) was ensured while FGD with female representatives of TB patient groups or TB patients in an identified TB treatment centre in the State (Urban or Rural).

## **Findings**

A host of barriers were identified and grouped into major themes as TB programs, health systems, socio cultural and patients-related barriers. Program barriers identified included inadequate infrastructures including low coverage of directly observed short-course centers and shortage of TB drugs. Health systems related barriers were lack of staff training, governments' poor funding of TB programs and intolerant to discriminatory attitudes of some general health workers excluding the

DOTS officers. Patients' related barriers included malnutrition and co-infection with HIV, poor TB knowledge and practices towards infectious disease control, and non-adherence to treatment and medical advice its devastating effects including earing-loss and other forms of deformities. Loss of job among TB patients and negative social beliefs were among the socio cultural barriers. Of major import was the case of language barrier in some medical facilities in Calabar, Cross River State among the Hausa communities.

## **METHODOLOGY**

### **Planning**

This involved debriefing and discussion with the in country Assessment Core Group, Completion and Submission of Grant Application/Concept Note and Budget to Stop TB, development of draft protocol and questionnaires for review by the Core group, planning for Multi-stakeholder Orientation Meeting, facilitating the Multi-Stakeholder Orientation meeting and finalizing and submitting the protocol and questionnaires to relevant regulatory bodies. Matters discussed during this planning meeting included how results of desk review will be used, which stakeholders will participate, the tool that will be used, how key populations will be prioritized in this meeting, the roles and responsibilities of each member and the time line to complete the activities were also be discussed.

### **DESK REVIEW**

The assessment involved a desk review of relevant documents related to the issues of key populations on TB in Nigeria. The resource materials were collated and reviewed centrally in Nigeria. The list of

the documents and sites reviewed are attached in the annex.

## **Findings**

Nigeria is among the 14 high burden countries for TB, TB/HIV and Multi Drug Resistant TB. The country is ranked seventh among the 30 high TB burden countries and second in Africa. The problem of TB in Nigeria has been made worse by the issues of drug resistant TB and the HIV/AIDS epidemic. It is estimated that 407,000 people in Nigeria have TB each year. This is the estimated number of HIV negative people. In addition there are an estimated 63,000 HIV positive people that get TB each year.

An estimated 115,000 HIV negative people die from TB in Nigeria each year and an estimated 39,000 HIV positive people also die. It is difficult to appreciate what it means for 154,000 people to be dying each year from TB so it can be helpful to read the page on dying from TB. It has been said that “achieving the reduction in TB incidence rate for attainment of the 90-90-90 target of the END TB strategy will be a mirage, if something drastic is not done.” The incidence rate is the number of new cases of TB in a population in a given time period, which is usually a year.

## **State and National Tuberculosis & Leprosy Control Program (STBLCO/NTLCP)**

The National Tuberculosis & Leprosy Control Program (NTLCP) was established in 1989 and officially launched in February 1991. Its mandate was to coordinate TB and Leprosy control activities in all states in Nigeria in order to significantly reduce the public burden of the two diseases. The NTLCP, which is part of the Ministry of Health, controls most of the funding for work on TB in Nigeria. Same structure of control is applicable across the 36 states of Nigeria including the FCT. The state TB and Leprosy Control Unit is led by the State TBLCO (STBLCO). The Ministry of Health has made considerable progress with the drafting of the National Strategic Plan for Tuberculosis Control which aims to provide Universal Access to Prevention, Diagnosis and Treatment by 2020 in line with its commitments to the World Health Organisation (WHO). However, there are several difficulties

affecting the success of this plan, such as inadequate budget provisions, access to hard to reach areas, unreported TB cases and inadequate human resources technical capacity.

### **Coordination and Civil Society Engagement**

The STBLCOs in each state displayed a strong working relationship with all stakeholders from his state team, TB Local Government Supervisors (TBLS), in some states there are CSO officers and in some there are ACSM Officers. Kano, Lagos, Benue and Cross Rivers states all have a very good working relationship also with the civil society organizations working on TB. There are 2 strong networks on TB in Nigeria. The Civil Society for the Eradication of Tuberculosis and the African Coalition on Tuberculosis ACT Nigeria.

### **Funding**

New implementation arrangements have been put in place for the TB programs funded through Nigeria's new TB and TB/HIV grants. Under the new arrangements, the National Tuberculosis and Leprosy Control Program (NTBLCP) in the federal Ministry of Health (MOH) will manage TB activities in public health facilities and communities as principal recipient (PR); and another PR, the Institute of Human Virology Nigeria (IHVN) — selected through an open competitive process — will manage implementation of the private sector component.<sup>1</sup>

According to information on the **Global Fund website**, the PRs for the current TB grants are the Association for Reproductive and Family Health (ARFH), and IHVN. The current IHVN grant is not focused on the private sector. The NTBLCP, which is part of the federal MOH, is a sub-recipient under the ARFH grant. To avoid service interruptions, the transition to the new implementation arrangements will take place over the first six months of 2019 and will be closely monitored. A number of mitigation measures have been instituted to ensure a smooth transition.

When Nigeria originally submitted a joint TB/HIV funding request in June 2017, the TRP recommended an iteration. An 18-month extension for the current TB and HIV grants, from 1 January 2018 to 30 June 2019, was granted to allow services to continue while Nigeria worked on revising its request.

**Table: Nigeria’s approved TB and TB/HIV grants from its 2017–2019 allocation<sup>2</sup>**

| SN           | Component | Name         | PR                                      | Program budget (\$) |
|--------------|-----------|--------------|---|---------------------|
| 1            | TB/HIV    | NGA-C-LSMOH  | Lagos State Ministry of Health          | 5,089,851           |
| 2            | TB        | NGA-T-IHVN   | Institute of Human Virology Nigeria     | 29,703,883          |
| 3            | TB        | NGA-T-NTBLCP | National TB and Leprosy Control Program | 36,422,481          |
| <b>TOTAL</b> |           |              |   | <b>71,216,215</b>   |

Dr Bassey Nsa, the Country Director (Challenge TB program) of KNCV, which partners the Federal Ministry of Health in TB control, treatment and prevention, said that a lot more political commitment and funding is required from the government at all levels to fight TB in Nigeria.

#### **Lagos State grant**

The new TB/HIV grant will be managed by the Lagos State Ministry of Health (LS-MOH). The GAC recommended an integrated grant for Lagos State. The plan is to add RSSH and HIV components to the Lagos State grant in the coming months, providing funding for these components is approved by the Board. Currently, the grant being managed by LS-MOH includes only an HIV component. As part of its grant, LS-MOH will pilot a mobile screening initiative with three vans to be procured jointly by LS-MOH and the Global Fund. If the approach is successful, the GAC said, it will be considered for wider implementation. Global Fund financing is contingent upon LS-MOH procuring one mobile van (using funds from its co-financing commitment) before the end of the first quarter of 2019. “Non-compliance will result in grant funds being reprogrammed,” the GAC stated.

#### **Matching funds**

Nigeria was awarded \$14.0 million in matching funds for the “finding TB missing cases” priority area. In the opinion of the TRP, Nigeria’s initial request for the matching funds did not sufficiently explain how the proposed interventions would contribute to the goal of finding missing cases. The issue was

addressed during grant-making and a revised plan was submitted which contained enough details to satisfy the TRP. The GAC noted that Nigeria failed to meet the increase in allocation condition, one of four conditions for accessing matching funds. This condition requires that the country invest more for the given priority area in programs funded by the 2017–2019 allocation compared to programs funded by the 2014–2016 allocation. However, in light of the expected catalytic impact of the matching funds, the GAC decided to waive this condition.

### **Co-financing**

According to the GAC, domestic financing in Nigeria remains a critical issue requiring continued attention. The GAC said that the majority of the willingness-to-pay requirements from the 2014–2016 allocation period were expected to be met by substantive commitments by the Government of Nigeria to a recent project on integrated testing and treatment. However, the GAC said, budget execution reports are not readily available at the federal or state levels, so tracking expenditures is challenging. In the end, the government and the CCM were unable to provide satisfactory evidence that the willingness-to-pay commitments were met. As a result, in December 2017, the Global Fund **reduced Nigeria’s 2014–2016 allocation** by \$170.61 million, an amount that is greater than the entire allocation of most countries.

Regarding the co-financing requirements for 2017–2019, the GAC said that the government was expected to commit to investing the required amount. However, the GAC noted that given the fiscal and economic situation in the country, fulfilment of that commitment faces “significant constraints and challenges.” As a result, the GAC said, the Secretariat proposed that certain conditions be included in the grant agreements that would enable the Global Fund to closely monitor attainment of the commitments. The Secretariat was also seeking a revised commitment letter from the federal government and a commitment letter from the State of Lagos.

### **Missing Cases**

A major issue with TB in Nigeria is the low TB case finding for both adults and children. In 2017 only 104,904 TB cases were detected out of an estimated 407,000 of all TB cases expected to be detected in 2017.<sup>3</sup> This indicates a treatment coverage of just 25.8 per cent. This leaves a gap of 302,096 cases which were either undetected or detected but the cases were not notified especially in “non DOTS

sites”. According to the World Health Organisation Nigeria is among the ten countries that account for 64% of the global gap in TB case finding. India, Indonesia and Nigeria account for almost half of the total gap. A total of just 1,783 drug resistant TB cases were notified out of an estimated 5,200. The Federal Ministry of Health has declared 2018 a year to accelerate finding and notification of TB cases in Nigeria. The huge gap in TB case finding is much higher among children aged zero to 14 with a child proportion of seven per cent for 2017.

### **Active case finding**

In order to improve the TB case finding Nigeria has added active case-finding in key affected populations. The health minister said this included people living with HIV, children, urban slum dwellers, prisoners, migrants, internally displaced people and facility based health care workers. Over 11,500 TB cases were detected through active house to house case searching in 2017. Although this is a useful initiative, the number of TB cases detected is a small percentage of the missing 300,000 cases of TB in Nigeria.

### **TB in children**

It is estimated by the WHO that 30,000 children get TB in Nigeria each year. There are also 47,000 children that are eligible to receive preventative treatment, which would help to prevent them from getting TB. However, only about 8,500 children actually receive this preventative treatment. Nigeria has however started to use the new TB treatment for children. This is the treatment that is both dispersible and flavoured and so it makes it much easier for children to take.<sup>4</sup>

### **Treatment supporters**

Studies have shown the important role played by treatment supporters. The support needs of patients whilst taking treatment which include the monitoring and supervision of daily drug taking,

motivational support to take the drugs as expected, provision of support for feeding (when there is little food), support for provision of transportation cost to visit TB clinic when the need arises. Patients with Treatment Supporters who were offered these supports tended to complete their treatment regimen and were less likely to default. There is more about food & TB and nutrition & TB.

### **Diagnosing TB**

USAID has provided Nigeria with two vans for mobile testing and treatment of TB. Although this is a useful initiative, with just two vans for the whole of Nigeria this initiative has a limited impact. The country has however progressed to having 6,753 DOTS centres compared to 3,931 in 2010. The total number of microscopy centres has increased from 1,148 in 2010 to 2,650 in 2017 and the total number of Genexpert machines installed in the country has increased from 32 in 2012 to 390 in 2017. However at the annual meeting of the NTBLCP it was noted that there is sub-optimal use of GeneXpert machines across the country.<sup>5</sup> It was also noted that the machines break down frequently due to thunder storms.

### **HIV/TB collaborative activities**

Nigeria has made progress with TB/HIV collaborative activity and currently 96% of people with TB in Nigeria and 82% of people presumed to have TB in Nigeria know their HIV status. In addition 84 per cent of co-infected people receive antiretroviral therapy (ARVs) and CPT.

### **Treatment of Drug resistant TB**

Treatment centres for drug resistant TB have increased from 10 in 2013 to 27 in 2017 and the number of TB reference laboratories has also increased from 9 in 2013 to 10 in 2018. The shorter regimen for the treatment of drug resistant TB was also introduced in 2017, although it is unclear what testing is available for drug resistant TB. This is needed to make sure that people are eligible for treatment with the shorter regimen.

Pulmonary tuberculosis has proven to be a hard nut to crack, because its prevalence continues to be interpreted in double digits as indicated in the current study and previous reports. Despite the step up in the management, control and prevention of PTB through WHO recommended DOTS program, TB is reemerging in the country like a 'malevolent genie' once uncorked will not be easy to be contained. This could be due to other risk factors such as increased incidence of HIV, increasing poverty level and urban explosion as a result of urban- rural migration. Result like the one obtained in this current study is relevant because Infectious Diseases Hospital (IDH) is a referral centre of which TB prevalence there reflect a trend of spread in the general populace around Kano, and its environs, as well as Katsina and Jigawa states.

### Desk Review References

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[http://www.aidspace.org/gfo\\_article/new-implementation-arrangements-global-fund%E2%80%99s-tb-grants-nigeria](http://www.aidspace.org/gfo_article/new-implementation-arrangements-global-fund%E2%80%99s-tb-grants-nigeria)
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3. "302,096 tuberculosis cases undetected in Nigeria - NTBLCP", March 15 2018, Vanguard, <https://www.vanguardngr.com/2018/03/302096-tuberculosis-cases-undetected-nigeria-ntblcp/>
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5. "NTBLCP Annual Review Meeting 2017" NTBLCP, "NTBLCP Annual Review Meeting 2017", <http://ntblcp.org.ng/news/ntblcp-annual-review-meeting-2017>
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## **STAKEHOLDER KEY POPULATIONS PRIORITIZATION PROCESS**

Nigeria is one of the countries with no official statistics about key populations to TB. The prioritization approach was a multi-stakeholder one, which involved diverse group of stakeholders from TB government officials, NGOs to members of key populations. They harmonized and triangulated information between available official statistics and the collective expertise of the stakeholders in the room acknowledging the fact that there were very little usually for most key populations as they are mostly not yet reached by government services. Having individuals belonging to key populations directly (and/or indirectly through NGOs working with or advocating for them) involved in the prioritization process also contributed to the outcome of the prioritization. The stakeholders meeting was designed for the Multi-Stakeholders for the prioritization of the Key Populations. The tool and process to be used for prioritizing key populations was shared and discussed. Findings from the Desk Review were presented at the Multi-stakeholder Orientation for feedback and recommendations.

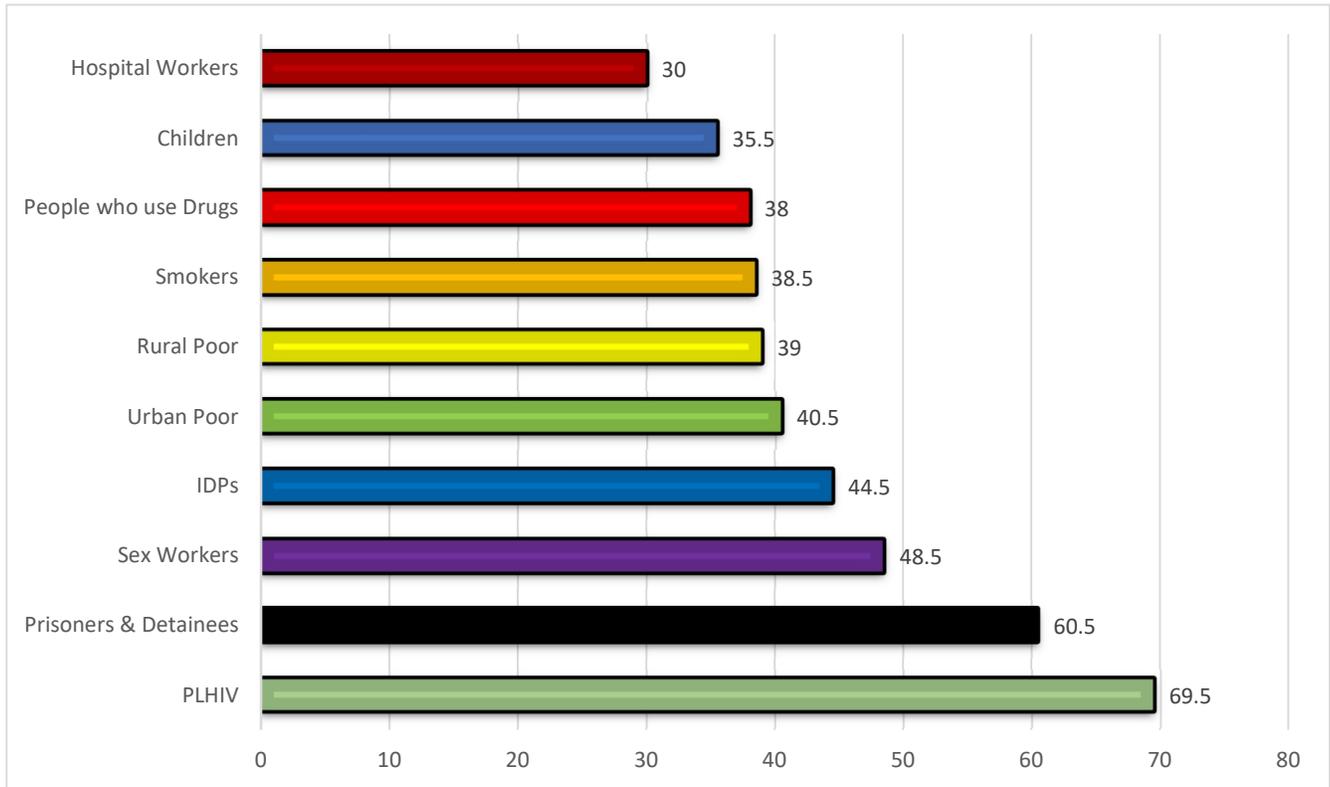
### **Prioritization Meeting in Nigeria**

The prioritization meeting was held amidst TB Stakeholders in Nigeria representing the government and non-state actors and a few key populations and the civil society organizations representing some key populations as well. The meeting also witnessed the presence of the Stop TB Partnership from Geneva – THANDI. The outcome of the process revealed that though the list of key populations look alike across board, there are still state specific populations that are still not yet reached with government interventions. The Nation TB Program team, Government representatives, Civil society, donors, technical agencies, key populations and others came together to prioritize and make recommendations on what needs to be done in order to ensure that the needs of these groups were addressed. Kindly find below the list and the ranking in order of priorities, the KPs for TB intervention in Nigeria:

## SUMMARY OF THE PRIORITIZATION OF KEY POPULATION PROCESS IN NIGERIA

|   | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | Total | Ranks            |
|---|-----|-----|-----|-----|-----|-----|-----|-----|-------|------------------|
| People Living with HIV                      | 6   | 9   | 9.5 | 10  | 10  | 7.5 | 8   | 9.5 | 69.5  | 1 <sup>st</sup>  |
| People with Silicosis                       | 3   |     |     |     |     |     |     |     | 3     |                  |
| Miners                                      | 3   |     |     |     |     |     |     | 2.5 | 5.5   |                  |
|   |     |     |     |     |     |     |     |     | 0     |                  |
| Migrants                                    | 5   |     |     |     |     |     |     | 5.5 | 10.5  |                  |
| Refugees                                    | 6   |     |     |     |     |     |     |     | 6     |                  |
| Internally Displaced People                 | 5.5 | 7   | 4.5 |     | 5   | 9.5 | 6   | 7   | 44.5  | 4 <sup>th</sup>  |
| Nomadic Populations                         | 3.5 |     |     | 8   |     |     | 5   | 6.5 | 23    |                  |
| Prisoners & Detainees                       | 6.5 | 10  | 9   |     | 6   | 10  | 10  | 9   | 60.5  | 2 <sup>nd</sup>  |
| People who Use Drugs                        | 3.5 |     | 9   | 8.5 | 6   |     | 5   | 6   | 38    | 8 <sup>th</sup>  |
| People with Alcohol Dependency              | 2   |     |     |     |     | 9   | 3   | 7.5 | 21.5  |                  |
| Smokers                                     | 3   | 10  |     | 9   |     | 6.5 | 3   | 7   | 38.5  | 7 <sup>th</sup>  |
|   |     |     |     |     |     |     |     |     | 0     |                  |
| Sex Workers                                 | 2.5 | 5   | 9   | 5.5 | 5.5 | 7.5 | 6.5 | 7   | 48.5  | 3 <sup>rd</sup>  |
| Lesbian, Gay, Bisexual & Transgender        | 2   | 2.5 | 10  |     | 4   |     | 4.5 |     | 23    |                  |
| Indigenous Populations                      | 2   | 1   |     | 5.5 |     |     | 2   | 4   | 14.5  |                  |
| Homeless                                    | 3.5 | 4   |     |     |     |     | 5   | 5.5 | 18    |                  |
| People with Mental or Physical Disabilities | 4   | 4   | 4.5 |     |     |     | 4   | 4.5 | 21    |                  |
| Urban Poor                                  | 5.5 | 4.5 | 4.5 | 9   | 4.5 |     | 3.5 | 9   | 40.5  | 5 <sup>th</sup>  |
| Rural Poor                                  | 3   | 3.5 |     | 5.5 | 5.5 | 10  | 3   | 8.5 | 39    | 6 <sup>th</sup>  |
| People with Diabetes                        | 3.5 |     |     |     |     |     | 3   | 6.5 | 13    |                  |
| Children                                    | 3   | 3   |     | 6   | 4.5 | 5   | 5.5 | 8.5 | 35.5  | 9 <sup>th</sup>  |
| Elderly                                     | 1.5 |     |     |     | 2.5 | 6   | 5.5 | 6   | 21.5  |                  |
|   |     |     |     |     |     |     |     |     | 0     |                  |
| Hospital Workers                            | 2.5 | 1   |     | 5.5 | 6.5 | 4   | 5.5 | 5   | 30    | 10 <sup>th</sup> |
| Prison Workers                              | 1   | 1.5 |     |     | 5   |     | 1.5 | 2   | 11    |                  |
| Refugee Camp Workers                        | 1.5 |     |     | 5.5 | 3.5 |     | 2   |     | 12.5  |                  |
| Community Health/ Outreach Workers          | 2   | 1   |     | 5.5 | 3   |     | 1   | 2   | 14.5  |                  |
| Hospital Visitors                           | 1.5 |     |     |     |     |     | 1   | 1.5 | 4     |                  |
| Prison Visitors                             | 1   |     |     |     |     |     | 1.5 | 1.5 | 4     |                  |
| Peri-prison Communities                     | 1   |     |     |     |     |     | 1.5 |     | 2.5   |                  |
| Peri-mining Communities                     | 1.5 |     |     |     |     |     |     | 1.5 | 3     |                  |
| Sex Worker Clients                          | 1   |     |     | 5   |     |     | 3.5 | 2.5 | 12    |                  |
| People Who Use Drugs Family Members         | 1   | 1.5 |     |     |     |     | 1.5 | 1   | 5     |                  |
| Miners Family Members                       | 1.5 |     |     |     |     |     |     | 1   | 2.5   |                  |

|                               |     |   |  |    |   |   |   |   |      |  |
|-------------------------------|-----|---|--|----|---|---|---|---|------|--|
| People at risk of zoonotic TB | 3.5 |   |  | 10 |   |   | 2 | 1 | 16.5 |  |
|                               |     |   |  |    |   |   |   |   | 0    |  |
| Street kids                   |     | 3 |  | 10 |   | 6 |   | 5 | 24   |  |
| Taxi Drivers                  |     |   |  | 10 | 4 |   |   |   | 14   |  |
| [Insert others as needed]     |     |   |  |    |   |   |   |   | 0    |  |



The first 10 prioritized TB key population group are People living with HIV, Prisoners & Detainees, Sex Workers, Internally Displaced Persons, Urban Poor, Rural Poor, Smokers, People who Use Drugs, Children and Hospital Workers. Other key population groups that were identified in the list include Miners, People with Silicosis, Migrants, Nomadic populations, People with Alcohol Dependency, LGBTQI, Indigenous populations, Homeless, People with Mental of Physical disabilities, People with Diabetes, Elderly, Prison Workers, Refugee camp workers, Community Health/Outreach workers, Hospital visitors, Prison visitors, Sex worker clients, family members of people who use drugs, Miners' family members and People at Risk of Zoonotic Tuberculosis.

## **STATE LEVEL PRIORITIZATION**

A mini prioritization process was conducted in the states and the outcome was not in any way different from the national priorities. The cases of TB were grossly not specifically clear with regards to key populations. The findings discovered inadequate data management with respect to categories of patients. The best response was the urban and rural dwellers in most facilities visited.

## **NEWLY IDENTIFIED KEY POPULATIONS**

The findings from the prioritization and rapid assessment showed that Street kids (Skolombos and La-Caseras), Truck drivers, Taxi Drivers, Okada riders (motorcycle transporters/operators) Keke NAPEP Drivers (tricycle transporters), Casual laborers in factories & industries and Quarry workers are still populations to focus and reach the target. The list is envisaged to be endless as these were the new KPs from the states surveyed which were only 4 states out of 36 states and FCT. In Lagos state, the urban slums and people living in highly populated areas like the Hausas in most Sabo settlements are usually at risk of the spread of TB. The Detainees in police cells, Traditional Birth Attendants in populated rooms are still areas being focused. Some of these were however, not mentioned in the national list.

In Kano, the population with TB are mostly housewives. The source of the TB may not be determined, however this may be associated with the living condition of the people, cultural and socio-economic factors. Other possible factors may include little or no enlightenment campaigns and difficulty in accessing treatments, and poor laboratory diagnosis.

*“My wife cannot to go hospital without my permission” – Muslim Cleric.*

## **Rapid Assessment in 4 Geo-Political Zones of Nigeria**

### **FOCUS GROUP & KII**

This was a qualitative study conducted among the stakeholders and TB patients in Nigeria (Benue, Lagos, Kano and Cross River) to investigate the barriers encountered in TB care services. Information was acquired through a focused group discussion (FGD) and key informant interview (KII). To recruit participants snowballing was done for the KII and homogeneity of participant was maintained in the selection for focus group discussion. The FGDs conducted among members of community service organisations (CSOs), DR-TB supporters, female TB patients, male TB patients, NGO TB group, and members of TB management in the State ministry of Health and TB home care givers. While there were XY KIIs with selected health workers and 6 TB patients. Interviewers guide were developed to collect information from the selected stakeholders using the voice recorder and notes were taken during the interviews to contextualize the interview and focus groups findings and to confirm the validity of interpretations. An interpreter was involved in Kano when in rural community of Kano. The interviews were conducted in English and transcription of the audio recording was done verbatim. The assessment was carried out in 4 goe-political zones in Nigeria. (1) South-West-Lagos; (2) South-South- Cross River; (3) North-Central-Benue; and (4) North-West-Kano. It was qualitative analysis using key informant interviews and focus group discussions.

The assessment included site visits to selected TB treatment sites in the States visited and an independent perspective on the processes involved in accessing TB diagnosis, treatment and care were noted. The FGDs comprised members of the eligible population only from diverse sectors of the population and comprised those who fulfill the eligibility. Questions focused on opinions and experiences about other key population members and not about the participant themselves alone. Each FGD had a maximum of 12 participants drawn from the following groups:

- FGD with male representatives of TB patient groups or TB patients in an identified TB treatment centre in the State (Urban or Rural)

- FGD with female representatives of TB patient groups or TB patients in an identified TB treatment centre in the State (Urban or Rural)

In each of the 4 locations, between 6 - 8 numbers of Key Informant Interviews were held with the following key influential persons. The people interviewed were mostly Government staff working with the sample population, Non-governmental organization (NGO) staff and health care providers who work directly with the population through service provision and outreach, Reps of Key Populations prioritized by the Core Group, People who come into contact with the population such as bar owners, employers, health clinics, border patrol and customs agents, TB Services Providers/ Health care providers (mix of both public and private facilities), Religious Leaders (Christian and Muslim), Community Leaders, MDR –TB care provider, Reps of Civil Society Groups working on TB in the respective States drawn from existing TB networks.

**Findings:**

Majority of health providers from government and partner organisations including civil society organization involved in TB care provision had some idea about signs and symptoms for presumptive TB as those common symptoms such as coughing for more than two weeks and with haemoptysis, fever, profuse sweating, sleepless night, weight loss, slowness of breath and tiredness were mentioned during the interviews. There was knowledge among health workers about the diagnosis method available for TB, as the most commonly used method which is applied for diagnosis of TB is Acid-fast Bacilli (AFB) sputum smear microscopy. The application of the more sophisticated molecular technique for diagnosis of TB and MDR-TB using Gen expert was not available in every laboratories. The present study further revealed the aspect that posed challenges to TB programming and management, and the themes that were identified presented as follows based on the existing theory on the challenges of TB management

The findings from the prioritization and rapid assessment showed that Street kids (Skolombos and La-Caseras), Truck drivers, Taxi Drivers, Okada riders (motorcycle transporters/operators) Keke NAPEP Drivers (tricycle transporters), Casual laborers in factories & industries and Quarry workers are still

populations to focus and reach the target. In Lagos state, the urban slums and people living in highly populated areas like the Hausas in most Sabo settlements are usually at risk of the spread of TB. The Detainees in police cells, TBA clients in populated rooms are still areas being focused. Some of these were however, not mentioned in the national list during prioritization process.

## **GENERAL INFORMATION ABOUT THE POPULATIONS**

The Global Plan defines '**key populations**' as people who are vulnerable, undeserved or at-risk of TB infection and illness. The Global Plan recommends a separate operational target of reaching at least 90% of the key populations through improved access to services, systematic screening, active new case-finding methods - and providing all people in need with effective and affordable diagnostics, treatment and care. From the 4 sites of this assessment in Nigeria, findings identified key populations in the 4 states according to estimates of the risks faced, population size, particular barriers to assessing TB case, gender-related challenges.

In Lagos, Health-care workers, PLHIV (1/3 of patients), Someone who live in over-crowded conditions, Prisoners, People that are using some hard drugs, Malnutrition, Smokers and Travellers in AC. In Kano, Poor people in urban slums, PLHIV, Detainees, Children, People that are using some hard drugs to treat rheumatism, Zoonotics and Schools. In Benue, Hospital workers, PLHIV, Prisoners, People who have severe kidney disease, Commercial Drivers, Rural Poor, Market women and Religious worshipers. In Cross River state, People who have HIV/AIDS, Relatives of TB Patients, Urban slum dwellers, People that are using some hard drugs to treat rheumatism, Children, Casual labourers in Quarries, Old Netim Bakoko (Sabo) Hausa Gettos & Nassarawa group.

### **DOTS spread**

More than half of the patients who were interviewed in the study noted that the distance from their homes to the DOTS centers was very far. The DOTS provider however did not agree to this fact, he mentioned how referrals are done to the nearest facilities. Treatment difficulty is usually experienced by patients due to distant location of DOTS. There were reports of patients missing their treatment because there are no treatment centers in their own community and will have to travel long distances to another community where a treatment centre is available. In Cross River, the distance has been bridged with available DOTS in many communities and the government is expanding the sites to the most rural communities.

### **Lack of support and funding problems**

The lack of support and funding were also found as major deterrent to TB health services. There were reports of delays in the disbursement of counterpart funds by the respective agencies meant for the running of TB programmes in the State and at the local government levels. Lack of political will by government to support TB programming was also reported as some of the hurdles faced by TB programs. Little or no support in terms of funding is given to the agencies that are managing TB services. With the advent of HIV/AIDS programmes and the rise in the incidence rate of Non-Communicable Diseases and other health interventions which are now getting more attention from the government and partner organisations, TB programmes are now receiving comparatively low support which is now creating constraints in the management and control of TB. “We need Support for funds. The government is the source of the counterpart fund and if the money is released we will be able to use the money for training and to buy equipment, training materials and modules, and also to give incentives. We are just managing without funds- we just sit here when patients come we give drugs and go, but we need training for health personnel, training for the health supervisors...” (DR-TB Treatment Supporter, St Vincent Benue State, private facility)

### **Lack of staff training**

Issues of lack of provision of training and workshops for the health personnel providing TB services

cropped up in many of the interviews. Some of the healthcare providers felt they lacked the skills and necessary knowledge to improve the TB care services currently experienced as they suggested that they needed training or to be sent to attend health workshops on TB. “We need a lot of support from the government as was earlier said, because as health workers we need knowledge but we don’t have any benefits of attending workshops and trainings, nothing in the past years.” (DR-TB Treatment Supporter, St. Vincent, Benue) However, for some of the participants at other DOTS centers who had received training for TB management the participants said that such training was reflected in quality of service that they provided in their facility, indicating that training is paramount for better TB health care provision.

### **Attitude of health workers**

The intolerant attitude of some health workers towards patients at the health centers was reported as some of the challenges faced by patients. Patients reported to suffer discrimination, maltreatment and even stigmatization at the hands of the health workers. DOTS providers are not particularly fingered in this. But there is a huge complain about the negative attitudes of healthcare providers generally in the health facilities.

### **Patients Related Barriers**

Malnutrition and co-infection Poor nutrition of patients contributed in the difficulty encountered in the management of TB cases. Health workers reported that the poor nutritional intake of the TB patients was a major factor limiting the recovery rate of TB patients. One TB NGO staff who when asked what the major barriers to TB case management were, a first response was

*“HIV causes weakening of immunity of an individual, so a person may have had TB germ but not the disease, but if the person gets infected with HIV then immunity of the person drops and then disease comes up. There are still some other factors that reduce immunity; even stress can reduce immunity, that’s why we advise people to take rest when they think it’s necessary” –*

*PLHIV*

In Kano, patients visiting Infectious Disease Hospital have overcome the social stigma, they care more

for their lives than what people will say. In most cases, people do not want to visit the facilities known for infectious diseases but those who care about their lives visit.

### **Poor TB knowledge and practices**

Awareness and knowledge about TB can help mitigate the impact of an adverse outcome for the disease. For example, knowledge about signs and symptoms of TB, preventative measure, awareness of availability of service and the proper infectious disease control practice can reduce the spread of TB infection. However, where the knowledge and practice towards the infectious disease is poor the eventualities and outcome of the disease will not be good. There are a few remarks of NGO Staff and patients relating to their knowledge and practice which highlights barriers to TB.

*“When people are aware of their health problems or have knowledge of symptoms of TB then they won’t stay at home. If not for the active search that we are doing very few cases come up to the facilities. Talking about awareness, once people don’t know the services that are available it won’t be accessed.” -NGO staff.*

When a female TB patient was asked about the things that could make TB spread, she had this to say;

*“I was advised not to spit everywhere to prevent spreading the disease” (Female TB patient).*

*“I contacted this disease through sexual intercourse with my wife, who has been coughing for long.” (Male TB patient).*

- This indicates that for those who do not receive such advice, inadequate practice from lack of knowledge will predispose to more spread of the disease. A community leader in Calabar lamented on the poor health seeking behaviour as a result of inadequate knowledge of TB. This was reported across majority of the respondents in all the states covered. So many attributes the cause of TB to exchange of cigarettes, drinking of alcoholic drinks, witchcraft, drinking of too much cold water and with all these the tendency to go for medical checkup is not there. Many begin treatment from the nearby chemists (59%) and patent medicines vendors, some do visit traditional healers (12%) while only a few visit the health facility (29%) for medical attention. In Kano State, 83% female respondents do not visit hospital until their

husbands approve it. This is also a socio-cultural barrier in seeking care. Whereas, the husbands can visit health facility for care without any discussion with their wives. Benue people believe that there are gods being offended to get down with TB. TB has a local name that is really promoting stigma and discrimination in most communities. In Nigeria, people are still under the impression that TB is a disease of poor people, mostly of those living in slums. The rich and affluent persons need to know that their cooks/house-helpers/drivers can be asymptomatic carriers of this deadly disease, right in their mansions, and hence they can potentially get infected with TB even without stepping into these slums. The consumption of unpasteurized milk or dairy products made from raw milk is another potential source of TB for humans, as there is ample evidence that TB gets transmitted to humans from cattle especially in Kano.

### **Availability & Adequacy of TB Services In The States**

To a large extent, there are DOTS centres in almost every LGA and there are availability of GenXperts in senatorial districts in Nigeria with a minimum of 3 facilities with GenXperts in each state. Most DOTS providers and other workers attending to TB Patients are well trained but there is room for retraining of these healthcare workers on latest findings (new regimen for management of DR-TB and other TB cases. The respondents confirmed that their service providers were good to them and commended them for not being judgmental. The only case of reported hostility was in the case of a TB patient in Calabar who was trying not to adhere to his medication. The DOTS officer coerced him to ensure compliance. Distance of existing facility was a factor to some respondents who are on drugs.

### **TB and Access to TB Related Healthcare**

TB is a major concern in the communities in Nigeria. TB is given different names in different societies. Some attribute TB to curses from their relatives in the village while some see TB as a spiritual attack. The community people do not know where to go if they have TB. The signs and symptoms of TB needs

more awareness among the people. Many people who live beside DOTS centres do not know what services and skills are provided in the facilities. Traditional medicines and unqualified healthcare providers are the first point of call for most people down with TB. Only a few go to the hospital for checkup while coughing. Respondents decried the attitudes of healthcare workers (Not DOTS) as a barrier to going to hospitals. In Cross Rivers, the nurse at the Chest Clinic in IDH commended the government for providing centres everywhere. When asked what can be done to improve access for the identified key populations, she wants the government to expand the DOTS to the riverine areas of the state. She also lamented on the lack of Motor bikes to access rural communities to enable provision of services for the rural dwellers. There are dedicated TB staff in CRS. There were some who use their personal resources to get their targets without waiting for the government or donors' financial supports.

#### **Non-adherence to treatment and medical advice.**

It was observed that the deplorable health condition of the TB patients could add to hinder treatment effort and cause non-adherence while patients on prolonged treatment got discouraged to continue treatment. There were recorded efforts by the State TB team in contact tracing exercises. *“No matter the counselling, some guys are just adamant. They prefer to die than being on drugs that will not allow them to access their HOT drinks”* – CRS TBLS

*“There was a case of an armed robber caught and imprisoned, co-infected patient who cannot resist taking his drugs (Injection drug users), but he is late now.”* – DOTS provider Kano.

*“They are not feeding us well here and they know the drugs make us very hungry and sometimes we will not eat until we take the drugs”* – Prisoner, Kirikiri-Lagos

Poor health-seeking behaviour, Inadequate government funding, lack of IEC materials for awareness, User fees of N500 in CRS and cost of X-Rays.

#### **Socio-Cultural Barriers**

## **Unemployment**

People do not access services even when down with TB because they also report to the health facilities when they have tried all other means to no avail. There are Loss of employment as a result of coming down with TB was a challenge mentioned by participants. Sometimes people who have been diagnosed with TB do not disclose their condition for the fear of losing their job. When employees with TB are discovered they are usually dismissed immediately from their work. Loss of employment poses major economic challenges to patients as the source of income is lost, which besides the direct effect it can have on the patient's capacity to cater for the cost in TB care, families wellbeing can be strained particularly if the patient were to be the breadwinner of the home.

*“When an employer discovers that a staff has TB within two or three weeks they will fire the person, we have cases like that. So patients usually hide to take their drugs”. – Bakery Baker in Benue.*

## **Stigmatization**

Stigmatization was identified as one of the social determinants that can interfere with management of TB. Some patients and health providers reported that stigmatization of people with TB in the community where they come from was a common habit with different local names used as a label on those with TB. Those individual who suffer stigmatization can be at risk of non-completion of treatment.

## **Socio cultural Belief and patronage of traditional healers**

This study observed that traditional beliefs and practices were some of the barriers to TB management as patients can be hindered from receiving formal diagnosis and treatment for TB which can lead to complications of their cases.

*“People told me to take all sorts of leaves that my cough will go, which I often squeezed the leaves and drank, but I was not cured and it got even severe” -Male TB Patient in Benue.*

*“Earlier I was receiving treatment traditionally from my children in Lagos. I have taken some herbal concoction, but after there was no change and my problem even increased before they,*

*my children, took me to the hospital” -Female TB patient.*

*“You know for diagnosis sputum sample is always required; we need sputum for culture, sputum for gen expert, sputum for microscopy. Sometimes when you want to take patient’s sputum specimen they are afraid of what you want to use their sputum for (laugh)!, as if we want to use it for fetish purpose. These are some of the several problem beliefs. Of course if you can’t get the sample you can’t do the diagnosis” - CSO representative.*

In other instances people still attribute diseases such as TB as a spiritual attack that is caused by someone. And in attempts to find cure for their problems through traditional and spiritual means a lot of financial losses are incurred.

*“There was a woman who brought her daughter here who is now placed on drugs. The woman said she had spent a lot of money on sacrifices and rituals thinking it was a spiritual attack from the family, so they sacrificed a goat, ram and offered other kinds of things spiritually, until she finally learnt it was TB. The local people don’t understand what TB is and think it is a spiritual attack and will go on spending money unnecessarily” (DR-TB Patients Treatment Supporter).*

### **Overcrowding and poor ventilation**

Overcrowding and poor ventilation are some of the issues that were identified that can influence TB spread. For instance, the use of air-condition in rooms reduces rooms normal ventilation and does not allow air to be expelled from the room. In the circumstance where a TB infected person is in the room and expels the bacterium into the air while coughing transmission can easily occur.

### **Prisons**

There are good DOTS services in the Nigerian Prisons. The healthcare workers in the prisons are well trained, but there is need to retrain the providers on latest information and practices on TB. In Kirikiri Prisons, there were no female TB patient as at the period of this study, but there were 8 male patients. The male TB patients testified to the good attitudes of the healthcare providers in the prisons. They lamented the lack of good food that can make them adhere to their treatment. “The

drugs make us more hungry” cried by a prisoner. There may be need for isolation of TB patients from the other inmates but there are no such infrastructural facility to accommodate them thus the high spread of TB in the highly congested prisons of Nigeria. A major factor fueling the spread of TB in the prisons is the high level of congestion. The prisons should have a temporary space for the management of the inmates with TB for some weeks in treatment before sending back to his/her room.

Screening of prisoners on entry into prison may have a role in early case detection. This is reflected by the study as 1.1% in this study were already being diagnosed with tuberculosis before incarceration. Overcrowding, poor nutrition, poor hygiene and long prison sentences promote tuberculosis. These are dominant features of Nigeria prisons and this may explain why 90% of cases were first diagnosed in prison. Overcrowding, poor ventilation, poor nutrition and inadequate or inaccessible medical care can facilitate the spread of disease in the prisons. Prisons act as a reservoir for TB, pumping the disease into the civilian community through staff, visitors and inadequately treated former inmates. Therefore, improving TB control in prisons will benefit the community at large. Community TB control efforts cannot afford to ignore prison TB. Most prisoners come from underprivileged sectors of the general population and are more likely to have contracted tuberculosis before their arrival in prison. In Kirikiri, a TB patient stated

*“I have contacted TB before coming to prison. I ran to the hospital after trying so many drugs suggested by my friends.” – Musa, Medium Prison, Lagos.*

## **PLHIV**

The PLHIV community have very good understanding of the devastating implication of TB on their health, the compromised immunity of PLHIV contribute to the effect of TB in them.

## **OBSERVATIONS & CHALLENGES IN ACCESSING TB SERVICES BY THE KEY POPULATIONS**

- 100% Patients on drugs across the states, confirmed the friendly attitudes of the Healthcare workers caring for them.
- DR-TB patients have maximal care in ensuring effective management and control of the spread of the disease.
- Majority of respondents 93.5 percent were not reached with either government programmes or any other form of enlightenment by even the civil society.
- They were client-initiated as a result of sickness that led them to the health facility for treatment after trying hard on trado-medical and across the counter medicines to no health changes.
- The myths and misconceptions around the possible causes of TB and the health seeking behaviour of the community members is too low.
- There is still high level of stigma associated with TB in most communities with reported cases of isolations and maltreatments by both family and health care providers in some cases.
- Some attributed the cause of TB to religious and fetish or totem inclinations.
- Despite government investments on TB awareness, there is still a huge low knowledge of TB among the identified KPs in all the states.
- Community response are donor-driven where available.

## **RECOMMENDATIONS**

- There is need for each state to identify their state-specific key populations at sub-national level according to estimates of the risks faced, population size, particular barriers to assessing TB case, gender-related challenges, and are also encouraged to report on progress in TB with data that are dis-aggregated by key population.
- Donors and development partners should design state appropriate interventions that will make each state address the gaps as against a generic template of program designs.
- Key populations are central to responding to TB in the best way. More KPs should be involved in the processes of Global Funds in Nigeria.

- There is need to strengthen existing social networks and organizations for support, advocacy and kinship as they can have a positive impact on the key populations.
- Improved funding for community system strengthening
- There should be funding of NGOs/CBOs to make them work with the identified KPs to draw action plans and implement with them
- Implementation of effective TB programmes, improved diagnosis and treatment of TB, provision of support for patients, increased awareness and education on TB by the healthcare workers and increase in government support.
- Implementation of programs suggestions were given to adopt in many other locations those effective community TB service.
- Ownership of TB programmes by stakeholder was suggested as imperative to sustainability of TB programmes.
- Capacity building of health providers to better equip health workers of the prerequisite skill and experience for management of TB cases in the community and provision of incentives and due payment to health providers were suggested.
- There should be adequate and effective counseling and treatment for TB patients, adoption of new technologies for diagnosis, adequate follow-up and new active case finding strategies.
- Provision of incentives and financial support to help ameliorate the financial burden of TB patients were suggested “Meal and transportation fare with effective monitoring and evaluation for effect and impact on a long term” .
- There were also a lot of suggestions for an increased awareness and education on TB through increased media awareness creation and community advocacy and sensitization.

## **CONCLUSION**

The Global Plan recommends a separate operational target of reaching at least 90% of the key

populations through improved access to services, systematic screening, active new case-finding methods - and providing all people in need with effective and affordable diagnostics, treatment and care.

## **ANNEXES:**

### **A. Multi-stakeholder Working Group Members and their Organizations**

### **B. List of Documents Reviewed**

The list of documents reviewed include the following:

- Report of the LEA conducted in Nigeria
- National TB Programme Reports (2012- 2017)
- Report of prior Key Populations Assessments (e.g. TB in the Private Sector conducted by USAID/SHOPs Plus)
- National TB Strategic Plan, Ministry of Health
- Nigeria Tuberculosis Facts Sheets
- Nigeria Country Operational Plan 2017
- Partnering to Achieve HIV & AIDS Epidemic Control by PEPFAR
- National TB Policies, Guidelines
- WHO Global TB Reports (2016 & 2017)
- National AIDS Response Survey (Latest)
- National HIV & AIDS Strategic Plan 2016 – 2020

### **C. Multi-stakeholder Working Group Meetings Agenda**

1. Orientation meeting
2. Prioritization meeting
3. Validation meeting

### **D. Key Population Prioritization Tool Used**

|  |
|--|
| <b>Qualitative Research Methods and Participants</b> |
|--|

| Method   | Participants  | Sex    | Location                            |
|--|---|--------|-------------------------------------|
| <b>Observations</b>                                | Health Care workers attending to TB patients  | Mixed  | Lagos, Cross Rivers, Kano           |
| <b>Focus Group Discussions</b>                     | Representatives of PLHIV Support groups   | Female | Lagos                               |
|  | Representatives of PLHIV Support groups   | Male   | Lagos                               |
|  | TB patients in Incarcération (Prisons)  | Male   | Lagos                               |
|  | Community Members   | Mixed  | Benue (Rural)                       |
|  | Current/Former TB Patients  | Male   | Lagos                               |
|  | Current /Former TB Patients   | Female | Cross Rivers (Urban)                |
|  | Current/Former TB Patients  | Mixed  | Kano (Urban)                        |
|  |   |        |                                     |
|  | Community Health Volunteers (Uwar Gida)   | Female | Kano                                |
|  | CSOs working on TB  | Mixed  | Benue                               |
|  | CSOs working on TB  | Mixed  | Cross Rivers                        |
|  | IDP Camp residents  | Mixed  | Benue ( Rural)                      |
|  | Urban Slum Dwellers   | Male   | Cross Rivers                        |
| <b>Key Informant Interviews TB Programme Staff</b> | 4 nos. State TB Programme Managers<br><br>*One of the States also had their State Team members in attendance) | Male   | Lagos, Cross Rivers, Kano and Benue |
|  | 2 nos TBLS  | Male   | Lagos                               |
|  | 1 no TBLS   | Female | Lagos                               |

|  |  |                    |                                     |
|--|--|--------------------|-------------------------------------|
|  | 2 nos TBLS   | Female             | Benue (Rural)                       |
|  | 1 DOTS Provider  | Male               | Benue (Rural)                       |
|  | 1 TBLS   | Female             | Cross River                         |
|  | 2 TBLS   | Male               | Kano                                |
|  | 1 DOTS Provider  | Male               | Kano( Semi Urban)                   |
|  | DOTS Provider, Prisons   | Male               | Cross Rivers                        |
| <b>Health Care Providers</b>                               | 2 Doctors in charge of TB/HIV clinics  | Male               | Lagos                               |
|  | Doctor, Male Prisons   | Male               | Lagos                               |
|  | Development Partner staff  | Male               | Benue                               |
|  | Officer in Charge of DR TB Ward  | Male               | Benue                               |
|  | Nurse, DOTS clinic   | Female             | Cross Rivers                        |
|  | Matron in charge Female Prisons  | Female             | Lagos                               |
|  | Doctor in charge of IDP Camp   | Male               | Benue                               |
| <b>People affected by all forms of TB including MDR-TB</b> | 7 nos People affected by all forms of TB including MDR-TB in urban, semi urban and rural communities | Female             | Lagos, Cross Rivers, Kano and Benue |
|  | 5 nos People affected by all forms of TB including MDR-TB in urban, semi urban and rural communities | Male               | Benue and Kano                      |
| <b>Community / Religious Leaders</b>                       | 5 Community /Religious Leaders   | 4 Males & 1 Female | Cross Rivers and Kano               |

### **Possible Key Populations**

1. People Living with HIV
2. People with Silicosis
3. Miners
4. Migrants
5. Refugees
6. Internally Displaced People
7. Nomadic Populations
8. Prisoners & Detainees
9. People Who Use Drugs
10. People with Alcohol Dependency
11. Smokers
12. Sex Workers
13. Lesbian, Gay, Bisexual & Transgender
14. Indigenous Populations
15. Homeless
16. People with Mental or Physical Disabilities
17. Urban Poor
18. Rural Poor
19. People with Diabetes
20. Children
21. Elderly
22. Hospital Workers
23. Prison Workers
24. Refugee Camp Workers
25. Community Health/ Outreach Workers
26. Hospital Visitors
27. Prison Visitors
28. Peri-prison Communities
29. Peri-mining Communities
30. Sex Worker Clients
31. People Who Use Drugs Family Members
32. Miners Family Members
33. People at Risk of Zoonotic Tuberculosis