

Tuberculosis is a global emergency and priority communicable disease of the poor. Kenya, in the TB80 group, has nomadic population with high TB prevalence despite 30 years of special approach and relatively low HIV/AIDS. Unfortunately TB Manyatta concept has never been evaluated and there is no documented information about nomadic communities lay perceptions, and social cultural beliefs and practices regarding TB. A cross-sectional study aimed at describing perceptions, beliefs, practices of the nomads regarding TB and TB manyatta concept was conducted in three ASAL districts of N.E. Kenya. Six FGDs were held with community leadership, 371 TB patients and 46 CHW were interviewed, also, a 2-year TB records reviewed.

Nomads knew tuberculosis for generations, had specific vernacular names, established handling and care procedures for it. TB was perceived as dangerous; highly infectious, incurable, killer disease with serious social stigma caused by curse but transmitted inheritably or through sharing food, drinks or linen. TB patients, due to stigma, attribute causes to trauma (20.8%), other illnesses (16.8%), sharing with TB patients (13.1%), and hard labour (10.7%). Recognized signs were those of late stage of PTB, the only form known. Men were perceived to get TB more often due to socio-economic ills. Infection puts to doubt the integrity of patients, cases are considered *hasid* (evil person out to infect others) and even after treatment, suspicion remains and history haunts forever. Traditional remedies were considered ineffective while modern treatment is believed to cure. TB manyatta is considered a noble course but only a treatment center. Patients took a mean 6.11 and 332.14 days from onset to first seek help at general health facilities (GHF) and TB Manyatta, respectively. Misdiagnosis at GHF (75.1%), self-treatment, use of alternative remedies (66.8%) and stigma increase patient's delay. Only after symptoms persist (58.6%) and suspect's health deteriorates (41.4%) are TB Manyatta services sought. Patients reported coughing without covering their mouth (93.3%) and spitting in houses and compound (99%) during the average year long illness before treatment. Nearest health facility was on the mean 17.13 kms, all had only 8 (1.3%) CHW trained in TB management and referred 32.7% patients to TB manyatta. Each TB Manyatta served a population of 254,067 and an area of 38,166 Km². Districts level DOTS coverage was 5.3%. All TB manyattas lacked community involvement, Public health education, CHW training in TB control, contact and defaulter tracing or follow-up. None had linkages with other ministry of health programmes and non-government health units. Majority of cases were from host districts (85.7%) and 69.75% from the towns or divisions within which the TB manyatta and hospitals were located. Perceived cause of tuberculosis, resultant stigmatization, and risky socio-cultural practices were the major societal factors hindering control effort. Poor access to low detection, and diagnosis quality at GHF, confinement of control to TB manyatta, were serious operational limitation. On-the-ground operations negate WHO guidelines for National Programmes. Case distribution suggests distance was the single most important factor in treatment seeking at TB Manyatta. Policy backed proactive public health initiatives to bridge knowledge and effort gaps are recommended