Newsletter

[Special edition]

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Message from the MSF Head of Mission for Kenya

My first experience with kala azar was in 1998. I was in Dadaab then as a field coordinator. We started to see kala azar cases around the camps, mainly in the nomadic people living in the area. From there we realized that there were many cases in the feeding projects in Somalia and also in Wajir.

In Dadaab, the kala azar patients were treated on a case by case basis as we did not receive so many patients. It is later in 2007 that we started a major response treating kala azar patients in Pokot, near the border with Uganda, where the disease is endemic. We started by working in tents, as no inpatient facilities existed yet, and at the time treated 60 patients. Today MSF treats and provide care to 40-50 people every month.

Initially one of the main difficulties was getting the full support of the MOH, in terms of prioritizing kala azar treatment but this is slowly changing as they have put in place a multi-year strategic plan for neglected diseases. There are also other partners who are coming on board.

Seeing the patients recover and the positive impact access to this treatment has had on the community has been very gratifying. As a Medical Doctor it has also been very rewarding on the medical side, even though the effective treatment of kala azar requires painful daily injections for over 30 consecutive days, the difference it has had on the people’s lives has been immense. The patients stay at the hospital for the duration of their treatment along with a family member or friend to help them with washing, cooking and to provide support during their stay.

MSF does not charge these patients for any services provided at the Kacheliba facility. We hope however that the national program will get the backing - also financially - to enable them implement their activities. The main focus should stay on assuring diagnostics and treatment in the affected areas.

To improve treatment and to save more lives MSF is also lobbying for the approval of rapid tests in Kenya as a first line diagnostic tool and for the Kenyan Ministry of Health to provide kala azar treatment free of charge.

Together I think that we can fight this disease and save the lives of the majority of the 4,000 people affected in Kenya every year.

Joke Van Petteghem,
MSF Head of Mission for Kenya
Controlling kala azar in Kenya has been a challenge for many health facilities in areas where the disease is endemic. This can be attributed to various factors that include: lack of diagnostic test kits, expensive drugs, and prolonged hospital stay as the treatment takes 30 days despite the poor conditions most of the affected community members live in.

More over, the disease requires specialized training to improve its detection among health personnel. Among the health facilities it’s only the Provincial and District Hospitals that are able to diagnose, treat and manage the disease. The peripheral health facilities have not been equipped to diagnose the disease hence they can only refer the patients. However, even at the district and provincial level they do experience drug shortages due to procurement and distribution channels.

The surveillance of the disease has been hampered by its presence in remote areas that are risky to reach and sometimes are invaded by cattle rustlers. So even though the disease is already recognized as a neglected one, there is a need to give it more priority in order to also improve on its surveillance and reporting.

The introduction of Neglected Tropical Diseases Programme (NTD) under the Ministry of Public Health and Sanitation tries to address some of these challenges. The NTD multi-year strategy (2011-2015) aims at guiding the implementation of Neglected Tropical diseases in an integrated way to maximize on the available limited resources cost effectively.

Some of the earmarked activities for the control of leishmaniasis include: training of health personnel in order to improve their skills on disease diagnosis, treatment and management, improvement of diagnostic kits and drugs supply, enlisting the drugs to be among the essential drug list, creation of awareness among the affected communities, improving its surveillance and reporting and empowering the communities to be able to protect themselves from infection.

Introduction of mobile clinics that will serve the unreachable areas will also be considered. This will ensure that every Kenyan is served wherever he lives. Applied research on the prevalence of the various forms of the disease, the vector species and the factors that lead to its transmission will also be addressed.

The challenges are great, but we are finally on the right track.

Dr Davis Wachira
Leishmaniasis Control Focal person, Neglected Tropical Diseases Programme, Ministry of Public Health and sanitation.
What is kala azar?

Kala azar, or visceral leishmaniasis, is a disease caused by the Leishmania Donovani Complex parasite. The name “kala azar” literally means “black fever”.

Kala azar is spread to humans by the bite of infected sandflies, which transfer parasites into the human body, and where parasites attack the internal organs. Without proper and timely treatment, kala azar is fatal in 99 percent of cases. It is an endemic disease primarily present in Sudan, Ethiopia, India, Bangladesh, Kenya and Brazil.

After malaria, kala azar is the second-largest parasitic killer disease, costing 500,000 lives worldwide each year and putting 350 million people around the world at risk. More than 85 per cent of the cases occur in Bangladesh, India, Nepal and Sudan.

Kala azar is characterised by an enlarged liver and spleen, irregular fever and anaemia, cough, loss of appetite and body weight and enlarged lymph nodes.

Historical background

Kala azar first came to the attention of Western doctors in 1824 in Jessore, India (now Bangladesh), where it was initially thought to be a form of malaria. The Indian state of Assam gave the disease its other common name, Assam fever. Kala azar is derived from “kala” which means black in Sanskrit, Assamese, Hindi and Urdu, and “azar” the Persian word for disease. Kala azar refers to the darkening of the skin on the extremities and abdomen that is symptomatic of the Indian form of the disease. The agent of the disease was also first isolated in India by Scottish doctor William Leishman and Irish physician Charles Donovan, working independently of each other. As they published their discovery almost simultaneously, the parasite species was named after both of them - Leishmania Donovani.

The disease is endemic in West Bengal, where it was first discovered, but has its most deadly impact in north and east Africa. It can also be found throughout the Arab world and southern Europe. And while the disease’s geographical range is broad, it is not continuous.
The disease outbreaks tend to cluster in areas of drought, famine, and high population density. In Africa, this has meant a nexus of infection centred in Sudan, Kenya, Ethiopia, and Somalia. Living conditions here have changed very little in the past century, and the people are constantly displaced which renders them vulnerable to infections.
Kala azar in Kenya

Background:

First detected in Kenya in 1935 in the Northern districts of Mandera and Wajir, kala azar was later also detected among soldiers in a battalion manning the northern border of Kenya during the Second World War. Since then the disease has regularly re-emerged in the areas where it is known to be endemic.

It is endemic in hot semi-arid lowlands of Rift Valley, Eastern and North Eastern provinces of Kenya. Although the disease burden is largely unknown, it is estimated every year about 4,000 people are infected with the disease. The main areas affected are: Baringo, Pokot, Turkana, Samburu, Isiolo and Wajir districts.

There is also no data on mortality attributed to the disease but if left untreated, kala azar kills 99 percent of the time.

A population ignored:

The limited reach of Kenya’s health services plays a crucial role in the delay in tackling this disease. Most kala azar patients do not receive adequate treatment and sufferers in remote areas have no means of calling attention to their plight. Their suffering is barely visible. For the most part they remain hidden in the remote rural regions or in city slums where they are beyond reach. Internationally there is scant knowledge about kala azar as wealthy industrialised countries are not affected.

Furthermore, because the people vulnerable to kala azar and those who have the disease live impoverished and marginalised lives, there is no incentive for pharmaceutical companies to invest in developing new medicines, vaccines or diagnostic products. The drugs currently being used to treat the disease were developed many years ago,
70 years ago in the case of Sodium Stibogluconate (SSG), which are known to have frequent side effects, and are difficult to administer.

Making treatment affordable:

Until mid-2006, the only drug available in Kenya to treat kala azar was a costly patented drug called Pentostan. MSF has lobbied the Kenyan government to allow for the use of a cheaper generic drug called Sodium Stibogluconate (SSG) and in 2007 SSG was registered in Kenya.

Where Pentostan costs 330 US$ per treatment course, SSG costs 70 US$, which means that instead of one patient, almost five can be treated if the generic is used. MSF has been providing the treatment for free since it has started treating kala azar in Kenya.

As kala azar can be difficult to diagnose, MSF is also advocating for the use of a rapid diagnostic test that is ideal for resource-poor settings and is encouraging the use of these tests in health centers around the district.

Long lasting solutions: Technical training for health workers

For many patients, misdiagnosis of kala azar often leaves them suffering unnecessarily. For there to be longer term solutions for the treatment of kala azar, it is necessary that health workers in the regions most affected receive adequate training. In response to this need, in 2011 MSF in collaboration with Ministry of Public Health and Sanitation launched a training programme in Kacheliba, Pokot and the neighboring districts of Turkana Central and Turkana South. Health workers from Wajir, Habaswein and Isiolo (Merti) districts are as well included in the training programme. MSF Teams will support and train Ministry of Health workers in case detection the disease, diagnosis, use of first-line treatment and, where that fails, in the use second-line treatment.

MSF CALLS FOR:

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<tr>
<th>Lowering price of existing drugs</th>
<th>This is a key barrier to patients receiving treatment as the costs of the current treatments are high and unaffordable to them.</th>
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<tr>
<td>Registration of drugs</td>
<td>Not all treatment options are registered in all endemic countries, making entry and use of these drugs in those countries difficult.</td>
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<td>New and simplified diagnostic tools</td>
<td>A practical and rapid diagnostic needs to be urgently included in the Kenyan national guidelines</td>
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<td>Investment in research and drugs</td>
<td>MSF calls for research on new drugs that are less toxic, given orally, with shorter administration and safe for women of child-bearing age and during pregnancy. Improved treatments are also required for patients who are infected with HIV. In Kenya, 17 day long treatment course with a combination of SSG and Paromomycin will be introduced very soon</td>
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<td>Improved funding of national control programs</td>
<td>Some degree of integration of kala azar diagnosis and treatment within public health facilities is already possible with existing tools and could be bolstered by improved funding and political will. The Kenyan Ministry of Health should provide kala azar treatment free of charge.</td>
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Treating Kala Azar in Ethiopia and Sudan – MSF’s experience

In Ethiopia, MSF started its response to kala azar in 1997. MSF established the country’s first vertical kala azar program in Humera, Tigray Region. In the following 12 years, MSF treated more than 2,600 kala azar patients. The program was finally handed over to the Ministry of Health in 2009. Today, MSF runs another kala azar treatment centre, in Abdurafi town, in Amhara Regional State.

In the North, MSF has focused on kala azar amongst seasonal migrant workers and settlers in rural Amhara region. Prevalence of HIV/AIDS in this region is double the national average at 4.3 percent prevalence, and as a whole, more than 30 percent of kala azar patients are HIV infected. The highly transient population, the high incidence of kala azar with the risk of co-infection with HIV/AIDS and/or TB, and the general absence of treatment options significantly increases the risks that the people in and around Abdurafi are being exposed to. Kala azar cannot be permanently cured in HIV infected patients, and will inevitably result in repeated relapse, even if patients are on antiretroviral therapy (ART).

Throughout 2010, MSF in Ethiopia treated 394 kala azar patients and 99 HIV/AIDS and TB co-infection cases with kala azar. A total of 1,307 patients were enrolled in the program.

In Sudan where kala azar (visceral leishmaniasis), is endemic, MSF reached an eight-year peak in the south of the country in November 2010. MSF treated 2,600 people for the disease in Upper Nile, Unity and Jonglei states.

In addition to this, in Sudan MSF opened a kala azar treatment centre in Al Gedaref state in collaboration with the Ministry of Health, and treated 1,100 patients.

Kala azar patients tell their stories:

**Long Distances to get treatment**

**Monica, mother of 6 children**

I barely slept when Rioner, my third born son, got sick. He was in so much pain; his fever would not go down. Every day, I would wake up early in the morning, clean him up and set off, together with my husband, for the journey to a health facility to find out why he was sick.

We live in Konyau which is eight kilometres away from the main centres like Kacheliba and Kenguria. The dispensaries are even further away. We have travelled to so many hospitals, both private
and public, and they all gave us different diagnosis as to what was wrong with my son.

After so much travelling and spending a lot of money on his health, my husband and I almost gave up. We packed our bags to go back home and wait for nature to take its own course. We knew he was going to die. My neighbour, who apparently had dealt with kala azar before, heard about my son's health and came to give me advice and told me which hospital I should visit. I decided to give it one last try.

We arrived at the Kapenguria hospital around noon. Immediately we were directed to the MSF kala azar facility. There Rioner, who is five, was tested and admitted on the spot. He was weak, emaciated, and had lost a lot of blood. His nose was always bleeding; something I later learnt is a common symptom of kala azar. I kept looking at the doctors, and asking them if he would be alright?

We stayed at the hospital for a month while Rioner got treatment. When they first told me that I would have to stay at the hospital for so long, my worry was how much those 30 days would cost me, as I had run out of all the money I had. I was so surprised when we were not even charged a cent! Every day I took care of Rioner, and the doctors did what they knew best. I began to see changes in my child, I was happy. This child, who we had lost all hope for was becoming his old self again. Today, he is well and running around.

Misdiagnosis and toxicity

Francis Somwoto, a 40 year old mechanic

It all started with a fever. Then I went for a blood test, and got confirmation that I had malaria. I was put on medication and a few days later, there was no change. I went back to the hospital and this time I did a typhoid test. I also tested positive and was put on different medications. Still nothing changed.

I then decided to travel all the way to Konyao hospital. Here I tested positive for kala azar. I was referred to Kacheliba hospital for treatment and when I got there I was immediately admitted at the MSF facility for a month. I have a wife and 5 children. I am their sole bread winner. Even though I did not have to pay for anything at the hospital, which I am grateful for, it still cost me because I lost income when I had to stop working for a month. But that was the least of my worries. I was getting better at last. The medication is really strong, sometimes after the injections, my legs would be paralysed for three hours. The problem we have here is the distance to health facilities, and also lack of health personnel in most of these facilities who can treat this disease.

Traditional medicine

5 years-old Rotich and his mother Regina

It started with a fever and Rotich was wasting away and his stomach was swollen. If he ate anything it would just swell even more.

First we tried traditional medicines to see if his condition would improve. There is a special tree among the Pokots that is thought to heal almost all diseases. So I would grind the leaves until they were fine. Then we would make an incision into his skin to reduce the swelling in his stomach and apply the leaves. We also made syrup with the leaves and made him drink the liquid, but this too did not work. Instead, he developed di-
arrhoea, and so we stopped the incisions and the syrup.

We then went to a traditional medicine man, who gave us some herbs. The instructions were to heat the herbs on a broken piece of clay, get under a blanket and allow the steam to go over the baby’s body.

When the leaves failed to work, we decided to go to the local dispensary. There I was told he had malaria and typhoid, and we were given medication but this too did not work. In fact, he kept getting worse. I took him back to the hospital where his stool was taken and tested for Bruscelli ulcer. They gave me medication for this too but it did not work either. That is when finally we were referred to the MSF clinic to have him tested for kala azar. Today, thanks to the treatment my baby is well again.

Blood Transfusion

Martha Kilel, a 38-year-old housewife

I had travelled for nearly a whole day, from Baringo to Kacheliba, to take my husband who had kala azar to the MSF clinic. After arriving at the facility, the staff tested my husband, and immediately I was told that he was in urgent need of a blood transfusion. In Kacheliba, the closest place for this was Eldoret. This was more than another 100km away. I thought he would not make it. He was as white as paper. I prayed and prayed, and we made it to Moi referral Hospital in time. We were fortunate and he was put on medication immediately.

After this experience, I hope the ministry of Health can look into this issue urgently, as some people may not be as lucky as my husband was.
MSF Staff:

James Rotich, Chief WATSAN (Water and Sanitation) Supervisor

I have been working for this project since 2006. I started in Amudat, Uganda and now I work here in Kacheliba. My role is to provide the hospital with clean water. We have managed to dig boreholes, and also track water from the river to the hospital.

When we arrived in Kacheliba, we had to really start from scratch. Despite this disease being in this region for ages, many people did not know what it was.

Locally kala azar is known as “termes” which means “swollen stomach”. Most of the communities here believe that it is a curse and use traditional medicine before seeking medical assistance. The result is that many people have died needlessly of kala azar.

When we started we did a lot of health education talks at the markets, speaking mostly about kala azar. We also used radio programmes to create awareness in this region. Slowly we have managed to change the perceptions of the people here, and now kala azar patients are getting services at the hospital first. Since this is the only hospital in the region, we get referrals from as far as Baringo which is about 100km by road.

We have clean water in the hospital; we also give the patients and their caregivers’ food rations, so that all they need is to look for transport to reach the facility, and the rest we provide. Of course, the treatment is free.
What is MSF?

Médecins Sans Frontières (MSF) is an international medical humanitarian organisation created by doctors and journalists in 1971. Today, MSF provides aid in nearly 60 countries to people whose survival is threatened by violence, neglect, or catastrophe, primarily due to armed conflict, epidemics, malnutrition, and exclusion from health care or natural disasters. MSF provides independent, impartial assistance to those most in need.

MSF first opened offices in Kenya as a support base for its operations in neighbouring Somalia and Sudan in 1987. In 1992 MSF started operations in Kenya, primarily providing assistance to Somali refugees. MSF runs programmes in Kenya, providing treatment and care for people affected HIV/AIDS and tuberculosis and also the Somali refugees and also responding to the plight of Somali Refugees. However MSF medical teams also run a kala azar programme in the Pokot region, near the Ugandan border. In early 2009 MSF started working in Dadaab refugee camp.

In 2010 MSF teams began working in the remote Ijara district, which is also host to many refugees. Staff focused on reproductive healthcare, working in Sangailu dispensary and Hulughho hospital, and aim to expand services to include immunisation and tuberculosis (TB) care.

Disease outbreaks, drought, nutritional crises and floods are common occurrences in Kenya and emergency response is a key part of MSF’s work in Kenya.

For more information, visit www.msf.org

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