REPUBLIC OF KENYA

MINISTRY OF HEALTH

Public Private Mix for TB Prevention and Care Action Plan 2017-2020

Ministry of Health

National Tuberculosis, Leprosy and Lung Disease Program

FOREWORD

The End TB Strategy which is the vehicle expected to lead to the health- related target under the Sustainable Development Goals emphasizes building strong linkages with all health care providers. The non-state or private health care sector is an important player in the delivery of health services in Kenya and ranges from large health institutions that offer state of the art health care services to unlicensed informal providers. The TB patient pathway analysis recommends greater engagement of the formal and informal private sector as a critical strategy to finding the missed TB cases.

This sector offers numerous opportunities for advancing public health gains in TB prevention and care due to its vibrant, growing and always in a competitive mode which could be utilized to enhance access and quality of TB prevention and care services. The Kenya Tuberculosis Prevalence Survey 2016 calls for the need to engage the private sector as one of the key strategies to provide a robust response that will ensure that no TB cases go undetected, untreated and will help place Kenya on the road towards ending TB.

This action plan gives greater emphasis on planning the overall PPM response. It has a national scope, a pathway to achieve national coverage using existing models and/or newly proposed models of care, and details about targets, costing, and assigned manpower and funding, broken down by PPM areas (e.g. hospitals, general practitioners (GPs), pharmacists, regulation, etc). The action plan document is designed to facilitate the integration of strong PPM components into national TB strategic plans.

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PREFACE

The importance of engaging all providers in tuberculosis (TB) care and prevention has been recognized for well over a decade in Kenya. Over 90,000 (40%) people with TB are missed each year by health systems and therefore do not get the care they need and deserve. Patient pathway analysis in Kenya have shown extensive use of the private sector, with an average of 42 % (in of initial visits being in the private sector. Failure to engage with these providers can result in long delays in diagnosis and treatment, resulting in further TB transmission, and poor quality diagnosis and treatment, leading to the development of multidrug-resistant TB (MDR-TB). The programmatic response to this need has been public-private mix (PPM) for TB prevention and care.

Engaging all relevant health care providers in TB prevention and care through PPM approaches is an essential component of WHO's End TB Strategy. PPM for TB prevention and care represents a comprehensive approach for systematic involvement of all relevant health care providers in TB control to promote the use of International Standards for TB Care and achieve national and global targets to end TB. PPM encompasses diverse collaborative strategies such as public-private (between NTP and the private sector), public-public (between NTP and other public sector care providers such as general hospitals, prison or military health services and social security organizations), and private-private (between an NGO or a private hospital and the neighborhood private providers) collaboration. The aims of this work are to identify people with TB symptoms as soon as possible, no matter where in the health system they first present, and to establish mechanisms that allow for efficient and high quality diagnosis and treatment.

This action plan have will help promote, scale up and enhance the quality of the public –private mix approach for TB prevention, care and support in Kenya. It is hoped that staff at all levels of the NTLP, technical and funding partners and the wide array of non-state health care providers will be guided by this action plan to enhance the scope and quality of PPM in Kenya.

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ACRONYMS

ART	Anti-retroviral therapy
CHS	Centre for Health Solutions
CPT	Cotrimoxazole Preventive Therapy
CXR	Chest X-ray
DOT	Directly observed treatment
FBO	Faith based organizations
GDP	Gross domestic product
GNI	Gross national income
HIV	Human immunodeficiency virus
IPT	Isoniazid preventive therapy
ISP	Informal service provider
ISTC	International standards of TB care
KANCO	Kenya AIDS NGOs Consortium
KAPTLD	Kenya Association for the Prevention of Tuberculosis and Lung Diseases
KCOA	Kenya Clinical Officer Association
KEMSA	Kenya Medical Services Authority
KMA	Kenyan Medical Association
KPA	Kenyan Paediatric Association
M&E	Monitoring and Evaluation
MDR-TB	Multi-drug resistant tuberculosis
NAK	Nurses Association of Kenya
NGO	Non-government organisation
NHIF	National Health Insurance Fund
NSP	National strategic plan
NTLD	National Tuberculosis, Leprosy and Lung Disease programme
PAL	Practical Approach to Lung Health
PLHIV	People living with HIV
PMDT	Programmatic Management of Drug-resistant Tuberculosis
PMS	Post-market surveillance
PP	Private Practitioners
PPB	Pharmacy and Poisons board
PPM	Public-private mix
PSK	Pharmaceutical Society of Kenya
TB ARC	Tuberculosis (TB) Accelerated Response and Care (ARC)

TB	Tuberculosis
TB/HIV	TB disease and HIV infection
TWG	Technical working group
UHC	Universal health care

Contents

1. INTRODUCTION

Kenya has a total population of 43 million spread across 47 counties[1]. Majority of the population is rural, and 24% population live in urban settlements. Nairobi, the capital city is the main urban area with a population of over 3 million people. The country is classified as a lower-middle income country with GNI per capita at US$1340, and has witnessed sustained economic growth with GDP annual growth rates expected to increase upwards from 5.87% in 2016 during 2017-2020[2]. The country has chronic poverty with an estimated poverty headcount ratio of 45.6% at national poverty line[3].

Purpose and scope

The action plan for public-private mix is a 4-year framework developed to guide the National Tuberculosis, Leprosy and Lung Diseases Programme (NTLD) and its partners in implementing public-private mix activities in Kenya. The plan describes goals, objectives and interventions for expanding and scaling up current PPM approaches and outlines innovative new models for PPM service delivery. The PPM action plan promotes the coordination and partnerships among NTLD, partners and private providers.

NTLD mission and strategic goal

The goal of the National Strategic Plan for TB control (2015-18) is to accelerate the reduction of tuberculosis through provision of people-centered, universally accessible, acceptable and affordable quality services in Kenya. The five strategic objectives as defined in the NSP include: sustaining gains made in TB control, intensifying efforts to find the "missing" TB cases, reduce transmission of TB, prevent active disease and morbidity, and enhancing the quality of TB care services. The impact measures include reducing the TB incidence by 5% by 2018, compared to baseline 2014 figures. The NSP for TB control is currently due for revision in 2017 to align with the END TB strategy. The strategic goals and objectives outlined in this PPM action plan have been designed to contribute to the overall NSP mission, while attempting to align with the END-TB strategy.

PPM goal and strategic objectives

The PPM action plan aims to strengthen and expand the engagement of private sector in the fight against TB, in order to strengthen efforts in finding missed cases, sustain treatment outcomes among diagnosed cases, and improve access to TB and MDR-TB care services. The goal will be to contribute to the national End TB targets by increasing the private health facilities contribution

[1] Kenya Facts and Figures, 2015; Kenya National Bureau of Statistics

[2] World bank country data, Kenya, 2016

[3] World bank country data, Kenya, 2016

in TB case notification from 15% in 2015 to 30% by 2020. The key strategic objectives are as follows:

Strategic objective 1: Ensure effective leadership and stewardship of PPM through resource mobilization, active oversight/management, and coordination of PPM activities

Strategic objective 2: Strengthen collaboration with professional associations and private sector partners

Strategic objective 3: Scale-up implementation of current service delivery PPM models and introduce innovative PPM models for TB care

Strategic Objective 4: Enhance the quality of PPM implementation by standardising monitoring, recording and reporting of PPM activities

Strategic Objective 5: Strengthen capacity building for public-private mix activities

Strategic objective 6: Strengthen the regulatory, legislative framework and promote UHC/social protection mechanisms for PPM activities

Plan development

The development process was guided by the NTLD and its key partners. The methodology involved reviewing key NTLD documents relating to public-private mix for TB care in Kenya. The background review was followed by an on-field visit to Nairobi, Kenya during the period 9-13 January 2017, in order to facilitate a national PPM consultation to develop the PPM action plan. A core PPM team comprising of NTLD PPM focal point, Advisor NTLD, and key partner representatives from KAPTLD, TBARC was formed during the briefing discussions. The core team accompanied the consultant during field visits and held wide-ranging discussions on PPM approaches to support the development of the draft action plan.

Interactions were conducted with key stakeholders: KAPTLD, CHS, KMA, KANCO followed by visits to the Pharmacy and Poisons board (PPB), Kenya Medical Services Authority (KEMSA), Nairobi county health services; and in-depth discussions with private providers in Nairobi (Nairobi private hospital, Melchizedek private hospital, Menelik private clinic and Lancet private laboratory). Visits were also made to the Kibera slum to interact with the informal services providers. A national consultation involving key stakeholders was conducted on 12 Jan 2017. Thematic areas were identified based on interaction with the core team and ensuing field visits. Over 50 participants attended the consultation and were divided in to 4 groups to facilitate in-depth discussions on the identified thematic areas. Representatives from NTLD, KAPTLD, Stop

TB National partnership, CHS, Nairobi hospital, KANCO and other partners participated in the group discussions providing experiential inputs on public-private mix for TB in the country.

The core team met to discuss the recommendations emanating from the national consultation on Day 4 afternoon and the entire day 5 to review the current NSP PPM activities, propose innovative PPM activities as part of the draft PPM action plan. A basic draft of the action plan with PPM activities was developed by 13 January 2017 as a result of the various deliberations with NTLD and partners working in TB care.

Plan execution

This action plan steers the focus of the NTLD and partners on the strategic PPM interventions that if implemented well has the potential to bring about significant improvements in TB care services in the country. The plan has been developed emphasising greater involvement of the private providers, where it is presumed a significant number of TB cases are being managed. The PPM models and interventions represented in this action plan were identified based on existing evidence and experience. NTLD and partners recognise that objectives and interventions must be flexible enough to accommodate new information. It is anticipated that the mid-term review due in early 2017 will provide new information that will need to be incorporated to this action plan. It may also be highlighted that while this action plan outlines key objectives and PPM interventions for the period 2017-2020, operational plans to be developed annually will refine interventions/approaches as necessary throughout the timeline of action plan implementation. Importantly, this proposed action plan as described in Section 7 aims at promoting collaboration among TB stakeholders to create a shared vision in the fight against TB in the country.

2. SITUATIONAL ANALYSIS

National context

NTLD has made substantial progress in TB care over the last decade: scaling up of TB-HIV services and IPT, expansion in availability and utilizing new diagnostics such as GeneXpert, sustained treatment outcomes both among drug-sensitive and drug-resistant TB, scale-up of MDR-TB diagnostic and treatment services, and introduction of improved paediatric formulations among others.

Despite the substantial service expansion by NTLD, gaps in case detection and accessing TB care services persists. Tuberculosis is a key public health problem in the country with incidence estimates for TB (all forms) at 233 per 100,000; and mortality due to TB (excluding HIV) at 20 per 100,000[4]. The principal causes of deaths and disability-adjusted-life-years (DALY) attributes TB to 6.3% of all deaths and 4.8% of DALYs in the country[5]. WHO has defined 3 new high-burden lists for the period 2016-2020: TB, MDR-TB and TB/HIV. The high-burden countries account for 87-92% of the global burden. Kenya is ranked among the top 20 countries across each of these 3 high-burden lists due to the absolute number of TB, MDR-TB and TB-HIV cases reported by the country.

The total tuberculosis cases notified during 2015 was 81,518, with the public-private mix activities contributing 15,531 cases that account to 19% of all case notifications within the country[6]. The treatment success rate among new cases and RR/MDR-TB was 87% and 82% respectively. TB patients with known HIV status was 97%, and 95% of co-infected patients were placed on anti-retroviral treatment.

A TB prevalence survey was ongoing and final analysis with results was expected by mid-2017. With an estimated incident cases per year at 138,105 the survey analysis indicate approximately 40 % missed TB cases within the country. Greater engagement of the private sector and expansion of TB services within the public sector remain critical to finding missed cases and addressing TB care within the country.

[4] Global Tuberculosis Report, 2016

[5] Kenya Health Policy 2012-2030

[6] Global Tuberculosis Report, 2016

Health care sector in Kenya

The country has a diverse health sector with the government owning 52% of the health facilities, while the remaining 48% is owned by FBOs, NGOs, and private institutions[7]. The public health sector include dispensaries, health centres, sub-district hospitals, district hospitals, regional or provincial hospitals and referral/tertiary hospitals also serving as teaching hospitals. Health centres and dispensaries are closest to the communities and provide primary preventive and curative services to population.

The public health facilities provide TB diagnostic and treatment services to the population. Within the scope of public sector, are also the military and prison health facilities. The military health facilities catering to the army personnel and their dependants, provides diagnostic services for TB, TB treatment including treatment for drug-resistant tuberculosis, HIV counselling and testing, CPT & ART, and record/report TB cases to the NTLD. The prison health facilities cater to the 89 prisons having a total prisoner population of approximately 40,000. Most of the prisons have a health facility that provide diagnostic and treatment services for TB.

The population utilizes health services from both the public sector and private sector. The private sector comprises of faith based organizations (FBOs), non-governmental organizations (NGOs), private self-financing institutions, for-profit individual private providers and non-qualified or informal providers. The NGOs/FBOs are the second largest provider of health services after the public services. Christian Health Association of Kenya and Catholic Church operates the largest network of faith-based health providers in the country. Anecdotally, the NGO/FBO provide 40% of all health care within the country. Specifically for TB, the NGO/FBO facilities provide diagnostic and treatment for TB, HIV counselling and testing, CPT & ART, and record/report TB cases to the NTLD.

The private sector may be more accessible, located closer to the homes and workplaces for presumptive TB cases, making it easier for people to utilise the more flexible operating times thereby enhancing access to TB care. This may be relevant both in urban areas (slums) as well as remote rural areas of the country. Self-financing private or for-profit private hospitals and facilities are spread across the country. The large private institutions provide tertiary health care services and mainly serve the affluent or those covered under corporate insurance coverage. The medium-small sized hospitals, also called nursing homes are abundant providing health and TB services for a fee.

[7] Guidelines for management of tuberculosis in Kenya, NTLD, version 2013

The individual private practitioners encompass medical doctors, clinical officers, nurses, medical laboratory technologists among others. KAPTLD conducted a mapping exercise in March 2015 that identified 2050 private facilities (individual and institutional) across 14 counties in the country. The coverage of these identified private facilities providing TB care has increased from 10% (210/2050) in 2015 to 17% (346/2050) by June 2016[8]. It may be highlighted that most of the private medical doctors are based in urban areas, while clinical officers do work in semi-urban or rural areas within the counties. Almost all patients seeking care from the private practitioners pay from their out-of-pocket for consultation, laboratory services and medicines.

The informal sector include traditional healers, herbalists, faith healers, grocers and shopkeepers, home based care groups providing care to PLHIV, community health care workers and community health extension workers[9]. The poor and vulnerable population often seek care from traditional healers, herbalists and other informal providers. Current evidence suggests that most patients initially self-treated with herbal remedies or drugs purchased from kiosks and pharmacies before seeking professional care[10]. Majority of the symptomatic (81%) sought informal remedies from private providers, and delayed seeking care from designated TB treatment facilities[11]. Initial delay ranged 3 weeks to several years with misinterpretation of symptoms, non-specific symptoms and financial constraints as main reasons reported for delay.

Corporate sector provides health services at workplace for workers and their dependants. While NTLD and partners have engaged the corporate sector in the past, opportunities to widen engagement of the corporates exists, particularly among those industries attracting poor and vulnerable populations to work in urban areas.

[8] PPM TB ARC report, KAPTLD, Q2 2016

[9] Guidelines for management of tuberculosis in Kenya, NTLD, ver 2013

[10] Ayisi et al; Care seeking and attitudes towards TB treatment; BMC Public Health 2011, 11:515

[11] Mutinda et al; Health seeking behavior, practices for TB; Journal of biology, agriculture and health care

PPM response in TB care

The NTLD has been a front-runner in implementing public-private mix activities in the country. The implementation of PPM activities was initiated in 1997 as a collaboration between NTLD and KAPTLD. KAPTLD has served as the only intermediary agency and medium of engagement reaching the for-profit or self-financing hospitals and providers for the last two decades. The initial phase of implementation targeted practising private chest specialists to work closely with the NTLD. While the national programme provided support through drugs, the chest specialists promoted standardised TB case management and mobilised peers to support TB care activities. KAPTLD subsequently negotiated with pharmaceutical companies procuring subsidized anti-TB drugs, and expansion covered over 250 private health facilities to diagnose and manage TB patients in line with International Standards for Tuberculosis Care (ISTC).

It may however be highlighted that the private provider also offered the patients a choice between free treatment in the public sector and subsidized treatment in their private clinic. As a case-holding mechanism, a pre-payment approach where patients paid for the entire course of treatment upfront was adopted for those patients opting to be treated at the private facility. This ensured patients remained on treatment and the private provider dispensed medicines at specified intervals and monitored patients for adherence, adverse effects and treatment outcomes. The approaches to diagnosis and case management, recording and reporting from these private facilities largely remain unchanged. Over the years, efforts have intensified to promote standardised TB care in the private sector through introduction of the ISTC.

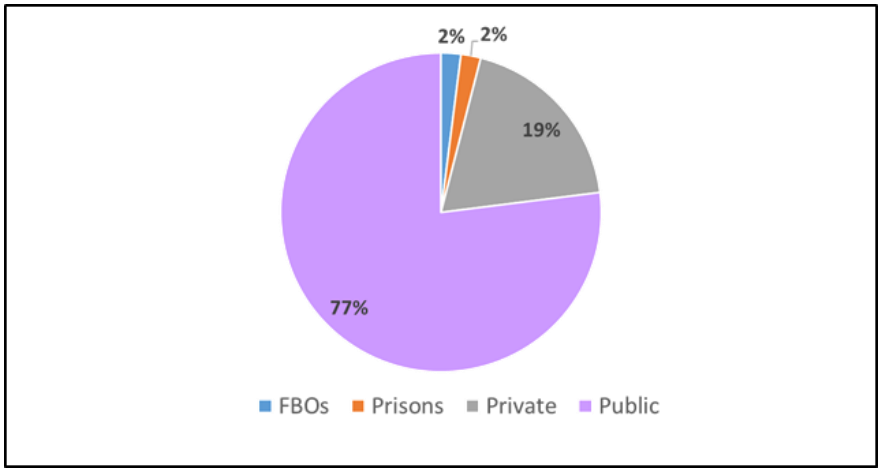

Figure 1: Sectoral contribution to TB care, 2015

Increasingly, many of the private facilities are now receiving free TB drugs from the NTLD and consequently do not charge their patients for medicines. Recent initiatives by the national programme include training and capacity building activities targeting clinicians and nurses on TB care in alignment with National Treatment Guidelines and ISTC. TB recording tools such as TB

case registers are also in use among the engaged private providers and cases are reported to the national programme.

Concerted efforts in engaging all care providers led by NTLD, KAPTLD and partners have consistently contributed to national TB case-finding efforts. This has resulted in a sustained increase in cases notified from the private sector rising from 7160 cases in 2010, 9039 (2011), 11000 (2012) reaching 15,531 cases in 2015. Figure 1 illustrates the sectoral contribution to TB care, with public sector contributing to 77% of all cases notified, FBOs and prisons contributing 2% each, while the private sector contributed to 19% of all case notifications in 2015.

Current PPM interventions

The National Strategic Plan (2015-2018) outlines four key strategic approaches for public-private mix activities. The main priority in the NSP is to scale-up the engagement of private sector actors providing TB care services.

i. Strategic approach 1: Sustaining the gains in areas where PPM is implemented. The core activities under this strategic approach included:
    a. Training health care workers on TB/HIV, PMDT, pediatric TB and PAL
    b. Organize symposia in annual scientific conferences of professional associations such as KMA, KPA, KCOA, NAP, PSK etc.
    c. Facilitate meetings with private health facility managers and staff to implement TB care services.
    d. Conduct supervision to private facility/clinic owners and provide support in implementing TB care services
    e. Counties receiving technical assistance on PPM from national team

The activities enlisted above were aimed to strengthen capacities of the private sector to sustain the implementation of PPM activities. The trainings planned included conducting 20 training events/year; each aimed to build capacities of 30 private sector participants, covering thematic areas of TB/HIV, PMDT, paediatric TB and PAL. These training events were not realised optimally, with the partners now considering the need to redesign and develop an integrated training programme covering all identified thematic areas.

ii. Strategic approach 2: Scaling up the number and diversity of private providers contributing to TB care services, in all counties. The core activities under strategic approach included:
    a. Mapping of private providers across 32 urban areas in 32 counties
    b. Revision of PPM policy guidance and dissemination of PPM guidelines to all counties.

Mapping of private sector facilities was ongoing, with 3 additional urban areas covered (baseline 14 and by end of 2016, 17 urban areas were mapped). The progress of mapping urban areas in the remaining 15 urban areas needed immediate attention in 2017. The PPM guidelines have been drafted as a pre-final version by end of 2016. It is expected that by mid-2017, the PPM guidelines will be finalised and disseminated to all counties implementing PPM activities.

iii. Strategic approach 3: Strengthen coordination mechanisms for PPM at national and county levels. The core activities under strategic approach included:

   a. Organizing PPM technical working group meetings (quarterly)
   b. Conducting annual county-level stakeholder meetings
   c. Recognizing best performing TB sites across all 47 counties (plaques and certificates)
   d. Organizing an annual national PPM meeting

The PPM TWG meetings aimed at promoting coordination for PPM at national level were not conducted as planned during 2015-16. The annual national level PPM meeting is planned for 2017. There is a need to strengthen the coordination mechanisms for PPM both at national level and county level.

iv. Strategic approach 4: Ensure quality of PPM activities for TB care: the activities enlisted under the strategic approach include facilitating peer supervision at county level, data quality audits to selected private facilities to improve surveillance. These activities have not been systematically implemented until end 2016.

Gaps relating to public-private mix

The key challenges in implementing PPM activities in the country as identified in the NTLD mid-term review, 2014 are as follows:

i. Sub-optimal engagement of the private sector: A significant number of private facilities were not yet engaged in TB service provision, particularly in the informal sector.
ii. Case management practices in the private sector are not in alignment with the National Treatment Guidelines and ISTC, especially among the larger private institutions.
iii. Limited inclusion of the private providers in trainings held at county level.
iv. Concerns relating to accountability, where TB cases from the private and FBO providers were not linked or notified to the NTLD.
v. Financial barriers to accessing care in private facilities remain, where costs for diagnosis and treatment caused delay in access to care.

While the NSP 2015-2018 laid out a plan to strengthen engaging all care providers (refer Annex 1), the limited on-site visits and action plan consultation further examined the NSP strategic

approaches to proposed revised PPM strategies as required to comprehensively address the above identified PPM gaps. During the interactions with stakeholders, the need to innovate beyond sustaining current levels of PPM implementation was extensively deliberated. Few areas that were discussed during the national consultation and ensuing core PPM group included:

- Delay in mapping of private providers across the 15/32 urban areas and the imperative need to scale-up the private sector model.
- While new initiatives targeting informal providers were implemented over the last 2 years (mid-2015 onwards under TB ARC project) across 5 urban areas in 5 counties, there is a need to strengthen quality of implementation and scaling-up of interventions involving the informal sector.
- Engaging other key stakeholders such as the corporate sector, pharmacists, private laboratories and define appropriate engagement strategies/models targeting these stakeholders.
- Focus on childhood TB targeting private pediatricians and develop a pediatric PPM model.

3. PROPOSED PPM SERVICE DELIVERY MODELS - 2017-2020

Private sector (institution and individual provider) model

The interventions under the private sector model are aimed to improve access, equity, efficiency and quality TB care through structured and sustainable engagement of the formal private health sector. KAPTLD with support from USAID funded TB ARC project and NTLD implements the private sector interventions in 23 towns across 14 counties. The 14 Counties in the country where the PS model is currently implemented are Mombasa, Kilifi, Nairobi, Machakos, Kajiado, Kiambu, Nakuru, Uasin Gishu, Kericho, Kisumu, Kisii, Migori, Kakamega and Bungoma (target areas in counties are towns with population >200,000).

A critical challenge identified in expansion of the PS model has been the limited financial resources restricting scale-up for effective implementation of TB care involving the formal sector. Proposed implementation of the PS model would include targeting an additional 20 urban areas across 20 counties during 2017-2020. Mapping exercise in each urban area, followed by sensitization events targeting both institutions and individual private providers will be conducted.

Provider engagement and targets: The plan is to increase from engagement of 30 individual providers and 270 institutional providers at baseline (300 facilities in 2016) to engage 150 individual providers and 600 institutional providers by 2020 (750 facilities). Following the expansion, it is expected that 10,596 cases (up from baseline 9000 cases) will be notified through the PS model by 2020 on a yearly basis.

Informal service provider model

KANCO has received support from TB ARC and NTLD to engage the informal providers in TB care. KANCO conducted mapping of informal providers in 5 urban areas across 5 counties, streamlining engagement among informal providers, and sensitizing the informal sector on TB care services. The high-burden counties of Nairobi, Homabay, Kisumu, Tharaka Nithi and hard-to-reach county Marsabit have been included in the pilot phase implementation during June 2015 ending May 2017. The informal providers mainly consisted of herbalists (36%), drug sellers (17%), traditional healers (13%), and traditional birth attendant (13%) among others. A total of 383 informal providers were engaged across the 5 counties yielding 23 TB cases during 2015-2016.

Action plan 2017-2020 proposes scale-up of informal provider model to an additional 20 counties by 2020. Key interventions will include mapping of ISPs, developing data collection tools and IEC tools for engaging the ISPs, conduct sensitization events targeting ISPs, and provide non-financial and financial incentives to optimize their engagement in referring presumptive TB cases. Given the limited yield over a 2-year period, intensive support to ensure quality of implementation

and subsequent monitoring of ISP intervention on case finding outcomes will be essential during expansion of the model.

Provider engagement and targets: The scale-up plan is to expand informal provider engagement from 5 counties to 25 counties by 2020. Following the expansion, it is expected that 2000 informal providers engaged will be responsible for identification and notification of 640 TB cases by 2020 on a yearly basis.

Corporate sector model

There are a number of corporate organizations providing health services to their employees and dependants. There have been few initiatives engaging corporates such as flower farms in Naiyasha, Kenya airways, Central bank of Kenya, Barclays bank, Kenya ports authority linking them to the NTLD providers offering TB services.

However there are no corporate sector intervention planned or systematically implemented under the NSP work plan for 2015-18. Based on the action plan consultation, intervention proposed to conduct a consultative meeting involving key corporates/factories from Nairobi and other counties. The objective is to implement work-place interventions among the corporates/factories/industries that employed poor and vulnerable groups. Illustrative activities could range from screening programmes targeting factor workers, training of peer educators, and treatment support programmes among others. The action plan proposes a work place model to be defined by the end of the consultation exercise in 2017, and ready for roll-out implementation starting Q1 2018 through until 2020.

Targets: It is anticipated that 300 factories with an aggregate employee base of 200,000 workers will be reached by 2020, and approximately 750 cases annually will be diagnosed from screening efforts and active case finding approaches targeting the factory workers. These diagnosed TB cases will be linked to treatment within the NTLD network of providers.

Pharmacist model

A slum TB project implemented by KAPTLD included both chemists and pharmacists as providers of care. Pharmacists are included in the array of providers, as people tend to seek medicines from them for their ailments. The current engagement strategy targeting the pharmacists have been mainly addressing the Pharmaceutical society of Kenya, with minimal direct interventions targeting pharmacists for service delivery.

The objective of the proposed pharmacist engagement model is to promote identification of presumed TB cases by the pharmacist and their prompt referral to the network of NTLD providers to facilitate early diagnosis and management of TB. Key activities proposed in the action plan

include mapping of pharmacists across 5 urban areas/year expanding to 30 urban areas by 2020; and conduct sensitization events targeting pharmacists to promote referrals of presumptive. It is anticipated that 20 pharmacists will be engaged in each urban area, 600 pharmacists over 30 areas by 2020. Financial incentives will be provided tied to a diagnosed TB case from the pharmacist referrals.

Provider engagement and targets: A phased expansion covering 5 urban areas in 2017, 5 additional areas in 2018, 10 additional areas each in 2019 and 2020. Following the expansion, it is expected that 600 pharmacists engaged will be responsible for identification and notification of 2400 TB cases by 2020 on a yearly basis.

Paediatric TB model

Paediatric TB accounts for 9% of all the TB cases reported in the country. Mid-term review 2014 indicated poor integration between MCH clinics, paediatric clinics and TB service providers to facilitate childhood TB diagnosis and treatment; poor identification of presumptive TB cases in children; and low diagnostic capacities for diagnosing childhood TB in the country. Concerns relate to limited access to diagnostics, including CXR, TST and Xpert have resulted in missed TB cases among children.

There are currently no public-private partnership activities for childhood TB in the country apart from periodic consultation with the Kenyan Paediatric Association (KPA). The action plan process explored the possibility to engage the private paediatricians to expand access to TB services for children. NTLD and partners will conduct consultative meetings with KPA to design a working model for paediatric TB in 2017. The paediatric model will examine and define targeted approaches to promote access to quality TB diagnosis and management of diagnosed childhood TB cases. The model will seek to engage private paediatricians across 6 major urban areas (Nairobi, Mombasa, Kisumu, Eldoret, Thika and Nakuru).

Provider engagement and targets: A phased expansion covering 50 paediatricians in Nairobi city, and 10 paediatricians each in other 5 urban areas is proposed during 2017-2020. Following the expansion, it is expected that 100 paediatricians will be responsible for identification and notification of 1000 childhood TB cases by 2020 on a yearly basis.

Laboratory model

There are 285 private laboratories currently providing TB diagnostic services mainly through smear microscopy and few Xpert in the country. Nearly 65% of the private laboratories (185/285) participate in the external quality assurance. It is currently unclear how many TB cases were diagnosed through these private laboratories. Proposed activities under the action plan will

strengthen the collaboration with the 300 private laboratories (additional 15 to be added from the baseline figure of 285 laboratories).

Linkages between public and private laboratories offering TB bacteriology services will be vigorously pursued to ensure that the TB laboratory service is quality controlled and quality assured. Mechanisms will be established to link diagnosed cases from the private laboratories to the NTLD network of providers for appropriate case management. It is expected that 2500 TB cases will be notified through the 300 private laboratories under this initiative.

Universal health care and social protection for TB care

Integrating with the proposed PPM service delivery models, the action plan proposes few activities to promote universal health care and social protection mechanisms for TB care. Under the objective 6.3, activities are suggested to engage the National Health Insurance Fund (NHIF) so as to ensure support for both out-patient and in-patient TB services. The plan also proposes incentives to support transport and nutrition to TB patients from vulnerable groups. This will particularly be targeted for patients from counties with high poverty prevalence and low case notification rates. A consultation meeting has been proposed to discuss UHC and social protection mechanisms for improved TB care.

4. REGULATORY APPROACHES FOR TB CARE

The Public Health Act (Cap 242) revised 2012, Part III relating to notification of infectious diseases, enlists all forms of tuberculosis as a notifiable disease[12]. The act stipulates the obligation of the medical practitioner attending the patient, to notify the TB patient accordingly to the nearest medical officer of health. The law also suggests those failing to notify will be guilty of an offence and liable to a fine not exceeding eighty schillings. However there is limited clarity on enforcement mechanisms currently in place to ensure notification of TB from the private sector. The review suggested in the action plan in 2017, will examine the application of law in practice, policy gaps, enforcement process and establish mechanisms to coordinate with professional associations (KMA, KPA etc.) and other regulatory authorities to strengthen notification from private providers. Anecdotal evidence suggest that pharmacies often flouted the minimal requirement of having a pharmacist or pharmaceutical technologist in retail pharmacies, and distinction between over the counter and prescription-only drugs was lost in practice. Current guidance in the TB programme suggests that no specific regulation limited retail pharmacies, chemists and drug shops from stocking and dispensing TB drugs. Few pharmacies visited in Nairobi during the action plan development however revealed no anti-TB drugs were available for sale over the counter.

Pharmacy and poisons board (PPB) is responsible for regulating the quality, safety and efficacy of all drugs, including TB drugs in the country. During the action plan development, discussions were held with PPB to understand the regulatory approaches governing the sale of anti-TB drugs in the country. The discussions clarified that the 2012 New Pharmaceutical Policy listed TB drugs as a part 1 poison and promoted rational use of TB drugs. PPB led post-market surveillance (PMS) for TB medicines and PMS found no TB drugs in drug sellers and chemists over the last 3 years. Action plan 2017-2020 proposes a detailed review of the regulatory framework for TB drugs and commodities to be completed in 2017. Review among other components to consider studying existing regulations on sale of TB drugs, enforcement mechanisms, conducting post-market surveillance, pharmacovigilance and cohort event monitoring in active surveillance.

The ensuing recommendations from the review to guide specific actions to strengthen regulatory approaches for TB drugs, and improving private sector notifications during 2018-2020, including the idea of implementing mandatory notification for TB cases.

[12] Public Health Act, Chapter 242, Revised edition 2012, National Council of Law, Kenya

5. IMPLEMENTATION ARRANGEMENTS

The NTLD will provide leadership and strategic direction towards the implementation of the PPM activities. The NTLD central PPM unit led by the PPM focal point and NTLD advisory support augmented by the PPM TWG working group and partners will facilitate implementation of PPM activities during 2017-2020.

KAPTLD has been the main intermediary agency implementing PPM activities over the last two decades with support from the NTLD. The proposed activities in this action plan will be implemented by the partners, through intermediaries: KAPTLD (for private sector model, pharmacist model), KANCO (for ISP model) and CHS for laboratory model, pediatric and corporate sector models. The figure 2 below highlights the linkages between NTLD and intermediary agencies, and the linkages with the diverse actors: private (institutional and individual), informal providers, professional associations, pharmacies, corporate sector and the private laboratories.

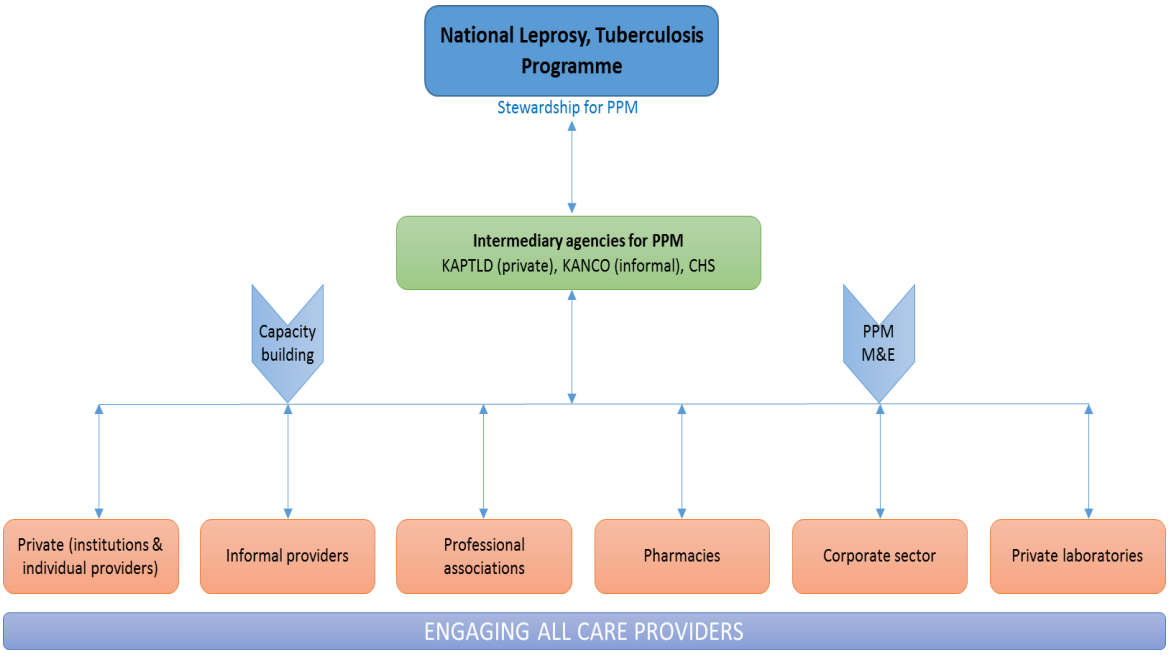

Figure 2: Implementation framework for PPM

The PPM action plan will align with the NSP 2015-2018 (due for revision), and the END-TB strategy to move from collaboration with the private sector, eventually integrating the public and private sector in providing patient centered TB care services. An annual operational work plan for PPM will be developed every year and discussed in the PPM TWG for guidance prior to implementation.

As highlighted in the action plan objective 1, the NTLD will provide the stewardship for implementing the PPM activities. The key activities include optimizing the functioning of the TWG and their representation at the national level, finalization and dissemination of the PPM policy guidelines, organize annual PPM workshops at the national level, and also strengthening PPM coordination mechanisms at the county level. The NTLD will also strengthen the capacity building of private sector, through appropriate training of the diverse providers, and continue CMEs on thematic PPM areas targeting the professional associations. Online-modules for TB care to enhance dissemination of educational material to private practitioners and promote the standardized TB care are also being considered.

In summary, the NTLD will facilitate collaboration with private providers for delivering quality TB services. The assistance provided to these providers will include: i) technical guidance on using NTLD guidelines and the PPM guidelines ii) training; iii) provision of TB drugs and logistics; iv) supervision and monitoring; v) ensure proper recording and reporting; and vi) input towards advocacy, communication and social mobilization.

Task mix for Public-Private Mix activities

The task mix in Table 1 enlists the diverse providers responsible in provision of TB care services in the country. NTLD and partners conduct analysis to map diverse the providers and engage them in TB care services. This includes listing of institutional and individual providers, and reviewing their current and potential engagement in providing clinical tasks and public health tasks necessary for TB control.

The NTLD and public sector is responsible in providing both clinical and public health tasks. Private institutions, corporate and individual private providers have the capacity to undertake all clinical and few public health tasks such as notifying TB cases, providing treatment support and tracing loss to follow-up. Quality assurance of laboratories, programme monitoring and evaluation, drugs and supply management, TB advocacy and overall stewardship for PPM is led by the NTLD and the public sector. The role of professional associations (KMA, KPA etc.) and regulatory authorities will be to train providers, M&E, drug supply management, and enforcement of policies.

To guide the task mix process, NTLD and partners have developed a matrix defining the providers and which provider can take which activity as illustrated in table 1. This task-mix will inform further planning for PPM activities, such as training and support required to engage the diverse private sector providers.

Table 1: Task-mix for diverse providers in TB care

		Government including military and prison health services				Faith based Organizations/NGO			Private providers Including corporate				Informal Sector	Professional/ Regulatory Bodies
	Task	NTP / DOTS agency	Hospitals	Health centers	Dispensary	Hospitals	Health centers	Dispensary	Hospitals	Clinics	Retail pharmacy	Standalone laboratories	TH/Herbalist/Faith healers	
CLINICAL TASKS	Identify presumptive TB cases	x	x	x	x	x	x	x	x	x	x	x	x	
	Collect Specimens	x	x	x	x	x	x	x	x	x	x	x		
	Refer and record presumptive TB cases	x	x	x	x	x	x	x	x	x	x	x	x	
	Carry out Smear microscopy	x	x	x	x	x	x		x			x		
	Gene-Xpert (where available)	x	x	x		x	x		x			x		
	Culture and DST	x	x			x			x					
	HIV testing and Counselling	x	x	x	x	x	x	x	x	x		x		
	Diagnose TB	x	x			x			x					
	Prescribe TB Treatment	x	x	x	x	x	x	x	x	x				
	Prescribe DRTB treatment	x	x			x			x					
	Patient education/awareness	x	x	x	x	x	x	x	x	x	x			
PUBLIC HEALTH TASKS	Notify cases	x	x	x	x	x	x	x	x	x	x			
	Provide treatment supporters (DOT)	x	x	x	x	x	x	x	x	x	x			
	Trace loss to follow-up	x	x	x	x	x	x	x	x	x	x			
	Contact tracing / investigations	x	x	x										
	Training of providers	x	x			x								x
	Supervision	x				x								
	Quality Assurance of Laboratories	x												
	Programme Monitoring and Evaluation	x												x
	Drug and other commodities supply management	x												x
	TB Advocacy	x												
	Enforcement of policies	x												x
	Provide Stewardship (regulation & financing)	x												x

6. MONITORING & EVALUATION

During the action plan implementation 2017-2020, NTLD and partners will scale-up the private sector model (institution & individual) and informal provider model; introduce new models: corporate/workplace model, pharmacy model, pediatric model and the private lab model. The table below provides the projected contributions from each of the service delivery models in terms of notifications by 2020. The action plan implementation projects a yearly notification of 17,890 TB cases from PPM interventions by end of 2020. The contributions during the years 2017, 2018 and 2019 will witness a gradual increase in cases YoY eventually reaching the notification target by 2020. To ensure the quality of PPM implementation is enhanced, NTLD and partners will provide necessary technical monitoring and supervision periodically led by the national level, and also conduct data quality assessments to improve TB surveillance in the private sector. Recording and reporting tools for PPM will be standardized, and a consultation on electronic notification and reporting from the private sector will be facilitated as part of the action plan.

Table 2: Targets from engaging diverse providers, 2017-2020

Type of non-NTLD provider or facility	# of providers or facilities	Number currently engaged	Target number engaged by 2020	Total target as % of total provider or facility number	Number currently notified in a year	Target number notified yearly by 2020	Total new yearly notifications
Provider or facility type #1 **Private providers**	3720	General/Specialist PPs (a):30	By model (a): 150	21%	By model (a): 900	By model (a): 750	**10600**
		Hospitals (b): 270	By model (b): 600		By model (b): 8100	By model (b): 9850	
		Total: **300**	Total: **750**		Total: **9000**	Total: **10600**	
Provider or facility type # 2 **Informal providers**	N/A	383	2000	N/A	23	640	**640**
Provider or facility type #3 **Corporate/workplace model**	N/A	0	300	N/A	0	750	**750**
Provider or facility type # 4 **Pharmacy model**	N/A	0	400	N/A	0	2400	**2400**
Provider or facility type # 5 **Paediatric model**	350	0	100	29%	0	1000	**1000**
Provider or facility type #6 **Private lab model**	N/A	285	300	N/A	0	2500	**2500**
Total						**17,890**	**17,890**

The NTLD will also monitor the action plan outcomes in its effect on the overall NSP 2015-18 impact measures/targets on incidence, treatment outcomes, mortality (refer table 3). The impact measures described below were set in 2014 NSP, and is due for change during the revision of the NSP in 2017. PPM outcome measures will be subject to revisions accordingly.

Table 3: NSP impact measures and PPM outcomes, 2017-2020

PPM Action plan contribution to NSP impact	PPM outcome measures
Impact 1: Reduce the incidence of TB by 5% by 2018, compared to 2014	• Increase private sector case notification contribution from 15% in 2015 to 30% by 2020 • Ensure treatment success of at least 90% of all DS TB patients managed by private providers
Impact 1.1: Reduce the prevalence of MDR-TB among new patients by 15%, by 2018	• Ensure treatment success of at least 80% of MDRTB patients managed by private providers
Impact 2: Reduce mortality due to TB by 3% by 2018	• Ensure treatment success of at least 90% of all DS TB patients managed by private providers • Reduce deaths among HIV-infected TB patients managed by private providers to 5% or lower
Impact 3. Reduce the proportion of affected families who face catastrophic costs due to TB	• Introduce reimbursements for TB-related expenses in all private and public health insurance schemes

7. PPM ACTION PLAN 2017-2020

PPM Strategic Goal: To contribute to the national End TB targets by increasing the private health facilities contribution in TB case notification from 15% in 2015 to 30% by 2020									
Strategic Objective	**Sub-Objective**	**Activity Description**	**Activity Timeframe**				**Lead/support organisation**	**Funder**	**Target**
			Y 1	**Y 2**	**Y 3**	**Y 4**			
Strategic objective 1: Ensure effective leadership and stewardship of PPM through resource mobilization, active oversight/management, and coordination of PPM activities	1.1 Effective functioning of the TWG in PPM representation and implementation at the national level	1.1.1 Review and update ToR and reconstitute the PPM TWG	x				NTLD		TOR for PPM Committee revised and TWG reconstituted by Jun 2017
		1.1.2 Conduct quarterly PPM TWG meeting	x	x	x	x			4 quarterly TWG meetings held and minutes shared with partners (2 during Y1 and 4/Y during Y2-5 = 18 total)
	1.2 Development and dissemination of PPM policy guidelines	1.2.1 Revise and finalise the PPM policy guidelines	x						Revised guidelines to be completed before Jun 2017
		1.2.2 Disseminate the PPM policy guidelines across counties	x	x	x	x			
	1.3 To conduct annual PPM workshop at the national level	1.3.1 Organise an annual National PPM workshop (100-150 participants) to review progress, disseminate PPM norms, standards, practices, reporting systems	x	x	x	x			Develop PPM specific Annual Operational Work Plan to be reviewed every year for progress during the workshop
	1.4 County level PPM coordination mechanisms are established and operationalised	1.4.1 Support county level PPM quarterly meetings, integrated with the TBHIV committees	x	x	x	x			4 quarterly PPM coordinating meetings held every year and minutes shared
Strategic objective 2: Strengthen collaboration with professional associations and private sector partners	2.1 Support conferences with TB symposia held at annual scientific conferences of professional associations	2.1.1 Support symposia and special sessions on TB at the annual scientific conferences of professional associations including KMA, KAPT, KCOA, NAK, PSK, to reach individual members of these associations (1/2 day symposium with each association - 6 symposia/year)	x	x	x	x	NTLD/ Partners		

	2.2 Facilitate dialogue meetings with private health facility managers and staff	2.2.1 Conduct dialogue meetings with private health facility managers and staff to design and implement facility specific TB and TB/HIV services (approx. 10 staff per facility) 25 meetings/year	x	x	x	x	NTLD/ Partners		
Strategic objective 3: Scale-up implementation of current service delivery PPM models and introduce innovative PPM models for TB care	3.1 Sustain and scale up the private hospital and **Private provider model**	3.1.1 Conduct 10-day mapping exercise in each urban centre (5 new urban centers covered every year) - Baseline -14 covered -2016; 20 additional 2017-2020	x	x	x	x	KAPTLD		Total 34 urban centres covered for PP model
		3.1.2 Sensitization meetings targeting hospitals (4 events/urban centre/year)	x	x	x	x			
		3.1.3 Sensitization meetings targeting individual private providers (4 events/urban centre/year)	x	x	x	x			
	3.2 Scale-up the **Informal service provider model**	3.2.1 Conduct mapping of ISPs in each area (5 new areas - urban/rural covered/year) baseline 5 counties -2016; add 20 counties-2017-2020)	x	x	x	x	KANCO/ Partners		Total 25 urban/rural areas covered for ISP model
		3.2.2 Develop data collection tools and IEC for engaging and scaling up the ISP model	x						
		3.2.3 Conduct sensitization events for informal service providers (4/year in each town)	x	x	x	x			
		3.2.4 Provide non-financial incentives for ISPs optimally engaged (flyers, caps, umbrella)	x	x	x	x			
		3.2.5 Provide financial incentives to ISP for referrals	x	x	x	x			

		(tied to a diagnosed TB case)							
		3.2.6 Conduct quarterly meetings between ISPs, CHW, TBC and others to review progress	x	x	x	x			
	3.3 **Corporate sector model**	3.3.1 To conduct consultative meetings involving key corporates/factories (identify factories where poor and vulnerable	x	x	x	x			2 consultations to be conducted during Q2 and Q 3 2017;
		3.3.2 To develop a work place intervention plan by Dec 2017	x						Consultations to develop and design the work place model before Q4 2017
		3.3.3 Implement targeted workplace interventions		x	x	x			Innovative work place interventions implemented starting Q1 2018
	3.4 **Pharmacy model**	3.4.1 To conduct mapping of pharmacists (5 urban areas/yr) - 20 urban areas covered by 2020	x	x	x	x			Total 20 urban/rural areas covered for Pharmacist model
		3.4.2 To conduct sensitization events targeting pharmacists (4//year)		x	x	x			
		3.4.3 Provide financial incentives to pharmacists for referrals (tied to a diagnosed TB case)		x	x	x			
	3.5 **Paediatric TB model**	3.5.1 To conduct consultative meeting with Kenyan paediatric association (KPA) to design a paediatric TB model	x						Consultative meeting by end of Q2 2017, model defined by Q3-4 2017; roll out inQ1 2018
		3.5.2 Roll-out and implement model in 6 major urban areas (Nairobi, Mombasa, Kisumu, Eldoret, Thika, Nakuru)		x	x	x			
		3.5.3 Conduct symposia on Paediatric TB through KPA		x	x	x			Ensure no duplication with 2.1

	3.6 **Laboratory model**	3.6.1 To conduct mapping of Private Labs (5 urban areas/yr) - 20 urban areas covered by 2020	x	x	x				
		3.6.2 To conduct sensitization events targeting Labs (5/year)		x	x	x			
		3.6.3 Bi-annual Review Meeting; Lab /Pharmacy		x	x	x			
Strategic Objective 4: Enhance the quality of PPM implementation by standardising monitoring, recording and reporting of PPM activities	4.1 Provide technical supervision and support by national team	4.1.1 Integrated mission for private facility supervision by Joint NTLD-Partners	x	x	x	x	NTLD/ Partners		
	4.2 Provide county level supervision of PPM activities	4.2.1 Quarterly supervision/OJT and mentorship across 255 sub-counties by CTLCs and TB coordinators (1020/yr)	x	x	x	x			
	4.3 Conduct data quality assessments to improve TB surveillance in private sector	4.3.1 Conduct DQA in selected provinces (5 private facilities for DQA/yr)	x	x	x	x			
	4.4 Standardise recording and reporting tools for PPM	4.4.1 Revise and standardise M&E tools for private sector (data collection, recording and reporting)	x						Completed by Q 3-4 2017 and ensure revised tools are utilized from Q1 2018
	4.5 Consultation workshop on electronic notification and reporting from the private sector	4.5.1 Facilitate consultation workshop on notification (mandatory?) and methodologies to generate consensus	x						Completed by Q 3-4 2017
Strategic Objective 5: Strengthen capacity building for PPM activities	5.1 Ensure the Private HCWs are trained on the integrated TB curriculum (TB,TBHIV, PMDT, Paediatric TB, PAL)	5.1.1 Conduct training targeting private HCWs in 15 counties (30 participants per training and 5 trainings/year)	x	x	x	x	NTLD/ Partners		

	5.2 Conduct continuous medical education on thematic PPM areas	5.2.1 Sensitize private HCWs on key thematic PPM areas (ex. innovative PPM models, regulation/notification, recording and reporting etc): 30 participants/CME, 5 CMEs/quarter; 20 CMEs/yr	x	x	x	x			
	5.3 Developing online modules for TB care to private sector	Online modules for MOs/pharmacist, CO, Nurses, Laboratory technicians	x						Modules to be completed by Q3 2017, pilot in Q4 2017 and roll-out by Q1 2018
Strategic objective 6: Strengthen the regulatory legislative framework and promote UHC/social protection mechanisms for PPM activities	6.1 Reviewing the regulatory landscape for notification and drugs/commodities	6.1.1 To conduct a review of the existing regulatory and legislative frameworks relating to drugs/commodities and notification (include labs)	x				NTLD/ Partners		To be completed by Jun 2017; review includes consultation with regulatory bodies and developing a brief paper (5 pages) to inform NLTD
	6.2 Certification of medical officers and clinical officers	6.2.1 To develop online education material and ensure the MOs/COs access the material and complete certification to provide TB care services	x						Online education material developed by Q3 2017, piloted in Q4 2017 and roll-out in Q1 2018
		6.2.2 The online courses are updated and available for access and certification		x	x	x			
	6.3 To promote universal health care and social protection mechanisms for TB care	6.3.1 To engage with the NHIF through consultative meetings to ensure support for both out-patient and in-patient services for TB patients from vulnerable groups (ex. patients from counties with high poverty prevalence and low CNR)	x	x	x	x			

		6.3.2 To provide incentives to support transport and nutrition to TB patients from vulnerable groups (ex. counties with high poverty prevalence and low CNR -inclusion criteria - women and children and other vulnerable groups - TBD in a consultative workshop)	x	x	x	x			
		6.3.3 To conduct formative research - mapping of populations eligible for support under UHC	x	x	x	x			

8. BUDGET AND COSTING FRAMEWORK

The proposed action plan for implementing PPM activities during the period 2017-2020 is costed at **US$ 6,085,987.07**. The NLTD is actively mobilizing resources from diverse funding sources (Governmental, Global Fund, Challenge TB, etc.) to support implementation of interventions as described in the PPM action plan.

Sub-Obj	Activity Description	Budget (US$)			
		Y1 (2017)	Y2 (2018)	Y3 (2019)	Y4 (2020)
1.1 Ensure the effective functioning of the TWG in PPM representation and implementation at the national level	1.1.1 Review and update ToR and reconstitute the PPM TWG	225.00	-	-	-
	1.1.2 Conduct quarterly PPM TWG meeting	1,800.00	1,800.00	1,800.00	1,800.00
1.2 Development and dissemination of PPM policy guidelines	1.2.1 Revise and finalise the PPM policy guidelines	17,750.00	-	-	-
	1.2.2 Disseminate the PPM policy guidelines across counties implementing PPM in line with the PPM action plan	15,045.00	-	-	-
1.3 To conduct annual PPM workshop at the national level	1.3.1 Organise a annual national PPM workshop (100-150 participants) to review progress, dissseminate PPM norms, standards, practices, reporting systems	4,000.00	4,000.00	4,000.00	4,000.00
1.4 County level PPM coordination mechanisms are established and operationalised	1.4.1 Support county level PPM quarterly meetings, integrated with the TBHIV committees	-	-	-	-
2.1 Support conferences with TB symposia held at annual scientific conferences of professional associations	2.1.1 Support symposia and special sessions on TB at the annual scientific conferences of professional associations including KMA, KPA, NNAK, KCOA, to reach individual members of these associations with TB task specific messages (1/2 day symposium with each association - 6 symposia/year)	32,800.00	32,800.00	32,800.00	32,800.00
2.2 Facilitate dialogue meetings held with private health facility managers and staff	2.2.1 Conduct dialogue meetings with private health facility managers and staff to design and implement facility specific TB and TB/HIV services (approx 10 staff per facility) 25 meetings/year	3,750.00	3,750.00	3,750.00	3,750.00

3.1 Sustain and scale up the private hospital and private provider model	3.1.1 Conduct 10-day mapping exercise in each urban center (5 new urban centers each covered every year) - Baseline -14 covered by 2016; 20 additional during 2017-2020	3,000.00	3,000.00	3,000.00	3,000.00
	3.1.2 Sensitization meetings targeting hospitals (5 event/urban center/year)	33,000.00	66,000.00	99,000.00	132,000.00
	3.1.3 Sensitization meetings targeting individual private providers (4 event/urban center/year)	228,000.00	288,000.00	348,000.00	408,000.00
3.2 Scale-up the informal service provider model	3.2.1 Conduct mapping of ISPs in each area (5 new areas - urban/rural covered every year) baseline 5 counties by 2016; additional 20 counties during 2017-2020)	9,250.00	9,250.00	9,250.00	9,250.00
	3.2.2 Develop data collection tools and IEC for engaging and scaling up the ISP model	3,250.00	-	-	-
	3.2.3 Conduct senistization events for infomal service providers (every quarter and 4/year in each town)	100,800.00	151,200.00	201,600.00	252,000.00
	3.2.4 Provide non-financial incentives for ISPs optimally engaged (flyers, caps, umbrella etc)	8,275.00	-	7,500.00	-
	3.2.5 Provide financial incentives to ISP for referrals (tied to a diagnosed TB case)	3,935.00	5,965.00	7,985.00	10,000.00
	3.2.6 Conduct quarterly meetings between ISPs, CHW, TBC and others to review progress	38,600.00	38,600.00	38,600.00	38,600.00
	3.2.7 Human resource	29,036.76	30,488.60	32,013.03	33,613.68
3.3 Corporate sector model	3.3.1 To conduct consultative meetings involving key corporates/factories (identify factories where people belonging to lower-SE background work) - 2 consultations/year	3,580.00	3,580.00	3,580.00	3,580.00
	3.3.2 To develop a work place intervention plan by Dec 2017	4,800.00	-	-	-
	3.3.3 Implement targeted workplace interventions implemented from Q1 2018	124,500.00	249,000.00	373,500.00	498,000.00
3.4 Pharmacy model	3.4.1 To conduct mapping of pharmacists (5 urban areas across counties/yr) - 20 urban areas covered by 2020	30,540.00	3,090.00	3,090.00	3,090.00
	3.4.2 To conduct sensitization events targeting pharmacists (5/ urban area/year)	13,750.00	27,500.00	41,250.00	55,000.00
	3.4.3 Provide financial incentives to pharmacists for referrals (tied to a diagnosed TB case)	9,750.00	8,000.00	16,000.00	24,000.00
3.5. Laboratory Model	3.5.1 To conduct mapping of Private Labs (5 urban areas across counties/yr) - 20 urban areas covered by 2020	-	-	-	-
	3.5.2 To conduct sensitization events targeting Labs (5/ urban area/year)	13,750.00	27,500.00	41,250.00	55,000.00
	3.5.3 Bi-annual Review Meeting; Lab / Pharmacy	22,080.00	22,080.00	22,080.00	22,080.00
3.6 Pediatric TB model	3.6.1 To conduct a consultative meeting with Professional association (KPA/KMA/KCOA/NNAK) to design a pediatric TB model	8,400.00	-	-	-

4.1 Provide technical supervision and support by national team	4.1.1 Integrated mission for private facility supervision by Joint NTP-Partners	17,750.00	26,625.00	26,625.00	44,375.00
4.2 Provide county level supervison of PPM activities	4.2.1 Quarterly supervision/OJT and mentorship across 255 sub-counties by CTLCs and TB coordinators (1020/yr)	120,000.00	180,000.00	240,000.00	306,000.00
	4.2.2 PPM Specific training for county and sub county Cordinators On Principles of PPM	12,200.00	6,100.00	6,100.00	6,100.00
4.3 Conduct data quality assessments to improve TB surveillance in private sector	4.3.1 Conduct DQA in selected provinces (5 private facilities for DQA/yr)	4,950.00	4,950.00	4,950.00	4,950.00
4.4 Standardise recording and reporting tools for PPM	4.4.1 Revise and standardise M&E tools for private sector (data collection, recording and reporting) and ensure revised tools are utilized from Q1 2018	6,650.00	-	-	-
4.5 Consultation workshop on electronic notification and reporting from the private sector	4.5.1 Facilitate consultation workshop on notification (mandatory?) and methodologies to generate consensus	2,750.00	-	-	-
5.1 Ensure the Private HCWs are trained on the integrated TB curriculum (TB,TBHIV, PMDT, Pediatric TB, PAL)	5.1.1 Conduct training targeting private HCWs in 15 counties (30 participants per training and 5 trainings/year)	61,650.00	102,750.00	102,750.00	41,100.00
5.2 Conduct continuous medical education on thematic PPM areas	5.2.1 Sensitize private HCWs on key thematic PPM areas (ex innovative PPM models, regulation/notification, recording and reporting etc):	3,300.00	3,300.00	3,300.00	3,300.00
5.3 Developing online modules for TB care to private sector	5.3.1. Online modules for Mos/pharmacist, CO, Nurses, Laboratory technicians	3,000.00	2,000.00	-	-
6.1 Reviewing the regulatory landscape for notification and drugs/commodities	6.1.1 To conduct a review of the existing regulatory and legislative frameworks relating to drugs/commodities and notification (include labs)	20,500.00	-	-	-
	6.1.2 Stakeholders forum to deliberate on the developed policy document 1/2 Day 60 Pax	2,700.00	-	-	-
6.2 Certification of medical officers and clinical officers	6.2.1 To develop online education material and ensure the MOs/COs access the material and complete certification to provide TB care services	20,500.00	-	-	-
	6.2.2 The online courses are updated and available for access and certification	100.00	-	-	-
		1,064,976.76	**1,351,848.60**	**1,673,773.03**	**1,995,388.68**
GRAND TOTAL					**6,085,987.07**

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ANNEX 1: NSP 2015-2018, ENGAGING ALL CARE PROVIDERS OPERATIONAL PLAN

Engaging All Care Providers Operational Plan									
Output Indicator(s)	**Intervention(s)**	**Year 1 Activities**	**Yr 1 Target**	**Year 2 Activities**	**Yr 2 Target**	**Year 3 Activities**	**Yr 3 Target**	**Year 4 Activities**	**Yr 4 Target**
Strategic Approach 1: Sustain the gains in areas where PPM is currently being implemented									
Number of HCWs trained on TB/HIV, PMDT, Paediatric TB, PAL	Train HCWs on TB using the national TB/HIV curriculum (15 counties)	n/a		5 trainings	150	5 trainings	150	5 trainings	150
	Train HCWs on MDR-TB using the national DR-TB curriculum (15 counties)	n/a		5 trainings	150	5 trainings	150	5 trainings	150
	Train HCWs on Ped TB using the national curriculum (5 counties)	n/a		5 trainings	150	5 trainings	150	5 trainings	150
	Train HCWs on PAL using the national curriculum (15 counties)	n/a		5 trainings	150	5 trainings	150	5 trainings	150
Number of conferences with TB symposia held at annual scientific conferences of professional associations	Support symposia and special sessions on TB at the annual scientific conferences of professional associations including KMA, KPA, KAPT, KCOA, NAK, PSK, to reach individual members of these associations with TB task specific messages	n/a		1/2 day symposia in six conferences	6	1/2 day symposia in six conferences	6	1/2 day symposia in six conferences	6
Number of facility dialogue meetings held with private health facility managers and staff	Hold dialogue meetings with 85 private health facility managers and staff to design and implement facility specific TB and TB/HIV service (approx 10 staff per facility)	10 dialogue meetings held at selected facilities	10	25 dialogue meetings at selected facilities	25	25 dialogue meetings at selected facilities	25	25 dialogue meetings at selected facilities	25
Number of supervision visits to private facility/ clinic owners	Provide TA (Sub CTLCs, PPM Coordinators) to private facility/ clinic owners	Hold quarterly supportive supervision in all 255	1,020	Hold quarterly supportive supervision in all 255	1,020	Hold quarterly supportive supervision in all 255	1,020	Hold quarterly supportive supervision in all 255	1,020
Number of counties offered technical assistance by national team	Provide Technical support/ support supervision by national level team	Integrated mission for private facility supervision yearly in 15 counties	15	Integrated mission for private facility supervision yearly in 15 counties	15	Integrated mission for private facility supervision yearly in 15 counties	15	Integrated mission for private facility supervision yearly in 15 counties	15
Number of private HCWs sensitized on recording & reporting	Support the national TB surveillance system among private providers	Conduct one day sensitization meetings on data collection tools targetting 30 health care providers from private DOT facilities	30	Conduct one day sensitization meetings on data collection tools targetting 90 health providers from private DOT facilities	90	Conduct one day sensitization meetings on data collection tools targetting 90 health providers from private DOT facilities	90	Conduct one day sensitization meetings on data collection tools targetting 90 health providers from private DOT facilities	90
Number of private facilities trained to use data from recording & reporting		Support 2 day data feedback/CQI forums (health care providers and TB coordinators) in 15 counties bi annually. (County clustering 3 counties per meeting, 5 meetings with 45pax)	30	Support 2 day data feedback/CQI forums (health care providers and TB coordinators) in 15 counties bi annually. (County clustering 3 counties per meeting, 5 meetings with 45pax)	30	Support 2 day data feedback/CQI forums (health care providers and TB coordinators) in 15 counties bi annually. (County clustering 3 counties per meeting, 5 meetings with 45pax)	30	Support 2 day data feedback/CQI forums (health care providers and TB coordinators) in 15 counties bi annually. (County clustering 3 counties per meeting, 5 meetings with 45pax)	30
Strategic Approach 2: Scale-up the number and diversity of private providers contributing to NTLD Program aims, in all counties									
Proportion of counties that have mapped private health providers	Map of all private care providers 32 urban centers in 32 counties	Conduct 10 day mapping exercise for private providers in 8 urban centres in 8 counties	25%	Conduct 10 day mapping exercise for private providers in 8 urban centres in 8 counties	50%	Conduct 10 day mapping exercise for private providers in 8 urban centres in 8 counties	75%	Conduct 10 day mapping exercise for private providers in 8 urban centres in 8 counties	100%
PPM policy guidelines updated	Revise the PPM policy guidelines	n/a		Conduct a 5 day policy revision workshop for PPM policy guidelines	1	n/a		n/a	
Number of PPM policy guidelines printed	Print the PPM policy guidelines	n/a		Print 1,000 copies of PPM policy	1,000	Print 1,000 copies of PPM policy	1000	n/a	

Engaging All Care Providers Operational Plan									
Output Indicator(s)	**Intervention(s)**	**Year 1 Activities**	**Yr 1 Target**	**Year 2 Activities**	**Yr 2 Target**	**Year 3 Activities**	**Yr 3 Target**	**Year 4 Activities**	**Yr 4 Target**
Proportion of counties with PPM policy guidelines	Distribute the PPM policy to all counties	n/a		Distribute PPM policy guidelines to 47 counties	100%	Distribute PPM policy guidelines to 47 counties	100%	n/a	
Proportion of counties with dissemination meetings for PPM policy guidelines held	Hold dissemination meetings for PPM policy documents targettting 32 urbarn centers in 32 counties	n/a		Hold dissemination meetings for PPM policy documents targettting 16 urbarn centers in 16 counties	50%	Hold dissemination meetings for PPM policy documents targettting 16 urbarn centers in 16 counties	50%	n/a	
Strategic Approach 3: Strengthen coordination mechanisms for PPM at the national and county levels									
Number of TWG meetings held	Supporting the national PPM TWG	Hold quartely PPM TWG meetings at national level	4	Hold quartely PPM TWG meetings at national level	4	Hold quartely PPM TWG meetings at national level	4	Hold quartely PPM TWG meetings at national level	4
Number of annual county PPM stakeholder meetings held	Support annual county PPM stakeholders meetings	n/a		Hold one day annual PPM stakeholders meeting in each of the 47 counties	47	Hold one day annual PPM stakeholders meeting in each of the 47 counties	47	Hold one day annual PPM stakeholders meeting in each of the 47 counties	47
Number of plaques and certificates printed and awarded	Print recognition certificates and plaques	n/a		47 plaques and 141 recognition certificates for best performing sites printed and awarded	47 141	47 plaques and 141 recognition certificates for best performing sites printed and awarded	47 141	47 plaques and 141 recognition certificates for best performing sites printed and awarded	47 141
Number of annual PPM meetings held	Hold an annual national PPM workshop for 150pax to disseminate PPM norms and standards, practices reporting systems and review progress	n/a		Hold a 2 day national PPM meeting	1	Hold a 2 day national PPM meeting	1	Hold a 2 day national PPM meeting	1
Strategic Approach 4: Ensure the quality of PPM activities for TB, leprosy and lung diseases									
Number of counties with peer to peer supportive supervision held	Development of the peer review tools			Development of the peer review tools	15	n/a	15	n/a	15
	Support a team of consultants in lung health at national and County level to provide mentorship in the Private sector	n/a		Support a team of consultant to conduct peer to peer support supervision in 15 counties		Support a team of consultant to conduct peer to peer support supervision in 15 counties		Support a team of consultant to conduct peer to peer support supervision in 15 counties	
	Support data quality assessments (DQA)/CQIs to improve the surveillance of TB, leprosy and lung diseases from private sector	na		Conduct DQA in selected private health facilities		Conduct DQA in selected private health facilities		Conduct DQA in selected private health facilities	

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