REPUBLIC OF KENYA

MINISTRY OF HEALTH

Public-Private Mix ACTION PLAN

2021 - 2023

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

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Foreword

Globally, there has been notable progress in the fight against TB with 54 million lives saved since 2000. The burden of TB disease and death due to TB remains enormous. In 2020, up to 3 million of the estimated 10 million people with TB worldwide were "missed" by national TB programs. Two thirds of them are thought to access TB treatment from public and private providers who are not engaged by the National TB Program.

In 2020, Kenya notified 72,943 people with TB; with an estimated incidence of 140,000, indicating that at least 48% of incident TB cases were either missed or not notified. A patient pathway analysis of 2017 revealed that the private sector is widely used, with an average of 42 % (of initial visits) in the private sector though only 20% (14,888) of all notified TB cases and an additional 4% were referred by the private sector (Private for profit [PFP] and faith-based organizations [FBOs]) in 2020. Engagement of all care providers in the public and private sectors, therefore remains an integral component of national TB strategies, to ensure that everyone with TB is detected and put on treatment early.

Engaging with all health care providers through Public Private Mix (PPM) approaches is essential to reach all people with TB who miss out on access to care due to either under-reporting or under diagnosis. The private sector (both private for profit and the NGO/ Civil Society Organization ([CSO]) plays a big role in delivering key services for the fight against TB as well as strengthening health systems in Kenya. The private sector ranges from large health institutions that offer state of the art health care services to unlicensed informal providers.

This PPM Action Plan 2021-2023 provides a guide on strengthening and expanding meaningful engagement and participation of the private sector in the fight against TB. It complements the Tuberculosis National Strategic Plan 2020-2023 using existing and reviewed models of engagements and providing a national scope.

Successful tuberculosis control is embedded in partnerships and not just between private and public health professionals. It encompasses quality public health practices, political uphold, continued funding and technical support.

Dr. Patrick Amoth, EBS

Ag. Director General for Health
Ministry of Health

Preface

The private health care sector remains an important player in the delivery of health services including TB control Kenya. Each year, nearly 40% of people with TB are missed by the health system and these people do not get the care they need and deserve.

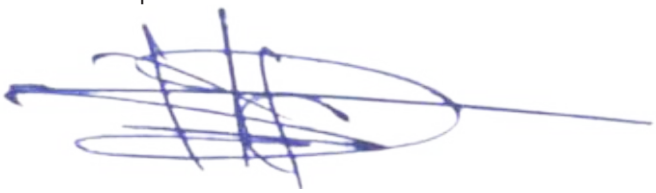
A patient pathway analysis of 2017 revealed that the private sector is widely used, with an average of 42 % of initial care seeking visits being in the private sector. Failure to engage all care providers can result in long delays in diagnosis and treatment, resulting in further TB transmission, and poor-quality diagnosis and treatment, leading to the development of multi drug resistant TB (MDR-TB).

The private sector offers numerous opportunities for advancing public health gains in TB prevention and care due to its vibrant, growing and always competitive mode which could be utilized to enhance access and quality of TB prevention and care services. The End TB Strategy lays emphasis on building strong linkages with all health care providers and engaging all towards ending TB in line with World Health Organization (WHO) recommendations.

The National TB program continues to engage all providers and strengthens the contribution of the private sector through the PPM.

PPM entails diverse collaborative strategies between the Ministry of Health-National TB Program and the private sector with an aim of identifying 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 PPM Action Plan will provide a guide towards scale up quality TB services and implementation of TB activities across all care providers in Kenya.



Dr. Mulwa A. M.

Ag. Director of Medical Services/Preventive & Promotive Health

Ministry of Health

Acknowledgement

The Division of National Tuberculosis, Leprosy and Lung Disease Program (DNTLD-P) is very grateful to all the stakeholders for their support and contribution towards developing the PPM Action Plan 2021-2023.

The period of implementation of the previous Action Plan was possible through great collaboration with the private sector and implementing partners in TB control. Stakeholders include the Government of Kenya, county governments, developmental and implementing partners, civil society organizations, FBOs and communities. Special thanks go to The Global Fund to fight Aids, Tuberculosis and Malaria (GFATM), World Health Organization (WHO), USAID CHS-TB ARC II, AMREF Health Africa, USAID KCCB KOMESHA TB, Population Service Kenya (PS Kenya) and Respiratory Society of Kenya (ReSoK) for their financial and/or technical support during the implementation period.

The Program would like to specifically thank USAID TB ARC II - CHS for their financial support during review of the previous action plan and development of the Action Plan 2021-2023.

Finally, special appreciation to the consultants and the PPM Committee of Expert (CoE) for spearheading planning, data collection and development of the PPM Action Plan 2021-2023.

Dr. Waqo Ejersa, OGW

Head, National TB, Leprosy and Lung Disease Program

Abbreviations

ACF	Active Case Finding
AFB	Acid Fast Bacilli
AKMLSO	Association of Kenya Medical Laboratory Scientific Officers
APTC	Administration police training college
ART	Antiretroviral Therapy
CHS	Centre for Health Solutions - Kenya
CHU	Community Health Units
CHV	Community Health Volunteers
CME	Continuous Medical Education
CoE	Committee of Excellence
COPD	Chronic obstructive pulmonary disease
CPT	Cotrimoxazole Preventive Therapy
CSO	Civil Society Organization
CSP	Community Support Platform
CU	Community Units
CXR	Chest X-ray
DNTLD-P	Division of National Tuberculosis, Leprosy and Lung Disease Program
DOT	Directly Observed Treatment
DR	Drug Resistance
DS	Drug Susceptible
EMR	Electronic Medical Records
EQA	External Quality Assurance
FBO	Faith-Based Organization
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
GoK	Government of Kenya
GSU	General Service Unit
HCW	Health Care Workers
HF	Health Facility
HFG	Partnership for a HIV free Generation
HIV	Human Immunodeficiency Virus
HR	Human Resource
IEC	Information, Education and Communication
ISP	Informal Service Providers
KAPH	Kenya Association of Private Hospitals
KCCB	Kenya Conference of Catholic Bishops
KHIS	Kenya Health Information System
KIC-TB	Kenya Innovative Challenge Tuberculosis Fund
KMA	Kenya Medical Association
KPA	Kenya Pediatric Association
LTFU	Loss to Follow-Up
M&E	Monitoring and Evaluation
MAF	Multisectoral Accountability Framework
MCH	Maternal and Child Health
MDR-TB	Multidrug Resistance TB
MLT	Medical Laboratory Technologist
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHA	National Health Accounts
NSP	National Strategic Plan
NTP	National Tuberculosis Programme

NYS	National Youth Service
ODK	Open Data Kit
OJT	On-Job Training
OPD	Out-Patient Department
PFP	Private For Profit
PHO	Public Health Officers
PMS	Post-Market Surveillance
POC	Point of Care
PPA	Patient Pathway Analysis
PPB	Pharmacy and Poisons Board
PPC	Public Private Collaboration
PPM	Public-Private Mix
PPP	Public-Private Partnership
PR	Principal Recipient
PS Kenya	Population Service Kenya
PSK	Pharmaceutical Society of Kenya
RandR	Recording and Reporting
RBF	Results Based Financing
ReSoK	Respiratory Society of Kenya
RODI	Resources Oriented Development Initiative
SCTLC	Sub-County TB and Leprosy Coordinator
SOP	Standard Operating Procedures
SORK	Society of Radiography in Kenya
TB	Tuberculosis
TB ARC	Tuberculosis Accelerated Response and Care
ToR	Terms of Reference
TPT	Tuberculosis Preventive Therapy
TSR	Treatment Success Rate
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
USAID	United States International Development Agency
WHO	World Health Organization

Definition of Terms

Faith-Based Organization: A faith-based organization is an organization whose values are based on faith and/or beliefs, which has a mission based on social values of the particular faith, and which most often draws its activists (leaders, staff, volunteers) from a particular faith group.

Private sector engagement: refers to the involvement of the private health sector in the provision of the health services within the TB care cascade.

Private for profit: is an organization (health facility) which aims to earn profit through its operations.

Private partner: defined by the Kenyan MOH to include any organization or individual working outside the direct control of the government, including for-profit organizations (companies and individuals) and not-for-profit organizations. These include medical practitioners, diagnostic centers, ambulance providers, health facilities such as hospitals and clinics, health organizations such as FBO and Non-Governmental organization (NGOs) and industries such as pharmaceutical companies, health insurance companies, Health ICT firms and others, as well as community-based organizations.

Public Private Collaboration (PPC): all arrangements and partnerships between a contracting (public) authority and a private party. These include the PPPs as defined in the PPP Act of 2013 and other forms of collaboration that do not fulfil the PPP requirements. These may include lower value partnerships, service level agreements and information exchange arrangements. The private partner receives a financial or non-financial benefit from the arrangement. Health Public Private Partnerships are one form of PPC.

Public Private Partnership (PPP): arrangements between a contracting authority and a private party governed by the Kenya PPP Act (2013), under which a private party (usually commercial party) undertakes to perform a public function, receives a benefit for performing a public function. For PPPs, the benefit is usually through compensation from a public fund or user charges. PPPs involve risk-transfer from the public to the private partner.

Private facilities engaged: in this PPM Action Plan, the context of private sector engagement is inclusion of private health facilities and FBO health facilities in TB screening, diagnosis and notification to TB program (refer to those offering the highest level of services which is TB treatment and care).

1.
INTRODUCTION

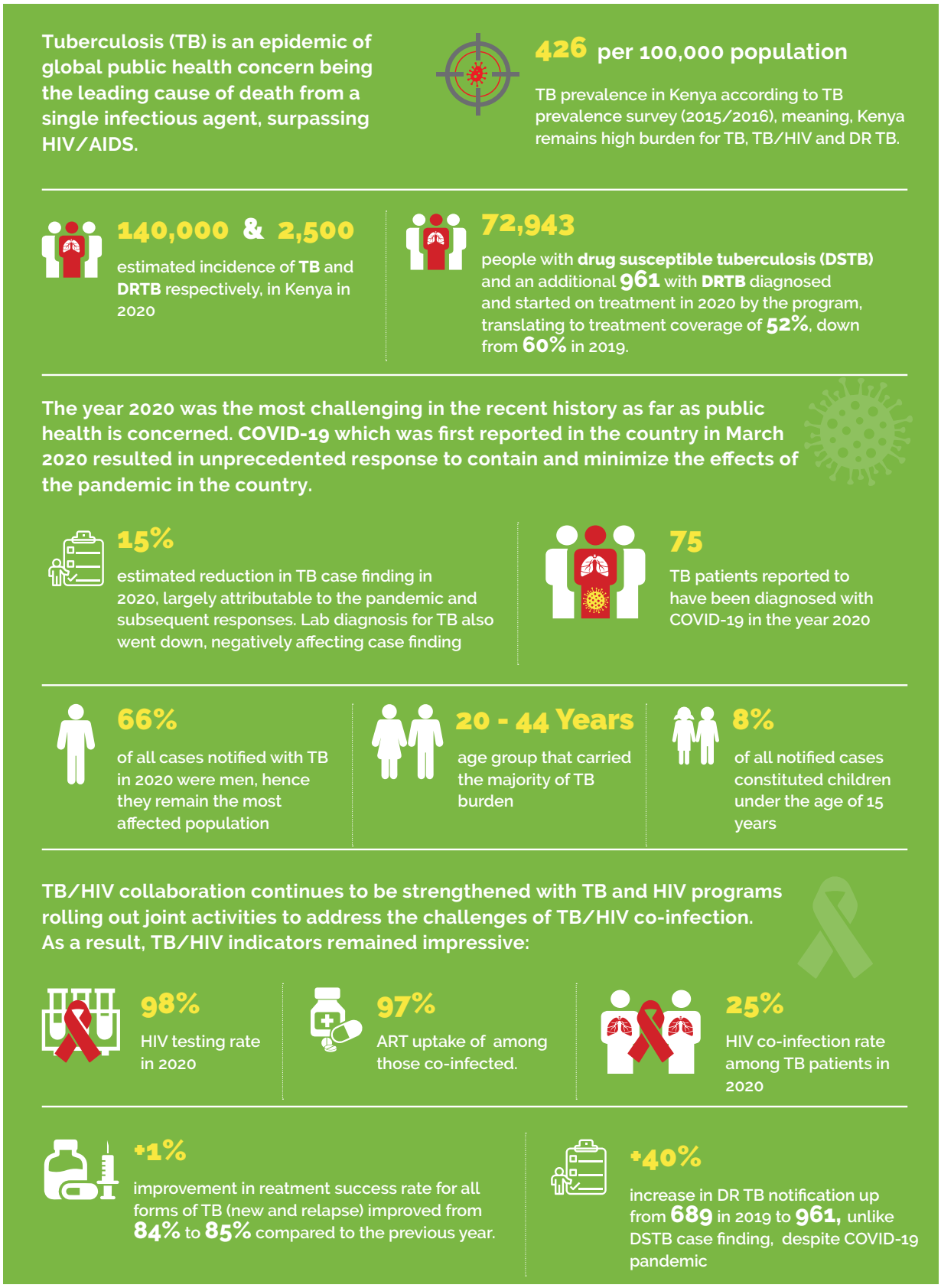
140,000	2,500	72,943	961	15%
Estimated incident Drug Susceptible TB (DS-TB) cases reported in 2020	Estimated incident Drug Resistant TB (DS-TB) reported in 2020	DS-TB cases notified in 2020 countrywide	DR-TB cases notified in 2020 countrywide	drop in TB cases in 2020 due to disruption of TB services especially TB diagnostic services due to COVID-19

1.1 TB Epidemiology

Kenya is classified by World Health Organization (WHO) as a tuberculosis (TB) and TB/HIV high burden country. However, the country has been transitioned out of the high DR TB burden countries list for 2021 – 2025. In 2016, the national TB prevalence survey revealed that the true burden of TB in Kenya was about 426 cases per 100,000 population. The annual TB incidence is estimated at 169,000 new TB cases. Between 2015 -2018, annual TB incidence decreased at 6%. In 2019, it was estimated that 146,445 persons had TB. However, the country notified 86,504 TB patients which translates to about 41% of the TB patients being missed to be diagnosed and treated. The estimated TB incidence is still high as of 2020 at 140,000 for Drug Susceptible TB (DS-TB) and 2,500 for DR-TB. The country only managed to notify 72,943 DS-TB and 961 DR-TB patients in 2020. The negative effects of COVID-19 in 2020 may have resulted in a 15% drop in TB cases due to disruption of TB services especially TB diagnostic services (see Figure 1).

The need to close the gap of finding missing people with TB is a priority for Kenya. Therefore, there is a call to action to find the missing people with TB through effective case finding strategies including engaging private health providers in TB control and care.

Figure 1. *TB profile in Kenya in 2020 (Annual DNTLD-P report, 2020)*



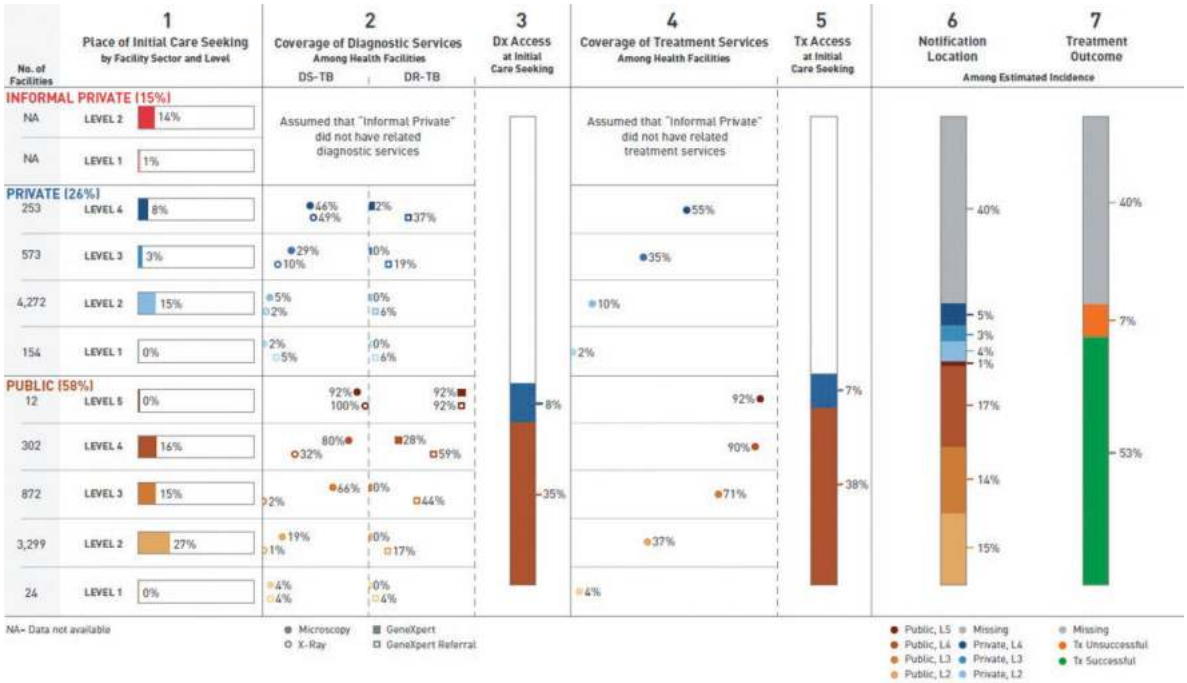
1.2 Engaging private sector to close the gap in TB control

Engaging all relevant health care providers in TB prevention and care through public private mix (PPM) approaches is an essential component of WHO's End TB Strategy. The emphasis is therefore building strong linkages with all health care providers to increase TB case finding, treat all and end TB. The non-state or private health care sector is an important player in the delivery of health services in Kenya accounting close to 50% of facilities and providers. The private sector may be more accessible, located closer to the homes and workplaces, and operating in more flexible hours for communities to access health care. Thus, 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 and offer numerous opportunities for advancing public health gains in TB response and control. The private health sector targeted for TB control includes:

- Private Sector (Institution and Individual Provider) which may be for-profit and not-for-profit.
- Pharmacy or chemists
- Standalone laboratory,
- Corporate
- Informal Service Providers (ISPs) and
- Unlicensed informal providers.

The private health sector in Kenya is not only 50% of the total health facilities, but also the first point of contact of about 42% of the people seeking care. The patient pathway analysis further provides evidence of engaging the private sector in the control of TB in Kenya (see Figure 2). Therefore, PPM is critical in the government efforts to control and end TB in Kenya.

Figure 2. *Patient pathway analysis for Kenya in 2017*



The private sector contribution to TB control as per the End TB strategy is proposed at 35% of the total notification in a country. Kenya has set the target for private sector contribution at 25% and is aiming to increase the target as there are initiatives being implemented to engage the private sector in TB control.

1.3 DNTLD-P Strategic Plan on TB Control and Private Sector

1.3.1 NSP on TB control

The National Strategic Plan (NSP) for TB, Leprosy and Lung Diseases 2019 - 2023 represents an evolution in the Government of Kenya's response to TB, Leprosy and Lung diseases. The NSP reflects a patient-centred approach to planning and evidence-based prioritisation of resource allocation to close the gaps along the patient pathway to quality care. The NSP is operationalised through a partnership framework aligned to each stakeholder's comparative advantage.

VISION

A Kenya free of TB and leprosy, and reduced burden of lung disease.

MISSION

To ensure provision of quality care and prevention services for all people in Kenya with TB, leprosy and lung diseases.

1.3.2 Close the private sector gap

Engaging the private sector in Kenya, is clearly stipulated in the first priority of NSP:

PRIORITY OF THE NSP:

Meet people who are seeking care anywhere in the health system with quality TB, leprosy and lung health services.

The NSP has a bold strategy to network all care providers into a cohesive web of support for people with TB, leprosy and lung diseases. The NSP outlines the following prioritized support systems to engage the private sector through:

i. strategic purchasing of private sector services,

ii. contracting for linkages to public sector capacities (such as diagnostic technology) and commodities (such as drugs), and

iii. enhanced functionality of the data system to link patient care with notifications and payments.

The activities capitalize on the concurrent expansion of Universal Health Coverage (UHC) and the potential for national health insurance to incentivize private providers to deliver quality care.

The private sector is composed of formal and informal health service providers.

Formal private providers:

- not-for-profit formal institutions such as faith-based organizations (FBOs) and non-governmental organizations (NGOs)
- for-profit providers including private self-financing institutions, individual private providers, retail pharmacies, chemists, laboratories, corporate and non-qualified or informal providers.

The large private institutions, which mainly serve the affluent or those covered under corporate insurance, mostly provide tertiary health care services. The medium-small sized hospitals, also called nursing homes, mainly provide health and TB services for a fee. Individual private practitioners include medical doctors, clinical officers, nurses, medical laboratory technologists, pharmacists among others. Corporate sector provides health services at the workplace for employees and their dependents but opportunities to engage more with corporates in industries attracting vulnerable populations should be explored.

The informal sector

The informal sector includes the health care providers who practice conventional medicine and those who do not. They tend to be within reach, convenient and attractive to a significant population in areas of residence. They comprise of:

- unregistered or unregulated skilled personnel service providers who include herbalists, traditional healers, grocers and shopkeepers, community health volunteers, traditional birth attendants among others.

Engaging all care providers in TB control is therefore critical in attaining the global and national targets. PPM collaboration is important as it improves early TB diagnosis irrespective of where the patients first seek care in the health system, and establishes mechanisms that allow for appropriate referral, efficient and high-quality diagnosis and treatment.

2.

PRIVATE SECTOR AND TB CONTROL IN KENYA

27
private health facilities visited to assess the status of TB services in the private sector, of which 59% were private for profit

70%
of health facilities had IEC materials on TB

3 out of 27
(11%) had the GeneXpert machine to test for TB, necessitating the need for sample referral transport

2.1 Status of TB Services in the Private Sector

In developing the PPM Action Plan, the status of TB services in the private sector was assessed. A total of 27 private health facilities were visited, of which 59% were private for profit. A majority of staff in these facilities were nurses and 49% of them were either trained or sensitized on TB in the past one year from the time of the review.

The summary of the findings from the situational analysis are as follows:

- **Types of services offered**: over 90% of the facilities offer services like TB screening and referral, testing, treatment and contact management.
- **Information, Education and Communication (IEC) materials**: 70% of health facilities had IEC materials on TB.
- **Recording and Reporting (R&R) tools**: sub-optimal use of registers like TB4 Register, the presumptive TB Register and the contact/TB Preventive Therapy (TPT) management registers. Incomplete filled registers may result in underreporting of TB patients diagnosed and treated at the private sector and underestimates the treatment success
- **Electronic Medical Registers (EMR)**: about 67% of the facilities use EMRs and 56% had TB screening questions captured in the EMR.
- **GeneXpert machines**: of the private facilities visited 3/27 (11%) had the GeneXpert machine to test for TB, necessitating the need for sample referral transport.

- **Turnaround time**: delays of laboratory results was reported. As concerns GeneXpert results. out of the 27 facilities visited, 5 reported on the turn-around time of receiving results for GeneXpert, with 2/5 receiving results within 24 hours, another 2/5 received results between 1-2 days and 1/5 received results usually within 3-7 days.
- **Cost of TB testing**: most TB services are not charged to the patients, though cost of GeneXpert test in some facilities could be as high as Ksh 9,000, while for Acid Fast Bacilli (AFB) was Ksh 1,100 and that of Chest X-ray (CXR) was Ksh 2,200.
- **Support to private health facilities**: include supervision, on-job training, training sensitization, Continuous Medical Education (CME), R&R, laboratory commodities, anti-TB medicines and IEC materials. The level of support from national, count and partner levels is shown in below Table 1.
- **Enablers**: 33% of the private providers reported that they were receiving enablers. The monetary enablers were aligned to achievement of processes in the TB care cascade, while the main non-monetary enablers were training/sensitization and support supervision.
- **TB and COVID-19:** bi-directional screening and testing was reported in 63% of HF visited.
- **Chemists and Laboratories:** the chemists and standalone laboratories visited during this rapid assessment had the task of TB screening and referral. About 40% of the laboratories were engaged in diagnosis and referral. Opportunity to identify TB symptomatic at the chemists was revealed by the type of clients received, many of them being over the counter and cough syrup requests. Most of the reporting on TB was done manually.

Table 1. *Description of type of support and provided by National, County and implementing partners*

Support	National	County	Partners
Support Supervision/ On-Job Training (OJT)	26%	85%	52%
Training/ Sensitization	30%	56%	48%
CME	7%	56%	48%
Recording and Reporting tools	63%	70%	30%
Laboratory Commodities	70%	67%	22%
Anti-TB Medicines	81%	59%	4%
IEC Materials	56%	48%	26%

- **Informal Service Providers:** noted knowledge gap of TB among them was noted including ISPs had misinformation on the cause of TB, they were a cause of delay in the referral of TB symptomatic, preferring to first provide their services or herbal concoctions to relieve the symptoms. Most of them had no recent training/ sensitization on TB, a probable explanation of their poor knowledge on TB. The willingness to work for the same goal with facility HCWs was expressed and would be best done comprehensively with an enabler.

2.2 Implementation Status

2.2.1 Overview of PPM Initiatives in Kenya from 2017 to 2020

A total of 7,252 private health facilities are in 47 counties in Kenya. About 1,100 (15%) of the private health facilities and FBO are TB treatment sites, and they notify TB patients through TIBU. Twenty-three (23) counties in the country were supported to implement various TB PPM models by intermediary partners during the implementation period 2017 -2020 (Annex 13.3). The GoK in collaboration with partners implemented the following initiatives:

i. **GoK**: Supported private health facilities and FBO through provision of commodities, medicine, staff secondment, R&R tools and supportive supervision.

ii. **Global Fund**: PPM interventions and Kenya Innovative Challenge Tuberculosis Fund (KIC-TB) implemented by Amref under the Global Fund as part of strategic initiatives.

iii. **USAID TB ARC II**: PPM activities through Population Services (PS) Kenya and engagement of ISPs through KANCO as sub-recipients. TB ARC II started direct implementation of PPM activities in October 2020.

iv. **KCCB KOMESHA TB:** Supporting FBO and private health facilities in Western Kenya.

v. **Respiratory Society of Kenya (ReSoK)**: Provision of subsidized TB medicine to large private health facilities in selected urban areas and capacity building activities and technical support to health care providers.

vi. **STOP TB Partnership**: TB REACH Wave 6, 7 and 8 (started in October 2020) engaging the private sector implemented by DNTLDP with Amref, OGRA and PS Kenya respectively.

2.2.2 Achievements in PPM for PPM Action plan 2017-2020

The achievement of the PPM gains was possible through collaborative efforts of NTP and implementing partners. The engagements were guided by the 2017-2020 action plan which entailed engaging the unengaged providers who have never provided TB services in the past as well as supporting the optimization of services in the already engaged health facilities.

- **PPM Committee of Experts (CoE) established**: a functional national CoE is in place to provide leadership, coordination and oversight. It has an expanded membership to include professional associations.

NOTE:

Technical Working Groups are also known as CoEs.

- **New private sector engaged**: significant improvement achieved by engaging the unengaged who are now able to screen for TB, refer or test for TB diagnosis with some becoming treatment sites. The chemist model has been scaled up (TB patients can be notified through this model and some are DOT centres). These efforts led to increase in referrals by private sector.
    - Improving and expanding private sector community partnership through franchised health facilities (Tunza) in 100 health facilities from eight counties: Nairobi, Mombasa, Nakuru, Kiambu, Tharaka Nithi, Meru, Isiolo and Embu. TB cases diagnosed were 61 out of 36,068 patients screened.
    - Through Amref, Global Fund TB Project, mapping was conducted in 10 urban centers in 8 counties (Garissa, Kajiado, Kiambu, Kisumu, Mombasa, Nairobi, Nakuru, and Kilifi) and 538 private facilities engaged. A total of 282,004 people were screened, 15,513 people presumed to have TB, 8758 tested and 856 diagnosed with TB and linked to treatment by between August 2019 and December 2020.
    - Kenya Innovative Challenge Tuberculosis Fund (KIC-TB) was implemented by Amref as part of the Strategic Initiatives. Implemented through 9 Sub recipient organizations including; ReSoK, Community Support Platform (CSP), Resources Oriented Development Initiative (RODI), North Star Alliance, Partnership for a HIV free Generation (HFG), TAC Health Africa, Heroes Oasis Counselling Center, Sema Limited and Nais Healthcare Ltd. A total of 275,303 were screened, 44,592 people presumed to have TB, 23,356 tested, 1,246 diagnosed with TB.
    - Scale up of innovative strategy aimed at integrating TB in the workplace policy. Six (6) counties of Kisumu, Nakuru, Nairobi, Mombasa, Kwale and Machakos engaged based on industrial status. Nine TB cases were identified among 1,147 workers screened.
    - 92 pediatricians in Nairobi, Mombasa and Kisumu counties were trained and engaged on childhood TB.
    - A total of 285 private laboratories are currently providing TB diagnostic services mainly through smear microscopy and 90 percent are enrolled in the national External Quality Assurance (EQA) system
    - Seven (7) counties implemented ISPs Model.

- **Mapped providers**: Mapped providers and initiated TB referral and linkage networks which were supported with Community Health Volunteers (CHVs) who were paired with private health facilities. Mapping was conducted in urban centers in 8 counties (Garissa, Kajiado, Kiambu, Kisumu, Mombasa, Nairobi, Nakuru, Kilifi). The private providers identified for engagement were 538. In 2019, 82 TB cases were notified from 18,681 people screened.

- **Case notification**: increase in the number of patients notified in the private sector from 14% in Q1 2020 to 17% in Q4 2020. Additionally, the proportion of TB cases

referred by the private sector increased from 3% in Q1 2020 to 5% in Q4 2020.

- **Increased testing**: engaged facilities were linked to the GeneXpert testing sites increasing access to GeneXpert testing to presumptive TB patients attending at the private health facilities.
    - GeneXpert machines were placed (Hub) and nearby chemists, private clinics and nursing homes (Spokes) tasked to identify people with presumptive TB whose sputum samples are referred to the hub for testing. By the end of December 2019, 634 tests had been performed through this project, 45 TB cases were diagnosed (44 bacteriologically) and all 45 placed on treatment.
    - Through the support of TB Reach Wave 6 project, diagnostic hubs to strengthen diagnostic capacity of laboratories in the private sector were established. Focus was in 5 counties which include Kiambu, Machakos, Kajiado, Nakuru, and Trans Nzoia.

- **R&R tools**: customization of reporting tools was carried out, a simplified TB screening register was developed, printed and distribute and had a very good uptake. In addition, the recording and reporting from the big hospitals was established and there are favorable treatment outcomes.

- **Involving FBO**: are now visible in the TB agenda, they have contributed to TB case finding which continues to improve, there is better coverage with the scale-up of uptake, community outreaches in hot spots that leverage on FBOs have good outcome, a focal person in the facility that attends to CHVs is able to account for cases referred from the community, Subsidized CXR payment for suspected TB in children has supported diagnosis of pediatric TB

- **TB Medicine access**: a medicines access program that targeted big private facilities (that may be unwilling to use GOK TB medicines) ensures access to quality-assured TB medicines at highly subsidized prices allowing providers to pass the cost benefit to their patients.

2.2.3 Implementation gaps/challenges

- **Engagement**: though major strides have been made, engagement of the private sector by the NTP remains suboptimal and the sector has been left behind when rolling out policy.
- **Enforcement of the legal framework**: that requires notification of TB is not implemented, thus many possibilities of some TB cases going without being notified.
- **Resistance:** there is resistance among the private providers to offer TB services including difficulties in reaching out to the proprietor/ facility owners and also mobilizing the providers for meetings

- **Inadequate resources**: to effectively support sample referral networks, capacity building and even to support continuous engagement, activities leverage on the NTP supplies (public sector) inconsistent supply result in service interruption or incomplete care (GeneXpert commodities).
- **Unmapped private health providers**: dealing with informal facilities who are not adequately mapped. The private sector is expanding - not fully reached the private sector, there is mushrooming of ISPs
- **Sub-optimal quality of TB Care**: leakage along the TB care cascade due to suboptimal adherence to standards of TB care at the health facilities. Linkages between public and private health facilities is also suboptimal.
- **High staff turnover**: need for continuous on job training/technical assistance, inadequate capacity for peer education for senior level physicians
- **Low DR-TB surveillance**: Inadequate surveillance and management of DR-TB within private sector facilities due to complexity of regimens and the monitoring of treatment.
- **TPT in the private sector**: TPT provision is done at a small scale for the intended target population needing TPT.
- **Complexity of using R&R tools**: inadequate recording of data; the tools are too many and lengthy. Some facilities have EMR systems, and these do not have TB data integrated.
- **Under-performances**: invested heavily in ISP, unfortunately the outputs were low, bulk of the work is referring, and this is not captured to translate to TB cases notified
- **Enablers**: positive results have been seen when enablers were introduced. However, it's not easy to clearly define the enablers and the incentives for keeping providers engaged in specific settings. Lesson learnt through implementation is the need to incentivize the processes rather than diagnosed TB cases only.
- **Sub-optimal involvement with CHV**: few private health facilities are linked with community health volunteers limiting the continuum of care of TB patients.
- **Operational research in the PPM**: PPM operational research was not done to assess and evaluate the implementation approaches.

Box: Constraints to private provider engagement for TB

1. Bias towards public provision
2. Insufficient funding
3. Lack of understanding of private healthcare markets
4. Few champions or orchestrators of system transformation
5. Fragmentation of the private market
6. Weakness of key health systems
7. Shortage of experienced and qualified implementers
8. Few inspiring models at scale
9. Challenges specific to TB
10. More attractive competing priorities

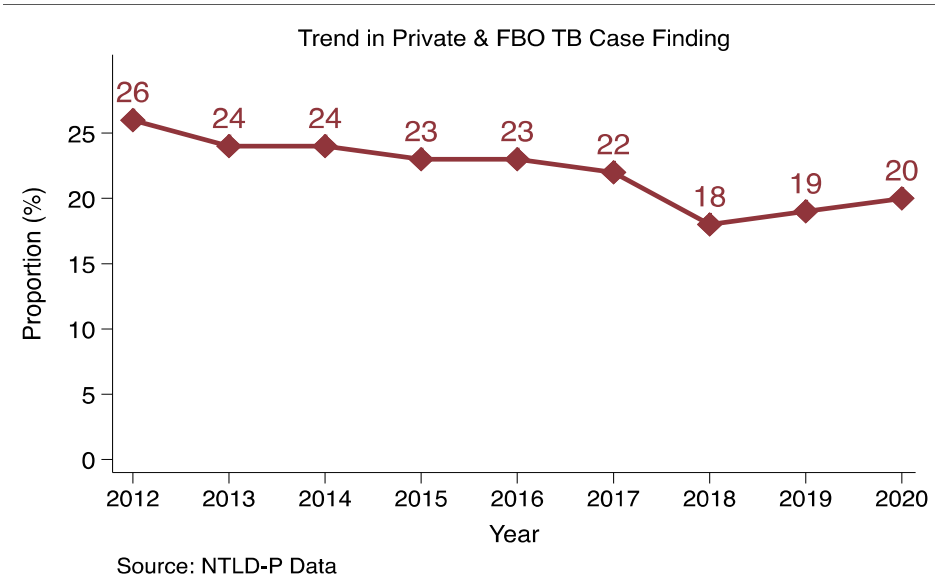
2.3 Trend of TB Case Finding and Treatment Outcome

The PPM action plan (2017-2020) provided guidance on private sector engagement and implementation of the interventions to increase TB case finding and support treatment of patients diagnosed with TB. The below sub-sections describe the contribution of the private sector in TB case finding and treatment outcome.

2.3.1 TB Case Finding in the Private Sector including FBO

Between 2017-2020, the private sector inclusive of private institutions, individual providers and FBOs contribution was the highest in 2012 at 26% of TB cases notified in Kenya. However, a steady decline is being observed to 18% TB notification contribution in 2018. The trajectory changed to positive gains in private sector contribution which increased to 20% TB case notification in 2020. The 20% TB notification contribution is below the planned national target of 25% by 2020. The FBO private health facilities have on average contributed between 4-6% of the TB case notifications between 2017 -2020. This category of facilities gives opportunity for TB PPM expansion through engaging the unengaged, considering the health are in both rural and urban settings. Over the years (2017-2020) the proportion of bacteriologically confirmed PTB in the private sector has remained constant between 45-48% which is lower compared to the national proportions ranging from 49.6 -59.4%.

Figure 3. *Trend in TB notification of private health facilities and FBO, 2012-2020*



2.3.2 Treatment Outcomes in the Public Vs Private sector 2017-2020

The private sector has demonstrated a good treatment success rate (TSR) of the TB patients diagnosed in the sector. The annual treatment success rate in the private sector ranged from 82% to 86% for the years 2015 and 2019 (Table 2). The TSR in the private sector is comparable with national TSRs which ranged from 82% to 87% over the same period (see Table 3).

Figure 4. *Trend of bacteriological and clinically diagnosed TB patients at the private hospital from 2017 to 2021.*

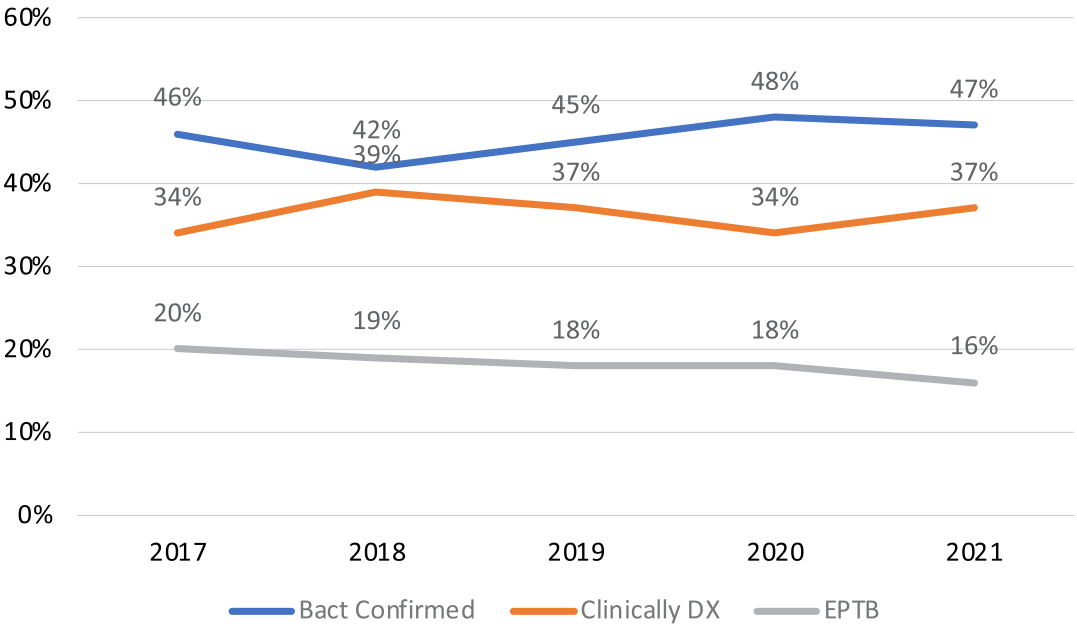


Table 2*. Treatment outcome in the private sector*

Treatment Outcomes in Private Sector					
Treatment Outcomes	**2015**	**2016**	**2017**	**2018**	**2019**
TSR	86%	82%	84%	86%	84%
Death Rate	6%	6%	8%	7%	6%
Loss to Follow-Up (LTFU) Rate	4%	5%	4%	5%	5%

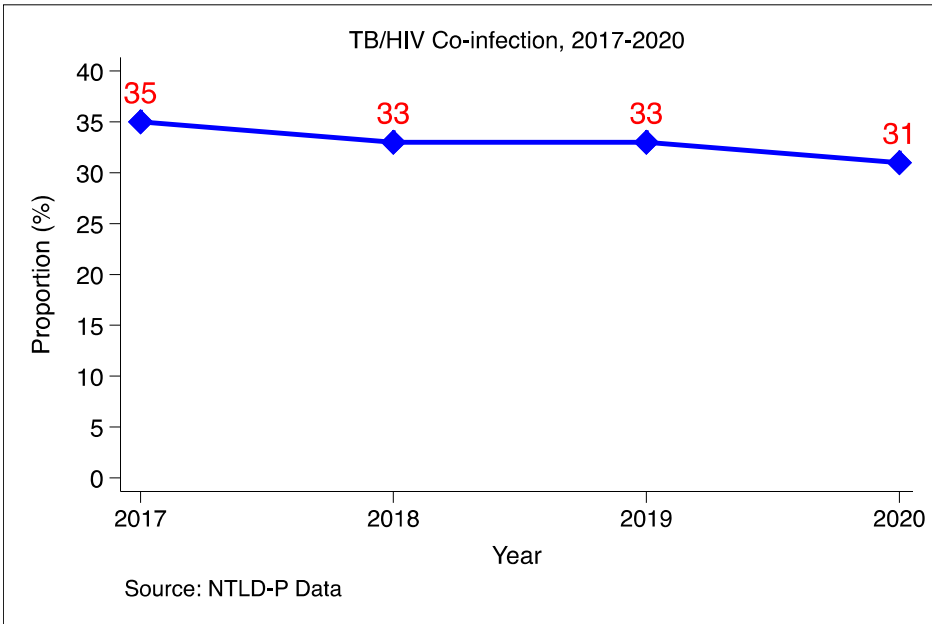
Table 3. *Treatment outcome in the public sector*

Treatment Outcomes in Public Sector					
Treatment Outcomes	**2015**	**2016**	**2017**	**2018**	**2019**
TSR	87%	82%	82%	84%	82%
Death Rate	6%	6%	6%	7%	6%
LTFU Rate	5%	5%	6%	6%	6%

2.33 TB/HIV care in the private sector

Similarly, to national rates, HIV testing rates among TB patients in the private sector has averaged about 97%. The downward trend of TB/HIV co-infection of TB patients in the private sector is like the national trend though the co-infection rate is slightly higher with 35% in 2017 to 29% in 2021. ART uptake rates have ranged between 97%-98% between 2017 -2020.

Figure 5. *TB/HIV Co-infection in the private sector from 2017 to 2020.*



2.4 COVID-19 Pandemic on PPM activities

2.4.1 Effects of COVID-19 pandemic

The COVID-19 pandemic since 2020 has affected not only the health care seeking behaviour among individuals but also negatively affected the health system. Below are the effects of COVID-19 in the private sector;

Figure 6. *Positive and Negative effects of COVID-19 in the private sector.*

Positive effects

- Through bi-directional screening of COVID-19, there was slight increase of TB screening at health facilities.
- More people went to the private sector as they were afraid of quarantine measures in the public sector.
- Improving IPC in the clinics
- Wearing masks may have reduced the risk of TB transmission.
- Observed reduction of other diseases.

Negative effects

- Reduction in TB case finding- patients with respiratory symptoms afraid to visit health facilities
- Closure of OPD services by some facilities-controlled camps e.g prison, General Service Unit (GUS) training school, Administration police training college (APTC) and National Youth Service (NYS)
- Some high volume facilities had to close temporarily due to staff diagnosed with COVID-19
- Initial fear in most labs to conduct TB work due to lack of PPEs.
- Patient self referral to up-county facilities at start of COVID pandemic

2.4.2 Mitigate Measures on COVID-19 Pandemic

GoK and the implementing partners instituted the following mitigating measures to ensure continuation of TB services in the private sector.

- **Developed TB and COVID-19 guidelines**: to provide guidance on the private health facilities on care and management especially on bi-directional screening of TB and COVID-19.
- **Quality of care**: Support for differentiated care for TB patients and strengthening quality of care which included longer return dates for TB patients to free up HCWs who supported COVID-19 pandemic response. CHVs were supported to offer drug delivery services to stable patients in both private and public facilities who were unable to visit the facilities due to financial constrains or fear.
- **Online solutions**: virtual platforms were used for data review meetings with counties, quarterly online Joint Coordinators/DNTLDP/CHS meeting, trainings, sensitizations and CMEs.
- **Streamlining of support supervision**: strengthening the quality of support supervision through coordinators. This included focused technical assistance to high volume facilities.
- **Use of mass media**: radio talk shows series and TV adverts campaigns for TB services demand creation.
- **Cash transfers**: to malnourished DS-TB patients was carried out to patients on TB treatment in both private and public facilities.

3.

PURPOSE AND OBJECTIVES OF PPM ACTION PLAN

3.1 Purpose and scope

The PPM action plan is a 3-year framework developed to guide the National Tuberculosis, Leprosy and Lung Diseases Programme (DNTLD-P) 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 DNTLD, partners and private providers.

3.1.1 Strategic Objectives and Sub-Objectives

STRATEGIC OBJECTIVE 1:

Ensure **effective leadership and stewardship** of PPM for TB prevention, care, and treatment

Objective 1.1. To strengthen coordination of PPM interventions at National, County and community levels through the technical guidance of PPM CoE.

Objective 1.2. To strengthen policy, guidelines, and regulatory requirements to sustain PPM

Objective 1.3. To harmonize and mobilize resources for PPM and increase the percentage of TB National budget dedicated to private provider engagement, from 1% in 2021 to 2% by 2023.

STRATEGIC OBJECTIVE 2:

Optimize delivery of people centered TB services across all PPM models

Objective 2.1. To increase private health facilities (private and FBO) providing TB treatment services in Kenya from 15% in 2021 to 30% by 2023.

Objective 2.2. To increase number of notified TB cases (all forms) by private/non-governmental facilities from 14,880 in 2020 to 33,504 by 2023 (we anticipate a 3% growth in the second year and 4% growth in the third year of TB cases from the private sector)

Objective 2.3. To increase the proportion of people with TB referred by private/FBO facilities from 4% in 2020 to 15% by 2023.

Objective 2.4. To capacity build health care workers from private health facilities to provide quality TB care services.

STRATEGIC OBJECTIVE 3:

Promote effective and efficient **monitoring and evaluation** of PPM interventions

Objective 3.1. To increase number of private facilities offering TB services using t-bu lite for recording and reporting, from zero in 2020 to 4,550 by 2023

Objective 3.2. To enhance support supervision, mentorship, and feedback mechanisms

Objective 3.3. To standardize the framework for monitoring and evaluating PPM performance

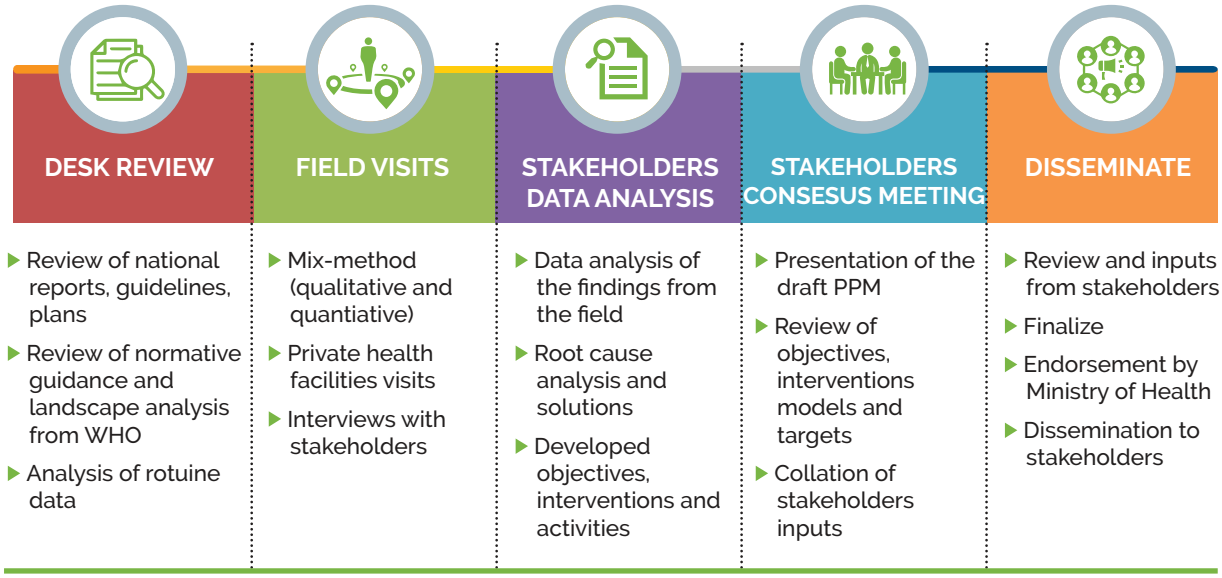
4.

DEVELOPING THE PPM ACTION PLAN 2021-2023

4.1 General Approach

The development of the PPM Action Plan followed the key 5 steps as shown in Figure 7. The whole process was undertaken with technical oversight from the PPM CoE.

Figure 7. *The approach of develop PPM Action Plan 2021-2023*



4.2 Tasks and Steps of Developing PPM Plan 2021-2023

The approach included: -

a. Desk review of key source documents and development of summaries or syntheses where required

b. Comprehensive mapping and profiling of non-state actors and stakeholders to TB response

c. Conducted a national situational analysis and assessment of private sector on COVID-19 effects

d. Field based data review from sampled implementing sites

e. Key informant interviews with main stakeholders

f. Coordination and facilitation consultative dialogue meeting between the main stakeholders, inclusive of implementing partners, private implementers, professional associations and civil society

g. Consolidation of findings, debriefing and endorsement of review findings

h. Development of the PPM plan 2021-2023 informed by the review findings

i. Dissemination of the new PPM action plan 2021-2023.

5.

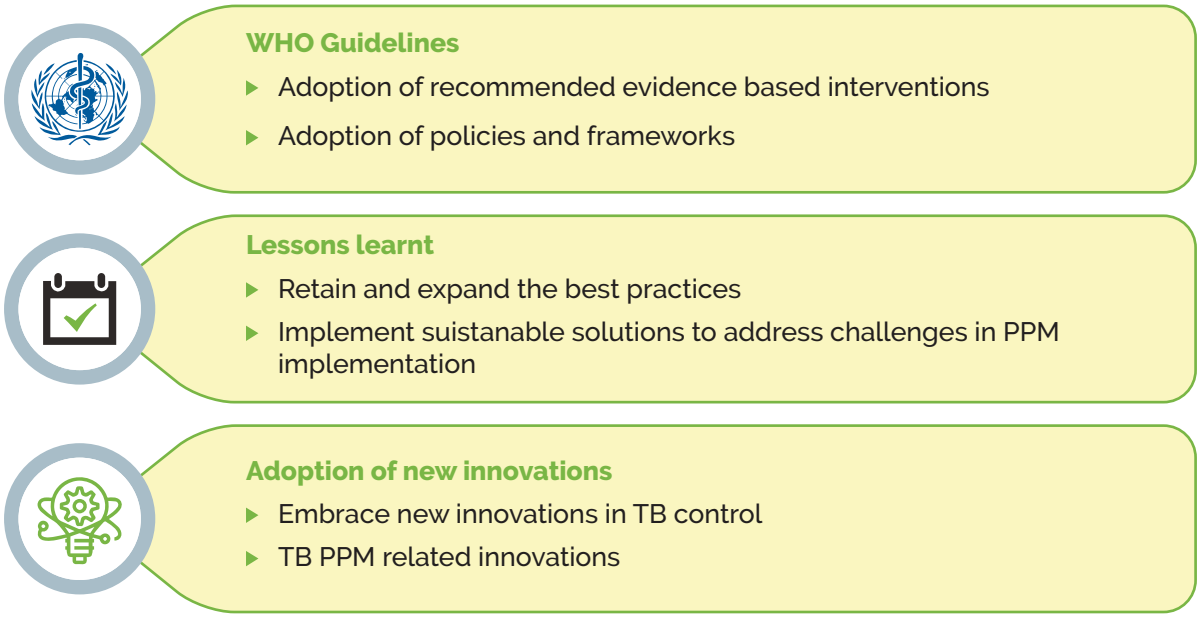
PPM COORDINATION AND SERVICE DELIVERY MODELS

5.1 Guiding principles

The interventions and under each PPM models are proposed based on the following guiding principles (Figure 8).

1. WHO guidelines with recommended interventions and reports that documents best practices from global evaluation of PPM intervention.
2. Retain and expand best practices from implementing PPM activities in Kenya and addressing the challenges of PPM implementation
3. Adopting new innovations in TB PPM intervention implementation including reporting and recording tools.

Figure 8. *Guiding principle in developing interventions for PPM Action Plan (2021-2023)*



The achievements, lessons learnt, challenges and proposed recommendations have been well described in the previous chapter. The below sub-chapters provide a summary of the WHO recommended priority actions to effectively engage private sector. effect

5.2 WHO PPM Roadmap

WHO has recommended roadmap[1] of 10 key actions which are required to scale up the engagement of all care providers towards universal access to care (Figure 9). The brief description of each priority actions:

- **Build understanding:** Building a strong evidence base understanding will be critical to transform mindsets as well as secure high-level commitment and investment. The information will also enable programmes to prioritize the types of providers for engagement.
- **PPM Targets:** Jointly with private provider representatives and other stakeholders, develop and set high-profile targets to scale up the engagement of private providers. This is essential to promote accountability and unite diverse stakeholders in a common effort. The targets will provide opportunity to drive the alignment of TB referrals and notifications with early patient care-seeking behaviours, ensuring quality outcomes for all TB patients, regardless of where they seek care.
- **Advocate:** Advocacy plays a critical role in establishing the foundation for sustained engagement of all providers. Such activities can be designed to:
    - build high-level commitment to "business unusual" approaches to TB care and prevention;
    - create an environment in which all health care providers are motivated to provide quality-assured TB care in partnership with the NTP; and
    - increase population-level demand for accredited TB care and associated support services from all providers.
- **Allocate resources:** Prioritization of private provider engagement must be reflected in budget allocations and expenditure. In countries where non-NTP providers play a major role in health care, PPM can no longer be treated as an optional extra, funded on a small scale by international donors, but must be integrated into core budgets. If intermediary organizations are contracted, their budgets must be adequate and include the costs of professional management structures

[1] Public-Private Mix for TB prevention and Care: A Roadmap. WHO, 2018.

Figure 9. *Ten priority actions in the WHO roadmap to improve TB PPM engagement.*

- **Partner:** Engaging with private providers and other unlinked providers takes significant effort, especially for the already overburdened NTPs. Private providers will also tend to focus on TB clinical tasks, leaving public-financed entities, such as intermediaries, to cover public health functions, such as contact investigation and tracing those lost to follow-up. Intermediary agencies could play a major role in bridging the gap between NTPs and private providers.
- **Policy and regulatory frameworks:** Policies and regulation can help drive engagement with private health providers and other unlinked public sector providers; they can also constrain effective engagement when poorly designed. Some of the health systems and policy foundations of effective private provider engagement for TB are listed below.
- **Adapt flexible models:** models should be adapted continuously over time to maximize performance. In the previous era of TB control, it was important to standardize everything in order to go to scale; but for PPM, standardization would limit scale and effectiveness. Implementers need to work with national programmes to adapt and adjust, both between health markets and over time.
- **Digital technologies:** make case registration easier and quicker but also enable additional innovations that further facilitate private provider engagement at scale, such as digital payment of incentives and enablers to both patients and providers, adherence monitoring technologies, distance learning and digital vouchers for

drugs and diagnostics. The continued rapid development of information and communication technologies constitutes a powerful enabler for improving engagement of all providers.

- **Incentives and enables:**_Well-designed incentives and enablers can help motivate care providers to engage in TB prevention and care. They can also ensure continued involvement of providers. Application of incentives may depend on the type of setting and may include a wide range of financial and nonfinancial motivations.
- **Monitor progress:** It is essential to continuously monitor and evaluate the contributions of PPM, in relation to the specific objectives and targets set by the NTP. This will help justify continued financial support for PPM activities, build accountability, as well as fine-tune PPM operations and target resources effectively.

5.3 Changes to the Service Delivery Models

The changes to the naming and formation of new models are informed by the findings of the situational analysis and assessment of the implementation status, and the recommendation from stakeholders. The summary of the changes is shown in Table 4.

The following changes are in the 2021-2023 PPM action plan.

- **Integrating Paediatric TB Model:** is aimed at engaging the private providers to expand access to TB services for children through integration between MCH clinics, paediatric clinics and TB service providers to facilitate childhood TB diagnosis and treatment. The model's sub-optimal implementation in the 2017-2020 PPM plan with zero paediatric patients diagnosed/reported under the model, has prompted change to the approach. This plan will promote integration of paediatric TB case finding strategies into all the other models
- **Diagnostic Model:** this is a new model which combines the previous Laboratory Model targeting standalone laboratories with imaging facilities which will be a focus for engagement in this PPM Action plan.
- **Workplace Model:** the change from Corporate to workplace model is meant to have a wider coverage of workplaces to include both formal and informal sectors and thus improve access to TB services at the workplace.

Table 4. *The summary of changes to the PPM service delivery models.*

Models in the PPM Action Plans		Comments
2017-2020	**2021-2020**	
Private sector	Private sector	No changes
Chemists and Pharmacists	Chemists and Pharmacist	No changes

Models in the PPM Action Plans		Comments
2017-2020	**2021-2020**	
Pediatric		The model will be integrated in all set ups. This is aimed at engaging the private providers to expand access to TB services for children through integration of TB services in MCH clinics, pediatric clinics and ensuring that health care workers facilitate childhood TB diagnosis and treatment.
Laboratory	Diagnostic	The model now includes the imaging practices/clinics which can help to screen and do imaging for TB related diagnosis.
Corporate	Workplace	To be inclusive of all the workplaces (both formal and informal), ranging from large corporates to small scale workplaces like Jua Kali artisans.
Informal Service Providers	Informal service providers	No changes.

5.4 Package of Services

The package of services should guide integration of pediatric services and bidirectional screening for the TB comorbidities (see Table 5). The package of services provides a guide to health care providers in the private sector on what services are to be offered based on what service model they belong.

- Provide a standardized services for the formal and informal private sector.
- Conduct bidirectional screening of TB and HIV, Diabetes mellitus and COVID-19.
- Identify relevant comorbidities and diagnose/refer for appropriate management.

Table 5. *Package of services for integration of pediatric TB services and TB comorbidities in the private sector.*

PPM Model	Package of Services	TB Comorbidities
	A	**B**
Private Sector	• Symptomatic TB screening for adult and Children. • Identify presumptive TB patients • Refer presumptive TB patients • Request diagnostic tests • Run diagnostic tests • Prescribe treatment and counsel/inform patients • Supervise treatment (dispense drugs)	In addition to the activities under (**A**) – bidirectional screening of TB and the following should be done: • HIV • Diabetes mellitus • COVID-19

PPM Model	Package of Services	TB Comorbidities
	A	B
	• Patient follow-up visits • DR-TB treatment supervision • TB/HIV diagnostic and treatment linkages • Contact Management • Loss to follow-up tracing • TPT provision • Recording and reporting, including notification • Market for the TB and comorbidities services	
Chemists and Pharmacy Model	• Symptomatic TB screening • Identify presumptive TB patients • Refer presumptive TB patients • Linkage to testing Services • Request diagnostic tests • DOT centres for willing patients	• To increase screening of TB patients at risk of having TB. • Refer patients with comorbidities and presumptive TB patients to managed to a nearby health facility.
Diagnostic Model	• Symptomatic TB screening of walk-in patients. • Identify presumptive TB patients • Refer presumptives for clinical review • Testing for TB • Relay of results	•
Work Place Model	• Routine health education on TB and other diseases. • Promotion of TB preventing and screening at work place. • TB screening at entry for the new staff. • Periodic TB screening, testing of the presumptive TB patients and linkage to care. • Contact management at work place and home. *Work place with a health facility/Clinic will offer all the services offered under the private model.* *Work places with no health facility/ clinic will work closely with local public health facility to ensure the following services are provided.*	
ISP Model	• Health education • Symptomatic screening • Identify presumptive TB patients • Refer People who are presumptive for TB for further clinical review	

5.5 PPM Policy and Coordination at Program Level

A PPM CoE is in place to oversee, coordinate and provide guidance towards implementation of PPM activities in Kenya. The other activities done by CoE include;

i. Providing technical advice to key stakeholders,
ii. Oversee implementation and monitoring of PPM policies,
iii. Strategies/interventions development,
iv. Planning and activities review and monitoring,
v. Document and disseminate information on PPM,
vi. Identify and develop strategies to address implementation gaps,
vii. Mobilize resources to support PPM activities and
viii. Identify research priorities to inform the design of more effective PPM interventions.
ix. Identify any policy gaps impeding the realization of PPM agenda in engaging private sector and escalate appropriately.

The interventions and implementations approaches are summarized in Table 6 below to guide the country.

Table 6. *Interventions and proposed implementation approaches for policy implementation and coordination of TB PPM activities.*

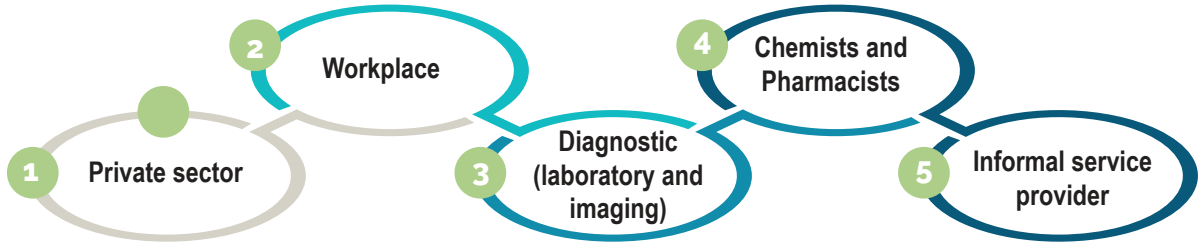
Interventions	Implementation Approaches
Strengthen coordination of PPM activities at National and sub national levels	Identify a PPM focal person at respective levels and establish PPM CoE which include key stakeholders with relevant expertise who are guided by clear terms of reference (ToR). The PPM CoE should hold quarterly meetings to discuss implementation progress, updates, and make recommendations for any adjustments. They should report to HSWG at the national level and CHMT at County level for information and follow-up of action items. At county level: County TB Leprosy Coordinators (CTLCs) will assume the roles of the PPM focal person who will work with chairperson and secretary to coordinate the PPM CoE/TWG at county level. The implementing partners to support establish PPM CoE/TWG which later needs to be included into the existing TWG at county level to ensure sustainability. Proposed goal, objectives and membership of county TWG in Annex 13.4.
Strengthen technical support for TB prevention and care in the private facilities.	The TB coordinators incorporate targeted private facilities in their monthly schedule of visits. Engage and sensitize the administrator or proprietor of the private facility on PPM interventions. Identify and capacity build key staff that will implement the intervention. Provide documentation tools, job aids and IEC materials. There should be monthly supportive supervisions (Sub-CTLC and implementing partners – Mentorship, review of data in t-bu lite and feedback) and provide technical assistance on quarterly basis by a joint team of TB coordinators, lab coordinator, pharmacist, implementing partner, a representative of the relevant professional body.

Interventions	Implementation Approaches
Improve capacity of administration and HCWs in private facilities and associations	Customize training packages for different cadres which should take into consideration their role in PPM activities, availability, and duration. Have specific focus on the business case to get their buy in. The coordinators have brief meetings with admin during their visits and provide feedback at the end. Provide a forum for sharing experiences and support the well performing ones to attend conferences organized by their association.

5.6 PPM Service Delivery Models for PPM Action Plan 2021-2023

The PPM Action Plan 20221-2023 will have the following models (Figure 10)

Figure 10. *Service delivery models for the PPM Action Plan 2021-2023.*



5.6.1 Private Sector Model

These are formal private for-profit health facilities or individual healthcare providers. The individual private practitioners encompass medical doctors, clinical officers, nurses, medical laboratory technologists among others. All formal private health providers will be engaged through structured and sustainable approaches to offer TB services across the cascade of care i.e., TB symptomatic screening, diagnosis, treatment and follow-up of patients, contact management, including drug-resistant TB. In addition, they will be supported to offer HIV counselling and testing, co-trimoxazole (CPT), antiretroviral therapy (ART) and follow up of people living with HIV. The following are key interventions under private sector model.

Prioritized Interventions	Implementation Approaches
Optimize ACF in private facilities	Develop tools to comprehensively capture the current situation including gaps during mapping. Develop selection criteria based on the scope of service for each type of provider. Provide the minimum package as per the guidelines based on key gaps identified from the mapping exercise. Provide the required supplies and commodities to support services at all key service delivery points. Define and sensitize on the available linkages and referral mechanisms. Strengthen sample referral networking and mobilize surrounding communities to access the services

Prioritized Interventions	Implementation Approaches
Improve contact management among private facilities	All private facilities that are treatment sites will be sensitized on the management of contacts of index TB patients and the contact management tools availed. Contact invitations can be through the patients or CHVs. The CHVs in the community units within which the identified facilities fall should be sensitized on the intervention then allocate CHVs to the respective private facilities/chemists. The TB coordinators will frequently monitor implementation progress and provide guidance.
Develop a network to support sample networking and referral	Define the hubs and spokes and sensitize providers on the linkages. Establish diagnostic services within private health facilities where possible and consider supporting additional HR at the hubs. Identify and sensitize the riders to participate in sample referral systems. Both the county lab coordinator and the implementing partner will coordinate implementation of this process. The identified private facilities with diagnostic services should be enrolled into the laboratory quality assurance
Streamline supply chain management for lab commodities in the private sector	Sensitize the providers on the supply chain management and the use of data for forecasting and quantification of their commodity requirements. Provide excel templates for ordering the commodities and sensitize on the processes to be followed. The joint supervision team to monitor the progress on a quarterly basis.
Increase TB treatment coverage	After the mapping exercise, private facilities with the required infrastructure and are willing should be upgraded to TB treatment sites. Requirements for qualifying facilities will include, the staff that are trained on TB management, provided with requisite R&R tools and commodities, and receive regular support supervision and mentorship.
To improve treatment outcomes among patients taking medication at the private facilities.	Regular support supervision and mentorship visits to ascertain quality of care provided to TB patients (ensure follow-up smears are promptly done and mortality audits are conducted).
Strengthen screening, diagnosis and referral of pediatric clients among the private providers providing TB services	Capacity building of HCWs and continuous mentorship on screening and diagnosis of TB among children. Identify focal facilities for referring children for further investigation.
Promote the use of electronic reporting mechanisms (TIBU, t-bu lite etc.)	Sensitize the providers on the available electronic avenues to report. Facilities with existing EMRs should incorporate TB screening questions in their systems. Facilities without EMRs to prioritize utilization of t-bu lite platform. The DNTLD-P M&E will regularly monitor the performance and provide TA where necessary.

5.6.2 Workplace Model

This model focuses on work-place interventions among the corporates and factories/ industries that employ workers on low wages who could be poor and vulnerable groups. Some corporate sector provides health services at the workplace for workers and their dependents. The corporate sector will be engaged in screening for TB through work-place screening programs targeting workers and referral for TB diagnosis and treatment services. Corporates that have company clinics on site will be supported to provide all TB services including screening, diagnosis, treatment and follow- up of DS-TB and DR-TB patients. These will also be supported to offer HIV counselling and testing, CPT, ART and follow up for workers living with HIV.

Table 7. *Workplace Model prioritized interventions and implementation approaches*

Prioritized Interventions	Implementation Approaches
Map all workplaces for engagement in TB prevention and care	Engage all stakeholders (County team, workplace associations - eg Kenya Association of Manufacturers, Transport SACCOs, *Jua Kali* Associations, and implementing partners) to develop a comprehensives workplace mapping tool and conduct a workplace mapping exercise in all counties and develop priority lists for engagement. Hold meetings with the different stakeholder groups to sensitize them on the TB workplace policies for their adoption and implementation. Disseminate workplace policy documents to the stakeholders during the mapping exercise.
Promote TB screening in all workplaces.	Conduct scheduled health education sessions at workplaces and institute regular TB screen the workers. Ride on existing medical assessments for certification to screen for TB in the workplace. Conduct ad-hoc targeted TB screening outreaches in hot spot areas
Strengthen linkage and/or referral to TB services/integrate TB services into the service package for companies with Staff Medical Clinics	Create referral networks for TB services between the workplaces and health facilities. County to work with workplaces to train Medical Clinic Staff on TB management. County and implementing partners to develop TB service directory with contacts, TB services offered and pricing. Adopt a suitable sample transport Mechanism (Courier, CHVs, HCWs, Riders). Use different approaches to reach and screen all contacts of index TB patient for TB including contact invitation and physical contact tracing.
Awareness creation/ Sensitization - Stigma reduction	The County TB coordination team will, working in consultation with the leadership of the different workplaces identify, train and engage TB champions to spearhead TB services at workplaces County to work with workplaces to train Workplace TB champions. Conduct a workshop with the different stakeholders to develop and customize TB IEC for the workplace.
Build capacity for recording and reporting	Provide technical support and OJT (on different aspects of TB and lung diseases including reporting) to private workplaces. This will be done through the county TB coordinators and implementing partners

5.6.3 Chemist and Pharmacy model

The objective of this model is to promote identification of presumed TB cases by pharmacists and their prompt referral or linkage to diagnosis, treatment and follow up. Pharmacies will be engaged to screen clients for TB and refer those who are presumptive for assessment and diagnosis. Selected pharmacies will also be linked to sample transportation networks to enable collection of sputum from presumptive clients. Pharmacies that have a clinic attached will also be supported to offer DS-TB and DR-TB treatment and follow up. Considerations should also be made to support designated pharmacies to act as collection points for TB medicines, CPT and ART for stable clients. Pharmacists will also be engaged to dispense HIV Self-test kits.

Table 8. *Chemist and Pharmacist Model prioritized interventions and implementation approaches.*

Prioritized Interventions	Implementation Approaches
Engage professional associations - in TB activities training, sensitization and policy review.	Promote the PPM Agenda in professional associations Invitation to CoE meetings, PPM training and sensitization meetings both virtually and physically Training and sensitization virtually or physically. Sharing TB update materials to the association leaders who will use their social platforms to disseminate. County and subcounty managers to include the chemist and pharmacy within their jurisdiction in support supervision
Engagement of the chemist owners	Mapping will be carried out in all counties to collect data on chemists/pharmacies identity, ownership, registration status, services offered, willingness to offer TB services. Mapping will be carried out by research assistants supervised by County/Subcounty/National team. During mapping all stakeholders will be involved to improve coverage and uptake. Open Data Kit (ODK) solution will be used for data collection.
Capacity building of the private providers on TB	Training/ Sensitization will be carried out to the providers. Flexibility in timing of the training based on the needs of their businesses. Training/Sensitization will address the various key areas in TB control. Ongoing Support supervision and OJT will be provided by the County/Sub-county teams and partners. Leaders of the association will be incorporated in the routine supervision team. Periodic TA by the national team will be carried out. Rapid orientation package will be developed to be used by the chemists/ private facilities to orient new staff. This will address the issue of high staff turnover.

Prioritized Interventions	Implementation Approaches
Strengthening Linkage/ Referral	Customize referral tools, develop a directory for referral services at Subcounty/county level and distribute it to all the private providers. Use of the referral module of t-bu lite. Chemists will be linked to the community units by attaching a CHV from the nearby community unit to support linkages. Develop directory of referral centres with different services and disseminate to the providers Attach all chemists/pharmacy to community unit Capacity build on use of t-bu lite to make referrals Map out the chemists within the community units Budgetary allocation to support incentivization Budgetary allocation to support procurement and distribution of the materials
Experience sharing meetings with the private providers	Plan for annual national experience sharing meetings and quarterly regional experience sharing meetings for private providers. Recognize best performing facilities. Some of the meeting can be carried out virtually.
Demand creation and Visibility	Develop branding materials for chemist/ Pharmacies for visibility of TB services. Printing and distribution of the materials. Materials to include posters, dust coats among others. A field visit to fix the materials in the private facilities. To support radio spots/ TV shows to discuss TB in the private facilities/ Chemists to increase demand for TB services.
Support Supervision, Mentorship and OJT	Quarterly support supervision for private providers by the County/ subcounty teams. Supervisors need to be very patient and flexible when dealing with the providers. Inclusion of a proportion of private facilities during routine County/Subcounty TA. Provision of support supervision books to the chemists for documentation of supervision findings. Provision of support supervision books to the chemist during routine support supervision by the sub county teams
Strengthen screening, diagnosis and referral of pediatric TB among the private providers	Training/ sensitization on pediatric TB. Review/ customize pediatric SOPs for the private/ chemist, print and distribute.
Strengthen MEAL in chemists-lab and workplaces to ensure M&E functions are conducted (R&R tools are available, EMR are in use and data quality audits are conducted)	Design, print tailored R&R tools for chemists Print and Distribute tools to chemists. Onboarding of chemists to t-bu lite. National team to sensitize and onboard the County and Sub-County team who will subsequently sensitize and onboard the providers. Provision of monthly data bundles to the providers to use t-bu lite. Conduct monthly support supervision to the chemists. Chemists to be included in routine support supervision by the County/ Sub-county teams. Quarterly DQA will be carried out. Association leaders to be involved doing support supervision.

5.6.4 Diagnostic Model

Interventions under this model are aimed at strengthening the collaboration with private laboratories through linkages between public and private laboratories offering TB bacteriology services and imaging such as Chest x-ray. This is to ensure that the TB laboratory services are quality controlled and assured. Laboratories will be engaged to offer TB symptomatic screening and referral of presumptive cases to diagnostic sites or linkage to a sample transportation network. Laboratories that have TB diagnostic capability should be supported to offer diagnosis and linked to public or formal private facilities for treatment, notification and follow up of any persons diagnosed with TB or DR-TB. In addition, they will also be engaged to offer HIV counselling and testing services.

Table 9. *Diagnostic Model prioritized interventions and implementation approaches.*

Prioritized Interventions	Implementation approaches
Develop a TB diagnostics mapping tool. Map all diagnostics for engagement in TB prevention and care	Conduct a 1 week national stakeholders' workshop with all relevant stakeholder (County teams - C/SC TB Coordinators, PHOs, MLTs, Pharm, Radiologists, Associations - KAPH, PSK, AKMLSO, SORK etc)) to develop comprehensives mapping tools Engage all relevant stakeholders (County teams - C/SC TB Coordinators, PHOs, MLTs, Pharm, Radiologists, Associations - KAPH, PSK, AKMLSO, SORK etc and implementing partners) to conduct a comprehensive mapping exercise in all counties and develop priority lists for engagement
Strengthen collaboration between the private laboratories, radiology units and the County Health Management Teams/ TB Program	Conduct sensitization of representatives of stand-alone laboratories and radiology centres on the management of TB and lung diseases (can be done through virtual/ online or face to face meetings) Establish a committee with members from both the public and private sector established to strengthen collaboration between private laboratories and radiology units and the county health departments. This will be done during the stakeholder consultative meetings
Strengthening sample networking and linkage to TB treatment services	Adopt a suitable sample transport Mechanism (Courier, CHVs, HCWs, Riders, drones). These will be county-specific Distribute directories of TB service delivery sites - with contacts, list and prices of services, etc and referral tools
Build capacity of standalone laboratory and radiology centres to screen for TB, collect and test/ refer samples for TB testing	Conduct training on TB for laboratory and radiology personnel using tailored training materials Develop or review existing guidelines/ SOPs and customize them for use in private laboratories and/ radiology units

Prioritized Interventions	Implementation approaches
Streamline commodities management	Sensitize staff in private laboratories on commodity management to adequately forecast and quantify laboratory commodities to avoid recurrent shortage of supplies Supply eligible private laboratories with laboratory reagents, cartridges, falcon tubes etc
Improve access to diagnostics - new TB diagnostics technology and CXR services	Provide technical support to GeneXpert sites for online reporting to improve TAT for results. This will be through quarterly site visits to GeneXpert sites by the County GeneXpert Super User or CMLC. Sensitize owners of private laboratories and radiology centres to promote the adoption of new available WHO-recommended technologies for TB diagnosis such as Truenat and Computer Aided Detection for imaging, etc)
Build capacity for recording and reporting by private laboratories and radiology centres	Develop/ review current tools to adapt them for reporting by stand-alone laboratories and radiology centres. Provide technical support and On-Job-Training (on different aspects of TB and lung diseases including reporting) to private laboratories and radiology centres. This will be done through the county TB coordinators and implementing partners

5.6.5 Informal service provider model

Informal service providers include herbalists, drug sellers, traditional healers, traditional birth attendants, faith healers, grocers, shopkeepers, unregistered individual clinics and chemists among others. This group of providers will be engaged to conduct symptomatic screening for TB and refer any persons presumed to have TB to the public or formal private sector for subsequent services. With adequate capacity building and linkage to sample referral mechanisms, some informal providers will also be engaged to collect sputum samples from presumptive clients. Informal service providers will also be supported to refer clients for HIV testing.

Table 10. *Informal Service Provider Model prioritized interventions and implementation approaches*

Prioritized Interventions	Implementation Approaches
Coordination of ISP leaders	Identify and engage key ISP focal person who will network to map other ISPs and their leaders via the Snowballing method and linked to the facility via Community Health Units (CHUs). Develop a database for all ISPs identified
Capacity Building ISPs	Incorporate use of simplified CHV TB training modules that contains audio, visual and practical sessions. Regular peer to peer mentorship on TB among the ISPs during implementation and support supervision phases. Provide IEC materials to the ISPs for distribution to their clients and community.

Prioritized Interventions	Implementation Approaches
Strengthen community, facility and diagnostic linkages	Sensitize facilities and CU on ISP engagement and referrals. Attach all ISPs to their focal person who then channels them to the community health assistance/CHV who links them to the facilities. Develop simplified ISP referral materials to facilitate linkages to the CHVs/facilities. Use of informal approaches during support supervision like having central supervisory meetings.
Advocacy and Demand Creation	Engage the focal ISP persons successfully implementing TB services to influence TB screening and referral among other ISPs by providing mentorship and IEC advocacy materials.
Recording and Reporting	Develop, print, distribute simplified customized ISP recording and reporting tools. Sensitize engaged ISPs on the use of t-bu lite.

6.

MONITORING AND EVALUATION PLAN

54%
Approximatepercentage of all health facilities constituted by private and FBOs in Kenya

4,700
Facilities where TB services are currently available, of which, about 1,100 (15%) are private/FBO

21%
Approximate percentage of all notified cases coming from the private sector, renderring it suboptimal

6.1 Overview of the M&E Plan

The program implements a patient-centered strategic plan with objectives that include the engagement of all care providers. In Kenya, private and FBO constitute about 54% of all health facilities. TB services are currently only available in 4,700 facilities where about 1,100 (15%) are private/FBO. The contribution of the private sector remains suboptimal with only 21% of all notified cases being from the private sector whereas, PPA 2017 showed that close to 50% of people seek care in private facilities.

This M&E plan was developed in line with the National Strategic Plan (NSP) 2019 – 2023 and is intended to provide a framework for monitoring and evaluating TB Public Private Mix (PPM) implementation in Kenya. The program already has a comprehensive M&E plan for monitoring the implementation of the TB strategic plan 2019-2023. This M&E plan is therefore an annex of that particular M&E plan. It details out how performance of the PPM action plan will be measured and spells out other evaluations that are specific to the private sector interventions in TB control.

The indicators of the results framework were determined by the objectives documented in the action plan and aligned to the key approaches and interventions across all the PPM models. This is critical in ensuring proper monitoring is conducted to provide the basis for accountability and informed decision-making at both programme and policy level. Key operations, research and evaluation priorities have also been defined in line with the gaps documented in the NSP.

In the formulation of this M&E plan, the findings, lessons learnt, best practices and achievements identified during the implementation of the previous PPM action plan were considered. Update of this document will be done during development of the NSP. The review will be done through multi-stakeholder engagement. Findings of surveys conducted before the review will also inform the updates.

6.2 Indicators and Targets

6.2.1 The Goal of the PPM action plan

To ensure the provision of quality care and prevention services for all people in Kenya with Tuberculosis.

Table 11. *Indicators, indicator definitions, measurements and targets*

Indicators	Indicator Definition	Baseline		Targets			Data source/ Methods/ Tools	Frequency of data collection	Responsible Person(s)
		Value	Year	2021	2022	2023			
Incidence rate per 100,000 population	Numerator: Number of new and relapse TB cases notified x 100,000 Denominator: Population	267	2020	250	235	220	WHO Global TB report	Annual	Head of program
TB mortality rate per 100,000 population	Numerator: TB deaths x 100,000	37	2020	34	32	30	WHO Global TB report	Annual	Head of program
	Denominator: Population								
Proportion of private notification as a percentage of estimated incidence	Numerator: Number of new and relapse TB cases notified by private/FBO facilities Denominator: Estimated incidence	11%	2020	20%	21%	24%	TIBU, WHO estimated incidence	Annual	Head of program

Indicators	Indicator Definition	Baseline		Targets			Data source/ Methods/ Tools	Frequency of data collection	Respos-nible Per-son(s)
		Value	Year	2021	2022	2023			
Zero families facing cata-strophic costs due to TB diseases	Numerator: Patients who suffered catastrophic costs Denominator: Notified TB patients all forms	27%	2020	0%	0%	0%	WHO Global TB report/Cost survey	Annual	Head of program
Percentage of TB National budget ded-icated to pri-vate provider engagement	Numerator: National budget allocated to implementation of TB in private sector Denominator: Total TB National budget	1%	2021	2%	2%	2%	TB budget work plans	Annual	Head of program
Proportion of TB expendi-ture by private providers against total national TB expenditure	Numerator: National TB expenditure in the private sector Denominator: Total National TB expenditure	1.9%	2018/19	2%	3%	5%	NHA(national Health Account)	once in 3 years	Head of program
Percentage of privately notified TB cases for which >90% of direct medical expenses for TB are covered by the public or man-datory benefits package	Numerator: Number of TB patients on treatment who visited private facilities and >90% of their direct medical expenses was covered by the public or mandatory benefits package Denominator: Total number of patients treated in the private facilities	0	-%	-%	-%	90%	Patient interview in private facilities.	once in 3 years	Head of program
Number of PPM CoE meetings held during the year at national and county levels	Number of PPM CoE meetings held during the year at national and county levels	4	2020	192	192	192	Meeting minutes	Annual	Head of program

Indicators	Indicator Definition	Baseline		Targets			Data source/ Methods/ Tools	Frequency of data collection	Respos-nible Per-son(s)
		Value	Year	2021	2022	2023			
Proportions of private health facilities (engaged) participating in supportive supervision at county and National level	Numerator: Number of engaged private health facilities participating in supportive supervision at county level Denominator: Total number of private health facilities (master facility list in TIBU).	45	2020	100%	100%	100%	Supervisory reports	Annual	Head of program
Number of private provid-ers mapped across all models	Private providers mapped across all models	1168	2020	4700	2350	2350	Mapping reports	Annual	Head of program
Number of annual dissemination and planning meetings held by NTP with the PPM stakeholders	Annual dissemination and planning meetings held by NTP with the PPM stakeholders	0	2020	1	1	1	Meeting report	Annual	Head of program
Proportion of private facili-ties providing TB treatment services in Kenya	Numerator: Number of private/ FBO facilities providing TB treatment services in Kenya Denominator: Total number of private/FBO facilities in Kenya.	15%	2021	20%	25%	30%	TIBU and Master facility lists. 54% of registered facilities are either private or FBO	Quarterly	Head of program
Number of private pro-viders offering screening and referral services	Number of private providers offering screening and referral services	Chemist/ Pharmacies - 176 Workplaces - 0 Private facilities/ Institutions - 432 ISP Diagnostic -12	2021	Chemist/ Pharmacies - 146 Workplaces - 0 Private facilities/ Institutions/ FBO - 336 ISP Diagnostic -1	Chemist/ Pharmacies - 405 Workplaces - 150 Private facilities/ Institutions/ FBO - 1798 ISP - Diagnostic -177	Chemist/ Pharmacies - 135 Workplaces - 50 Private facilities/ Institutions/ FBO - 599 ISP Diagnostic - 60	TIBU	Quarterly	Head of program

Indicators	Indicator Definition	Baseline		Targets			Data source/ Methods/ Tools	Frequency of data collection	Respos-nible Per-son(s)
		Value	Year	2021	2022	2023			
Proportion of notified TB cases (all forms) by private/non-governmental facilities	Numerator: Number of TB cases all forms notified by private/non-governmental facilities Denominator: Total number of TB cases all forms notified	20%	2020	13,679 (27%)	29,974 (30%)	33,504 (34%)	TIBU	quarterly	Head of program
Treatment success rate of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapse cases	Numerator: Total number of patients with outcomes cured and treatment completed Denominator: Total number of TB patients notified	87%	2020	90%	90%	90%	TIBU	quarterly	Head of program
Cure rate for bacteriologically confirmed TB managed by private/FBO facilities	Numerator: Number of TB patients who were cured Denominator: Total number of bacteriologically confirmed TB patients notified	68%	2020	90%	90%	90%	TIBU	quarterly	Head of program
Proportions of People with TB referred by private/ FBO facilities as a percentage of total notification	Numerator: Number of TB patients referred by private/FBO facilities Denominator: Total number of TB patients notified	4%	2020	5%	10%	15%	TIBU	quarterly	Head of program
Percentage of bacteriologically confirmed TB patients notified by private/ FBO sector	Numerator: Number of bacteriologically confirmed TB patients notified by private/FBO facilities Denominator: Total number of TB patients notified by private/FBO facilities	60%	2020	65%	70%	75%	TIBU	quarterly	Head of program

Indicators	Indicator Definition	Baseline		Targets			Data source/ Methods/ Tools	Frequency of data collection	Respos-nible Per-son(s)
		Value	Year	2021	2022	2023			
Proportion of patients notified by private/FBO facilities with DST results	Numerator: Number of TB notifications with DST results in private/FBO facilities Denominator: Total number of TB patients notified by private/FBO facilities	62%	2020	75%	80%	80%	TIBU	quarterly	Head of program
Number of pri-vate facilities offering TB services using t-bu lite for recording and reporting	Private facilities offering TB services using T-bu lite for recording and reporting	0	2020	1,100	4110	4550	TIBU	quarterly	Head of program
Proportion of engaged facilities that are notifying TB cases to NTP	Numerator: Number of engaged private/ FBO facilities notifying TB cases Denominator: Total number of engaged private/ FBO facilities	78%		80%	85%	90%	Supervisory reports	Annual	Head of program
Extent of under reporting in private/FBO facilities	Inventory study to measure under reporting	Inventory study					An inventory study is due.	Once in 3 years	Head of program
Knowledge, Attitude and practice in private sector	KAP survey	KAP					Include the private sector in the GF funded KAP study	once in 3 years	Head of program

6.3 TB PPM MAF M&E Related Indicators

The following proposed indicators in Table 12 will track the implementation of the action plan and are aligned to the four components of the MAF and customized to PPM. The score of 5 being the highest score for excellent performance and 1 the lowest for weak performance. The annual ranking of these indicators will help to track commitment, assess implementation performance and inclusion of TB PPM in the national policy documents and plans.

Table 12. *Indicators to track implementation of the TB PPM Action Plan Implementation in Kenya.*

ITEM	Score					COMMENTS
	1	2	3	4	5	
COMMITMENTS						
Have national political leaders made recent statements or declarations prioritizing partnership with the non-state sector in health?						
Does the National Health Policy emphasize engagement of non-state healthcare providers and lay out clear approaches to productive engagement with them?						
Does the NSP include clear targets for PPM, including treatment outcomes, notifications, quality of care, referrals, and numbers of active providers in each category?						
ACTIONS						
Does the NSP include data on the total numbers of different kinds of providers in the country[1], their role in general health care-seeking, and their role in TB?						
Does the NSP include estimates of the volumes of private TB drug sales or their market share?						
Is the budget allocation for PPM in the NSP proportionate with the role of non-NTP providers in the health system?						
Is mandatory TB notification covered under current legislation or decree, with accompanying implementing regulations?						
Have simplified digital systems been established to facilitate TB notification by non-NTP providers[1]?						
Do criteria for professional licensing and accreditation include any specific reference to provider expectations regarding TB?						
Does the government use its own budgetary resources to purchase TB services from non-state healthcare providers?						
Is there any official public recognition of high-performing PPM providers at least annually?						

ITEM	Score					COMMENTS
	1	2	3	4	5	
MONITORING AND REPORTING						
If there is a published annual report on TB, does it include an analysis of PPM?						
Do routine monitoring reports at the national and subnational level include data on PPM: outcomes, notifications, quality of care, referrals and numbers of active providers, by category[1]?						
Are TB outcome data routinely presented separately for patients managed by different kinds of providers[1]?						
Do routine data systems permit provider-wise tracking of TB performance over time?						
Are data on PPM publicly available on-line?						
REVIEW						
Do formal, routine (annual and/or more frequent) reviews of the NTP at the county, sub-county and national level include a separate agenda item for PPM?						
Are PPM targets included in the main list of priority indicators used by health sector leaders and politicians to review progress in TB?						
Do representatives of PPM providers participate actively in reviews of the TB program at county, sub-county and national levels?						
Are there any mechanisms to provide feedback to non-NTP providers on their performance in TB?						

6.4 Digital Innovations under PPM

6.4.1 TIBU

The TB program is implementing a case-based electronic reporting system (TIBU) that follows the minimum WHO recommended reporting standard of disaggregation of data by sector (Public, Private, Prisons and FBOs). Currently, reporting at the Sub-County level is paper based, recording is done by clinicians and the data is uploaded by the sub-county TB and leprosy coordinators into TIBU.

TIBU is integrated into Kenya Health Information System (KHIS) and plans are underway to integrate it into other systems such facility EMRs, laboratory systems, GeneXpert Laboratory Information Management Systems (GX LIMs).

6.4.2 t-bu lite

DNTLD-P Kenya utilizes t-bu lite as a national case-based surveillance system for TB and Lung Diseases. This electronic version (t-bu lite) seeks to go beyond recording and reporting and into case based patient management. It's built to provide options for care seeking and knowledge on how to manage TB screening, referral and treatment.

Designed for HCWs, CHVs and Private Pharmacies/ Chemists, t-bu lite app provides quick reference to TB treatment guidelines in addition to the screening, contact management treatment and client appointment modules.

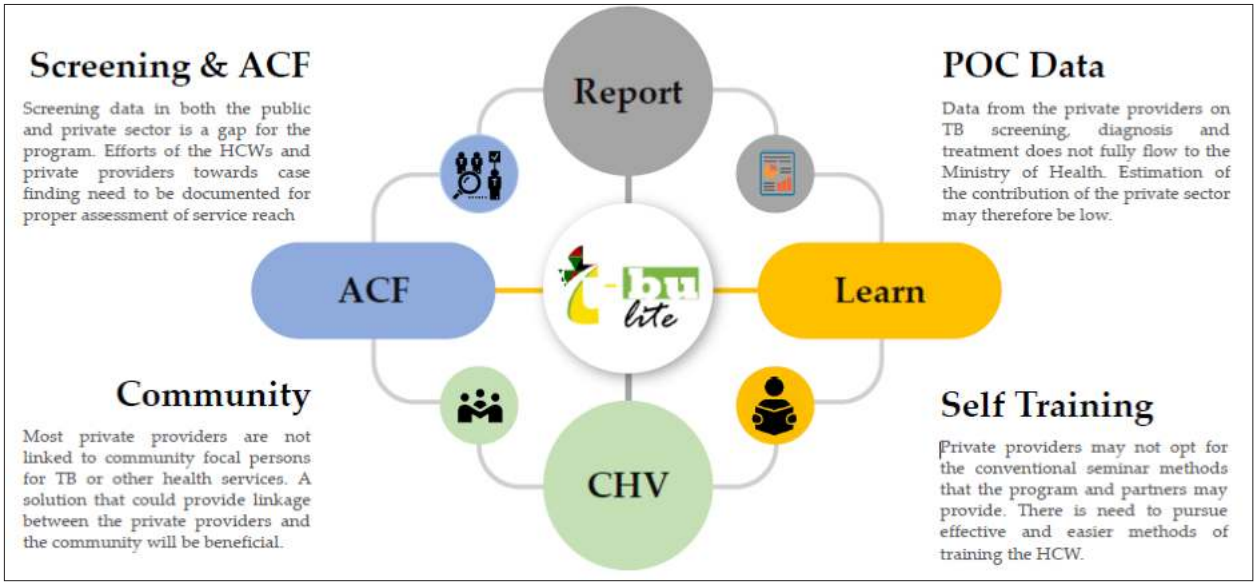
App Name:
t-bu Lite

App Description:
a digital patient centered Approach for TB Care in Kenya.

Owner:
Ministry of Health, DNTLD-P

Description:
the app brings a patient-oriented approach to TB treatment and management in Kenyan health facilities and communities.

Figure 11. *Android-based t-bu lite modules*



Within the app (see Figure 11), all users are be able to:

- Read the integrated TB guidelines
- Do self-tests on the TB guidelines modules completed
- Record all TB screening encounters at facility, community and private sector settings
- Referral of all screening and symptomatic clients to the TB diagnostic and treatment sites in Kenya
- Manage contacts for TB clients including initiation of TB preventive Therapy (TPT)
- Manage TB and DRTB patients with clear tracking of appointments to enhance favorable outcome
- Earn reward points for achievement of every target in the rewards matrix.

t-bu lite app is an upgrade of the existing TIBU reporting system which is managed by the county and sub county TB coordinators in Kenya. The app automatically relays data to the TIBU cloud server for validation without any need for integration. The app also benefits from the existing TIBU infrastructure and maintenance efforts. It has been developed by the Ministry of Health Kenya (DNTLD-P), the Global Fund, USAID, Amref Health Africa and Iridium interactive limited.

6.4.3 PPM Dashboards

The National TB program will enhance the TIBU dashboard to optimize visualization of reports and promote TB data demand and information use. The dashboard will support Kenya in regularly collating key PPM data on contribution and outcomes, which will also play an important role in strengthening national TB strategic plans and inform funding proposals. This dashboard will support the country in the long term and will be integrated into national M&E systems making them sustainable. This is also part of promoting a people-centered approach to care.

Consequently, the dashboard will ensure that information is available to inform gaps and key decisions under the implementation of PPM interventions including commitment to PPM targets and performance.

- **Indicators of commitment** will include information on the policy environment for respect to non-state providers, allocation of budgets for engaging non-state providers, information on the role of social health insurance schemes (where relevant), and the availability and use of data to monitor progress.
- **Indicators of performance** will include information on both TB case finding (notifications) and case management (quality of care, outcomes). Dashboards will also distinguish between private for-profit, private non-profit and public non-NTP sectors, and between levels of the healthcare system (community, primary, secondary, tertiary) and PPM models.

6.4.4 Operational Research in the PPM

The TB NSP[2] has provided guidance on the national research priorities areas which if done can include PPM related questions on the following themes (see Table 13).

- Promoting care
- Quality of care and ensuring cure
- TB and co-morbidities
- Data for programmatic monitoring and planning

[2] National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023. Nairobi, Kenya, page 98.

Table 13. *Proposed PPM related prioritized operational research questions*

Thematic Areas	Research priorities
Promoting care	• TB knowledge attitude and practice survey
Quality of care and ensuring cure	• Measurement of patient quality of care- 'Mystery shopper' evaluations • Adherence surveys: Uptake of digital solutions and effect on patient follow up and adherence in the private sector. • Assessment of risk factors and barriers to access to TB services and care in the private sector. • Assessment on TPT implementation in the private sector
TB and co-morbidities	• Assessment of TB and co-morbidities services integration in the private sector
Data for programmatic monitoring and planning	• TB inventory study • Impact assessment of strategic initiative in TB case finding in the private health facilities.

7.

REGULATORY FRAMEWORK FOR TB IN KENYA

7.1 Policies

A regulatory framework is key in the development and implementation of action plans intended for effective, accountable and sustainable engagement with the private sector. The WHO recommends the following health systems and policy foundations to effectively engage private health providers:

Figure 12.*Health systems and policy foundations to effectively engage private health providers*

01 Policy, regulations, enablers (such as simplified digital systems) and enforcement mechanisms for notification of TB cases;

02 Policy, regulations and enforcement mechanisms regarding sales of anti-TB drugs and inappropriate diagnostics;

03 Policy and systems for quality assurance of healthcare practitioners and facilities (licensing, certification, registration, accreditation);

04 Policy, systems and specialist staff dedicated to contracting and to purchasing of packages of health services.

7.2 Health Policy landscape in Kenya

As prescribed by the preamble of the Constitution of Kenya, 2010, meaningful inclusion and engagement of stakeholders has been considered as a principle. To actualize this, the Ministry of Health (MOH) in 2019, established a multi-stakeholder process of developing the first Kenya Health Public Private Collaboration Strategy. The Strategy's Vision is to see a healthy, productive and globally competitive nation which is to be achieved through partnerships. The Mission of the said strategy is the provision of a framework that fosters transparent, informed and effective engagement between the public and private sector towards promoting access to quality and affordable healthcare.

Hence it is in this, that this action plan derives its mandate and strengths. The Strategy proposes achieving these with the guidance of eight principles which are herein the **guiding principles** engaged in the development of this plan:

- Transparency and Accountability;
- Equity;
- Integrity;
- Value for Money;
- Mutual Beneficence;
- Inclusivity;
- Social Responsiveness; and
- Demonstrated Impact on the Health of the Public.

According to the strategy, there are key objectives as herein below prescribed:

01 Support the creation of a policy and regulatory environment that allows effective private sector participation in meeting public health goals

02 Leverage private sector efficiency strengths, and innovation and technological capacity to improve public health service delivery

03 Harness private sector resources and channel them towards equitable financing of public health services

04 Guide contracting authorities on identifying and prioritizing projects that can deliver better value through collaboration with private partners

05 Develop mechanisms for effective information sharing to promote transparency and accountability between the public and private health sectors

06 Build the capacity of stakeholders to initiate and engage in public private dialogue and establish mutually beneficial collaborations for maximum impact

7.3 Kenya Health Public Private Collaboration Pathways

The guide to Collaborations Between the public and Private Health Sector in Kenya (2020) provides a pathway to collaboration grouped into two based on the need for investments: i) no capital investment needed and ii) capital investment needed. Figure 13 summarizes the pathways highlighting the thematic areas, objectives and main laws and policies that supports the engagement with private sector.

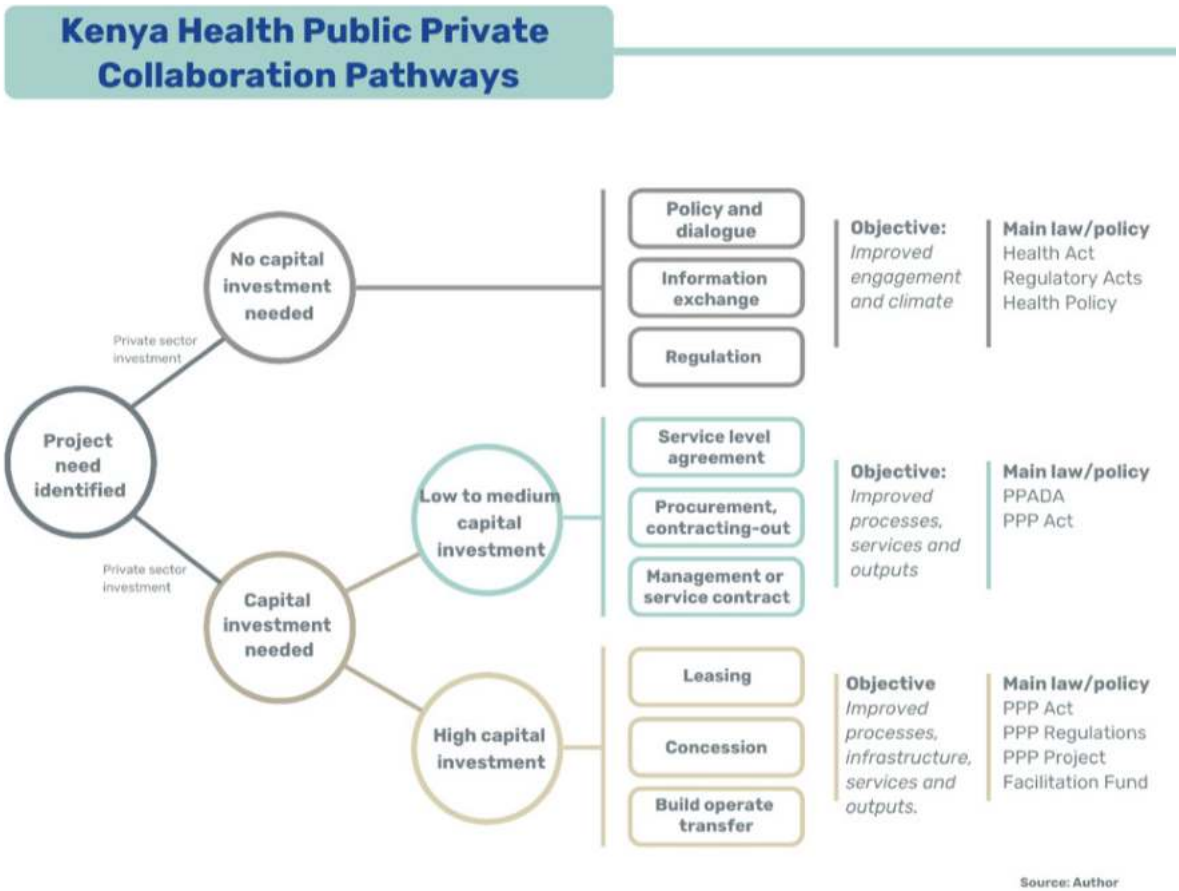
7.4 Applicable Laws

This action plan has been guided and will be implemented in consideration of the following Laws of Kenya:

7.4.1 Constitution of Kenya, 2010

The Preamble to the Constitution lists equality, participation and inclusion as part of the essential values upon which to base governance. This is given legal force and emphasis by Article 10 of the Constitution, which provides the national values and principles of governance, which include, among others:10(2a) the rule of law, democracy and participation of the people.

Figure 13. *Kenya Health Public Private Collaboration Pathways.*



7.42 Health Act 2017

Under Part XIII and precise section 88-92, prescribes for the administrative management of private healthcare providers and or workers with regard to licensing, supervision and practice. In this, it encompasses and exacerbates the constitutional inclusion and integration of and in the healthcare system. The Act mandates the national government to coordinate the development of guidelines for public private partnerships (PPPs) in health. Secondly, it specifies that counties and national public entities may enter in PPP arrangements to support the achievement of health goals.

7.4.3 Public Health Act

The Public Health Act (Cap 242) revised 2012, Part III relating to notification of infectious diseases, enlists all forms of tuberculosis as a notifiable disease12. The act stipulates the obligation of the medical practitioner attending the patient, to notify the TB patient according 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 shillings. However, there is limited clarity on enforcement mechanisms currently in place to ensure notification of TB from the private sector.

7.4.4 The PPP Act and Regulations

The PPP Act (2013) defines PPPs as 'Arrangements between a contracting authority and a private party, under which a private party undertakes to perform a public function, receives a benefit for performing a public function through compensation from a public fund of the collection of charges or fees, and is generally liable for risks arising from the performance of the function.' This Act is operationalized further through the PPP Regulations of 2014 and the PPP Project Facilitation Fund Regulations of 2017.

7.4.5 Pharmacy and poisons Regulations

It 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.

7.4.6 The Kenya Health Policy, 2014–2030

It gives directions to ensure significant improvement in the overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments. It demonstrates the health sector's commitment, under the government's stewardship, to ensuring that the country attains the highest possible standards of health, in a manner responsive to the needs of the population

7.4.7 The Health PPC Strategy

In addition to the formal definition for PPPs in the PPP Act of 2013, the Kenya Health PPC Strategy (2020) defines non-PPP collaborations that include alternative arrangements between a public authority and a private party that do not fall under the PPP Act's definition of a PPP.

7.4.8 The National Strategic Plan for National Tuberculosis (TB) Leprosy and Lung health 2019 -2023 (NSP)

The Strategic Plan has dual objectives of sustaining close collaboration with development and implementing partners by enlisting and nurturing new local and international partnerships.

7.4.9 Data Protection Act of 2019

Aa ACT of Parliament to give effect to Article 31(c) and (d) of the Constitution; to establish the Office of the Data Protection Commissioner; to make provision for the regulation of the processing of personal data; to provide for the rights of data subjects and obligations of data controllers and processors; and for connected purposes.

7.4.10 Kenya Health Sector Partnership and Coordination Framework 2018-2030

The framework reinforces the strong relationship between the Ministry of Health and partners towards working in concert to achieve national health development priorities, the Sustainable Development Goals, and other internationally agreed development goals. The content of this framework confirms that the cooperation between the Ministry of Health, County Departments of Health, and partners is based on the development of partnerships with strong national and county government ownership and leadership in development and implementation.

7.4.11 County Governments Act (2012)

Section 6 (3) gives counties power to enter into partnerships with private entities for any work, service or function within their area of jurisdiction, as long as they comply with PPP-related laws. Section 87 requires counties to use public-private partnerships as one of the principles for strengthening citizen engagement.

7.4.11 Sessional Paper Number 10 of 2012 - Vision 2030

Kenya Vision 2030 is the long-term development blueprint for the country and is motivated by the collective aspiration of a better society by the year 2030. The vision aims to create a globally competitive and prosperous Kenya with a high quality of life. Health is part of the social pillar of Kenya Vision 2030: the purpose being to provide equitable and affordable quality health services to all Kenyans. This is in recognition that good health and nutrition boost the human capacity to be productive.

8.

IMPLEMENTATION ARRANGEMENTS

8.1 NSP Guidance on PPM Implementation

The DNTLD through the national TB strategic plan has provided a comprehensive strategic direction towards implementation of PPM activities. Implementation and scale up requires strong collaboration between the private, public and other key stakeholders. The DNTLD has built partnerships with key stakeholders and continues to provide leadership and stewardship towards implementing the PPM activities. The DNTLD will further continue to strengthen collaboration with private providers in order to facilitate delivery of quality TB services. The Government continues to provide anti-TB medicines and laboratory commodities and supplies including access to more sensitive WRD tests like GeneXpert to the private sector for free.

8.2 PPM CoE Oversight

A PPM CoE is in place to oversee, coordinate and provide guidance towards implementation of PPM activities in the country. Other activities conducted by the CoE include; providing technical advice to key stakeholders, oversee implementation and monitoring of PPM policies, strategies/interventions, plans and activities, document and disseminate information on PPM, identify and develop strategies to address implementation gaps, mobilize resources to support PPM activities and identify research priorities to inform the design of more effective PPM interventions.

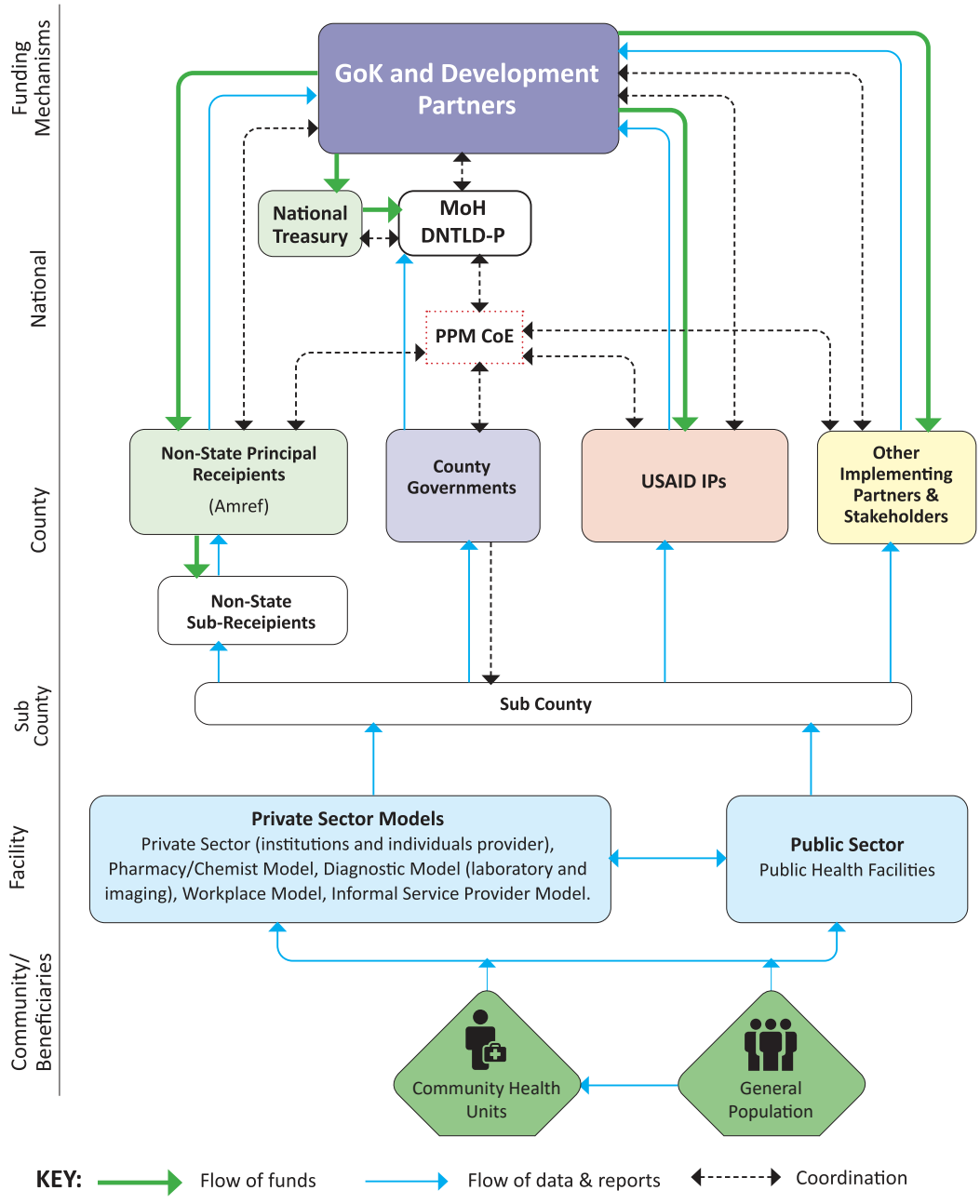
8.3 Funding and Coordination (National and County Level)

PPM activities in this action plan will be funded through various mechanisms including the government of Kenya and development partners like the Global Fund, USAID, TB REACH etc. The global fund monies are channeled to the country through two Principal Recipients; PR1 – the National Treasury and PR2 – AMREF. The two PRs further provide

funding to sub recipients who are the main implementers of PPM activities. The brief roles of IO are shown in Annex 13.5.Other development partners provide direct funding to various implementing partners who support implementation of PPM activities at county, sub-county and facility levels.

At county level, the county government will support implementation of PPM activities by providing a conducive environment for private sector players across the PPM models and implementing partners to implement PPM activities. The county government will also provide oversight and coordination of PPM activities being implemented in the county. The sub counties will support engagement of private facilities as well as support linkages to diagnosis and care. At this level, verification of facility data is done before it is submitted to the county level and to the implementing partners and finally reported to the DNTLD-P by the county TB coordinators through TIBU. Health facilities will be supported to do their reporting through the t-bu lite application.

Figure 14. *Implementation Arrangement of TB PPM Activities in Kenya 2021-2023.*



The five PPM models described in Chapter 5 above will be implemented in the entire country. Referral linkages between private and public facilities as well as community health units will be strengthened to ensure the general population receives people centered, acceptable and affordable quality TB services through the PPM models and arrangements.

Figure 14 highlights the linkages between DNTLD, private sector implementing partners, counties and other diverse actors.

8.4 Task mix for PPM activities

The Table 14 is the summary of propose task-mix for public and private providers which are indicative and can change as new innovations are deploying in TB care and control.

Table 14. *Summary of task-mix for health care providers (public and private)*

	Tasks	Government			FBO			Private provides Workplace		Retail pharmacies and chemists	Standalone laboratories	Imaging	Informal sector
		NTP	Hospital	Health centers	Hospital	Health centers	Dispensary	Hospital	Clinics				
SERVICE DELIVERY TASKS	Identify TB symptomatics		X	X	X	X	X	X	X	X	X	X	X
	Refer symptomatics		X	X	X	X	X	X	X	X	X	X	X
	Request diagnostic tests		X	X	X	X	X	X	X				
	Run diagnostic tests		X	X	X	X	X	X	X		X	X	
	Prescribe treatment and counsel/inform patients		X	X	X	X	X	X	X				
	Supervise treatment (dispense drugs)		X	X	X	X	X	X	X				
	Patient follow-up visits		X	X	X	X	X	X	X				X
	MDR-TB treatment supervision		X	X	X	X	X	X	X				
	TB and comorbidities diagnosis and treatment linkages		X	X	X	X	X	X	X				
	Contact investigation		X	X	X	X	X	X	X	X			
	Loss to follow-up tracing		X	X	X	X	X	X	X	X			
	Recording and reporting, including notification		X	X	X	X	X	X	X	X	X		X
PUBLIC HEALTH TASKS	Stewardship, financial management	X											
	Drugs and Supply Management	X	X										
	Monitoring and Evaluation	X											
	Laboratory Quality Assurance	X											
	Supervision or quality improvement	X											
	Training, Orientation or Sensitization	X											
	CME contributions and knowledge dissemination to providers	X											
	Mapping and enrollment of private providers	X	X										
	Organizing quarterly programme oversight	X	X										

9.

SUISTANABILITY MECHANISM

9.1 Overview of Themes to Sustain the PPM activities

Themes for consideration for the sustaining the gains of PPM activities in the country may include:

Figure 15. *Thematic Areas Considered for Sustaining PPM Activities in Kenya.*

9.2 Enabling Environment

The MOH through DNTLD-P takes leadership to engage the private sector and ensure quality TB services to sustain the gains in PPM activities. The following are considered under enabling environment:

A. **Regulatory frameworks**: the policies and laws governing engagement of the private sector are key and are discussed in the Chapter 7.

B. **Provide technical standards**: take leadership in providing technical standards in through guideline development and training packages. These should be coupled with relevant TA for different models of service models under PPM.

C. **Supply of tools and commodities**: supply of tools for R&R and also ensure constant supply of supply of commodities

9.3 Financing Models

Financing models to sustain the PPM activities in the country are important and need to be considered. There are several that have already been proposed from experts and the potential models for financing for PPM initiatives typically comes, or could come, from one or more of the following sources[3]

1) **Government budget, paying for inputs**: Government funding is more predictable and reliable than other funding streams. It also brings with it the advantage of local ownership; the authority to regulate and enforce program requirements and quality assurance; and the ability to scale up and sustain programs. It establishes the public sector as not only a provider of services, but as the steward of services provided by the private sector. The inclusion of PPM activities in the Counties health plans indicates the counties commitment to support PPM initiatives.

2) **Donor financing of inputs**: Donor financing helps to establish the concept of PPM activities, and have already demonstrated that PPM is a viable method for increase TB case notification and improving treatment outcomes. Donor funds have the advantage of greater flexibility and are ideal for testing new, innovative models. The country should continue to mobilize resources from different funding mechanisms like Global Fund, USAID, STOP TB Partnership to fund PPM activities in Kenya.

3) **Government or donor budget, paying for outputs**: Results-based financing RBF can take many forms which may include:

   a. Cash on delivery model where money is directed to government budgets for specific outcomes.

   b. Pay for performance schemes for CHWs (e.g., workers are given a set amount per client initiated and/or per client completing DOT.

   c. Provider recognition programs.

[3] Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives. A working meeting co-convened by USAID and the World Bank, in collaboration with the Stop TB Partnership's PPM subgroup, and organized with PATH 27-29 May 2014, Washington, DC

d. Contract-based financing to non-governmental organizations (NGOs) based on program deliverables.

e. Conditional cash transfers to individuals for specific outcomes.

4) **National health insurance:** has the potential to cover the greatest number of people and services like TB diagnosis, treatment and prevention. National health insurance has potential of reducing the out-of-pocket payments for the current clients in the public and private sectors. National health insurance also offers the promise of bringing what are now opposing and diverse dichotomies of health financing and purchasing (e.g., vertical vs. horizontal health programming) under one roof—leading to a more efficient and equitable system.

5) **Government social protection:** social protection schemes address a range of social risks (e.g., poverty and unemployment) which often target the lowest quintile in a population—where TB is more prevalent. Social protection requires active government involvement and a highly knowledgeable local implementer. They include the use of conditional cash transfers or other forms of subsidies.

6) **Out-of-pocket, including fees paid at a social business or franchise outlet:** in low-income settings, out-of-pocket payments are the most common financing mechanism for healthcare. Social business or franchise models charge out-of-pocket fees for some services, while other services may be free of charge. Fees from clients can then help to support, at least partially, the running costs of a franchise or social business.

An assortment of these financing sources can be combined to achieve the goal of UHC —the idea that all people should have access to affordable health services—including the financing of PPM.

9.4 Organizing providers and enforce quality control

PPM has two major players:

- **NTP** acted as a steward for policies, guidelines, technical standards for diagnostic, treatment standards and quality control.
- **Intermediary organization** translates the standards to the multiplicity of different private providers.

Consolidating individual private providers—either into formal organizations or into more informal networks with shared quality standards—could bring efficiency gains, improved service standards and quality of care. The models proposed in organizing providers include:

- **Traditional** PPM models
- **Social franchising** "works by creating a highly visible network of health care providers that are contractually obligated to deliver specified services in accordance with franchise standards under a common brand
- Under a **social business model**, high-quality, low-cost services are sold in order to finance social objectives. Because the model generates its own revenue, social businesses have the potential to become self-sustaining.

9.5 Integrating TB services

Linking TB with other health services to cross-subsidize TB control efforts and expand program reach. Integration of TB with other health services will be particularly important for PPM initiatives.

i. PPM features prominently at the first step of TB control—the point of health seeking by individuals with non-specific symptoms, and thus is operating in a general, not specialist, healthcare environment. Hence opportunity to include other health conditions that are being treated in the same facility.

ii. TB is a relatively rare diagnosis. A PPM scheme will therefore be more attractive and cost-effective if it includes multiple disease areas.

iii. TB is a disease of the poor, with a lengthy treatment, and any private sector TB services will likely need to be cross-subsidized by services where higher fees can be charged.

Example of linking TB programs with those that target diabetes, asthma, chronic obstructive pulmonary disease (COPD), anemia, HIV and/or malaria, for example, can help to identify a greater number of TB cases – particularly among those who would otherwise not seek care due to TB-specific stigma.

9.6 Incentives and enablers to engage private providers

The private sector needs incentives and enabler to ensure they remain engaged and offer the quality TB services. The incentives can either be non-financial or financial as briefly discussed below:

Non-financial incentives for these programs may include:

i. Providing awards, certifications and/or recognition to providers. For private providers, this kind of recognition could help to set them apart from other providers and increase their overall client base.

ii. Appealing to a provider's social responsibility (i.e., the use of moral persuasion and peer pressure).

iii. Offering information, support, training/capacity building, networking and access to lower priced health commodities.

Financial incentives:

The financing models discussed above in the sub-section 9.3 may be a good motivation and incentive for private sector to engage in TB prevention and care. Examples of these financing models include:

a) Government budget, paying for inputs

b) Donor financing of inputs

c) Government or donor budget, paying for outputs: Results-based financing RBF

d) Cash on delivery model

e) Contract-based financing to NGOs based on program deliverables

f) Conditional cash transfers to individuals for specific outcomes

g) Supply of drugs and commodities.

h) Seconding HR from public to private.

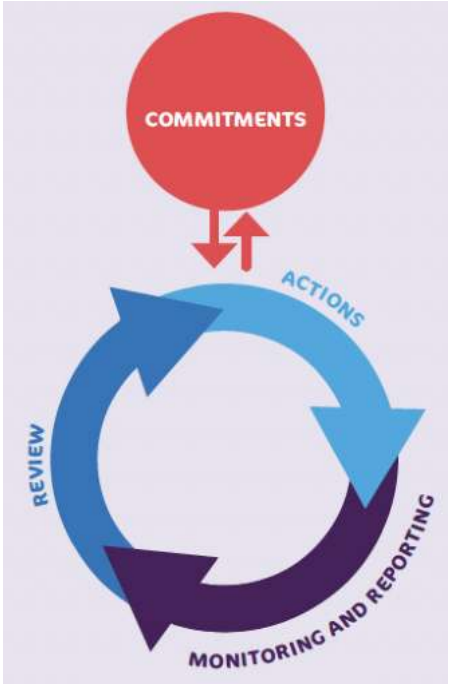
i) Supporting best performing providers to attend conferences and experience sharing forums.

9.7 Multisectoral Accountability Framework and PPM

The MAF-TB aims to guide the strengthening of accountability by Member States, as well as multisectoral partners and stakeholders, at national, regional and global levels in order to accelerate progress to end the TB epidemic by 2030, including the meeting of commitments and targets set for 2022 and 2030 in the UN Sustainable Development Goals, the WHO End TB Strategy and in the Political Declaration of the 2018 UN General Assembly High-Level Meeting on the fight against TB.

The MAF-TB can help support the process of defining who is accountable, what they are accountable for, and how they will be held accountable, at country and local levels, as well as at regional and global levels. The four essential components of the MAF-TB are shown below in a cycle. These components are consistent with frameworks and measures in many other fields across sectors.

Figure 16. *Essential components of the MAF-TB*



- **Commitment:** the country commits to International and national goals and targets. The PPM targets national targets are well described in the NSP and also mentioned in this action plan.
- **Review**: Periodic (e.g. annual) review of the TB response in the private sector using a national-level review mechanism needs to be in place.
- **Actions**: National (and local) strategic and operational plans on PPM involving multisectoral perspective and covering government and partners needs to be involved in development, funding and implementation.
- **Monitoring and Reporting**: routine R&R of TB cases, treatment outcomes and other End TB Strategy indicators via national information system need to be consistent with WHO guidance and that meets WHO quality and coverage standards for tuberculosis surveillance. t-bu lite (further described under 6.4.2) provides the means to improve data quality in the private sector.

10.

PPM OPERATIONAL PLAN 2021-2023

Policy and Coordination							
		-	Activity Timeframe				
Strategic objective	Sub-Objectives	Activity Description	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	1.Strengthen leadership and coordination	Develop a PPM policy in a consultative manner with all policy stakeholders (The policy should include: TA policy statement, policy communication on the introduction of virtual training, verification of the policy on provision of commodities to the private providers by GoK,	X	X	-	DNTLD-P	-
		2.Revamp and expand the CoE, define participation and membership	X	X	X	DNTLD-P	-
		3. Involvement of private providers during development of guidelines and policies	X	-	-	DNTLD-P	-
		4. Update, disseminate and create awareness on patient charter	X	-	-	DNTLD-P	-
		5. In consultation with the HR department, develop an addendum to include TB-specific in the JDs for the staff deployed in the TB Program	X	-	-	DNTLD-P	-
		6. Develop a circular from the national level to the County HMT on the roll out of TB PPM engagements	X	-	-	DNTLD-P	-
		7. Map Counties that have staff seconded from Public to private/ FBOs, draw lessons and strengthen the mechanism for secondment in consultation with the HR department	X	X	-	DNTLD-P	-
		9. Development of the e learning modules and uploading them in a common platform with access guidelines	-	X	-	DNTLD-P	-
		12. Conduct trainings that target the private sector that have flexy timings.	-	X	-	DNTLD-P	-

Policy and Coordination							
		-	Activity Timeframe				
Strategic objective	Sub-Objectives	Activity Description	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
		13. Develop evidence based advocacy briefs and submit to the budget making processes in the ministry and Counties	-	X	-	DNTLD-P	-
		14. Participation in the budget making processes at national and County level (MTEF among others)	-	X	X	DNTLD-P	-
2. Optimise delivery of people centred TB services across all provider types	1. Creating awareness and dissemination of Program guidelines and policies among private players	1. Customize the integrated curriculum to be more responsive to the private sector	X	X	-	DNTLD-P	-
3. Promote effective and efficient monitoring and evaluation of PPM interventions	2. Promote data use for decision making and OR to generate evidence	Involvement of private sectors representatives in PRM	-	X	X	DNTLD-P	-
Private Facilities Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Strengthen coordination of PPM activities at National and sub national levels	Conduct a workshop to disseminate key documents (Action plan, Mapped facilities, reporting framework, SOPs etc) to all stakeholder	X	X	-	DNTLD-P	CHS
		To Establish PPM CoEs at county and/or Sub county level.	X	X	X	DNTLD-P	CHS
		Develop a business case to encourage private sector to uptake TB services and invest in them.	X	-	-	DNTLD-P	NTP, Amref
		Support and facilitate implementation of policy and regulatory mechanisms through the county leadership and associations/ councils and refugee leadership	-	X	-	DNTLD-P	TBD
		Create engagement forums with associations leadership	X	X	X	DNTLD-P	Amref
		NTP and counties to include TB symposia during professional associations conferences	-	X	X	DNTLD-P	NTP, Amref
		Provide regular technical assistance to the private facilities	X	X	X	DNTLD-P	NTP, Amref, CHS, Komesha TB, Health IT, others
		Conduct regular technical site visits at national level	X	X	X	DNTLD-P	

Private Facilities Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
	Improve capacity of administration and HCWs in private facilities and associations	Customization of training curriculum/ materials/Programme for the various cadres (virtual trainings,media ie Print and digital, split CME sessions)	X	X	-	DNTLD-P	Health IT, Amref
		Training of various cadres on different aspects of TB prevention and care	X	X	-	DNTLD-P	Komesha, Amref, CHS
		Continuous OJT and CMEs on different aspects of TB prevention and care	X	X	X	DNTLD-P	Komesha, Amref, CHS
		Create a technical platform where HCWs in private facilities can share experiences and challenges e.g. WhatsApp, t-bu lite and other media platforms	X	X	X	DNTLD-P	Health IT, Komesha, Amref, CHS
		Identification of technical experts to provide technical assistance to private provider in various platforms (Involve associations to support this)	X	-	-	DNTLD-P	
		"Providing Enablers/ Incentive to the private providers - Non-monetary incentives - Bonga points, CPD points, training, recognition and awards. Monetary incentives"	X	X	X	DNTLD-P	Amref, Komesha, Health IT,
		Service provision mapping at county level	-	X	-	DNTLD-P	Amref
		Decentralize ACF to all SDP	X	X	-	DNTLD-P	TBD
		Integrate screening questions into the existing facility EMRs and link to TIBU platform	X	X	-	DNTLD-P	Amref, CHS, Komesha TB, Others
2. Optimise delivery of people centred TB services across all provider types	Improve contact management among private facilities	Counties to conduct OJT to HCWs to line list all contacts including social contacts	X	X	X	DNTLD-P	Amref, CHS, Komesha TB, Others
		Counties to conduct OJT to HCWs to line list all contacts including social contacts	X	X	X	DNTLD-P	Amref, CHS, Komesha TB, Others
	Develop a network to support sample networking and referral	Counties to identify GeneXpert/ X-ray sites, negotiate/draft MOUs to support diagnosis and create linkages with private facilities	X	-	-	DNTLD-P	NTP
		County TB coordinators to engage Associations to optimize sample networking	X	X	X	DNTLD-P	NTP, Amref, CHS, Komesha TB, Othe

Private Facilities Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
	Streamline supply chain management for lab commodities in the private sector	Streamline distribution of supplies to the private facilities - Include private providers in commodity security meetings	X	-	-	DNTLD-P	NTP
		Sensitization on quantification, ordering, supply and reporting of commodities in private facilities	-	X	X	DNTLD-P	NTP, Amref, CHS, Komesha TB, Other
	Increase TB treatment coverage	Counties to engage more private facilities to be TB treatment sites.	X	X	-	DNTLD-P	NTP, Amref, CHS, Komesha TB, Other
		Counties to mobilize funds for support supervision and identification of treatment sites.	X	X	X	DNTLD-P	TBD
		Empower PPM providers to use TIBU at the SDP	X	X	X	DNTLD-P	NTP, Amref, CHS, Komesha TB, Othe
		Use the existing structure to provide support to the private facilities - TOT/ mentors to support expansion.	X	X	X	DNTLD-P	NTP
	To improve treatment outcomes among patients taking medication at the private facilities.	NTP to source for child friendly formulations	X	-	-	DNTLD-P	NTP
	8. Strengthen screening, diagnosis and referral of pediatric TB among the private providers	1. Capacity building on pediatric TB	X	X	X	DNTLD-P	NTP, Amref, CHS, Komesha TB, Othe
		2. SOPs on pediatric TB	X	X	X	DNTLD-P	NTP, Amref, CHS, Komesha TB, Othe
		Skill development for collection of samples - Sputum induction/NPA/ NGA	X	X	X	DNTLD-P	NTP, Amref, CHS, Komesha TB, Othe
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Dissemination of electronic reporting mechanisms (TIBU, t-bu lite etc.)	Scale up t-bu lite application to private providers	X	X	X	DNTLD-P	Health IT

Pharmacist/Chemist Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	"1. Engage proffesional associations -KPA,PSK in TB activities trainings, sensitization and policy review - KPA and PSK	1. NTP and counties to include TB symposia during professional associations conferences	X	X	X	DNTLD-P	-
		2. Train and sensitize association leaders on TB	X	X	X	DNTLD-P	-
		3. Use of local network of providers - Whatsapp groups,	X	X	X	DNTLD-P	-
		4. Linkage of the chemists to county and sub county management	X	X	X	DNTLD-P	-
2. Optimise delivery of people centred TB services across all provider types	1. Engament of the chemist owners	1. Develop/ Review mapping tool.	X	X	-	DNTLD-P	-
		2. Mapping of chemists	X	X	-	DNTLD-P	-
		3. Engagement meetings/forums with the private providers	X	X	-	DNTLD-P	-
		4. Signing of MOUs with the private providers	X	X	-	DNTLD-P	-
		5. Regular review meetings	X	X	X	DNTLD-P	-
	2. Capacity building of the private providers on TB	1. Customization of training materials for private providers	X	X	-	DNTLD-P	-
		2.Training/Sensitization of HCWs from chemists	X	X	X	DNTLD-P	-
		3. Continuous OJT and CMEs on different aspects of TB prevention and care to the chemists	X	X	X	DNTLD-P	-
		4. Sensitization of chemists on t-bu lite resources for self- training	X	X	X	DNTLD-P	-
		5. Development, printing and distribution of SOPs and IEC materials	X	X	-	DNTLD-P	-
	3. Strengthening Linkage/ Referral	1. Customize, print and distribute referral forms	X	-	-	DNTLD-P	-
		2. Develop a directory of referal centres for different services and disseminate to the providers	X	-	-	DNTLD-P	-
		3. Referral through the digital platform (T-bu lite)	X	-	-	DNTLD-P	-
		4. Link the chemists to the community units (CHVs to support the chemist to strengthen referral	X	-	-	DNTLD-P	-
		6. Provide cooler boxes and sample packaging materials	X	X	-	DNTLD-P	-
	5. Experience sharing meetings with the private providers	1. Annual PPM experience sharing meetings	X	X	X	DNTLD-P	-
		2. Regional Quarterly experience sharing (Virtual)	X	X	X	DNTLD-P	-
	6. Demand creation and Visibility	1. Workshop to development branding for private providers.	X	-	-	DNTLD-P	-
		2. Print and distribute branding materials	-	X	-	DNTLD-P	-
		3. Radio spots,TV Shows,social media for TB screening demand creation	X	X	X	DNTLD-P	-

Pharmacist/Chemist Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
	7. Support Supervision, Mentorship and OJT	1. Inclusion of chemists in routine support supervision by the National,county and Subcounty teams	X	X	X	DNTLD-P	NTP-GF
		2. provision of support supervision books to the chemist	X	X	X	DNTLD-P	-
	8. Strengthen screening, diagnosis and referral of pediatric TB among the private providers	1. Capacity building on pediatric TB	X	X	X	DNTLD-P	NTP-GF
		2. SOPs on pediatric TB	-	X	X	DNTLD-P	NTP-GF
		3. Promote use of x-ray for diagnosis of TB in children	-	X	X	DNTLD-P	NTP-GF
3. Promote effective and efficient monitoring and evaluation of PPM interventions	1. Stregthen MEAL in chemists-lab and workplaces to ensure M&E functions are conducted (R&Rtools are available, EMR are in use and data quality audits are conducted)	1. Provide recording and reporting tools	-	X	-	DNTLD-P	NTP-GF
		2. Sensitization and onboarding of the chemists to the t-bu lite	X	X	-	DNTLD-P	NTP-GF
		3. Provide monthly data bundles to providers to promote use of T-bu lite	X	X	X	DNTLD-P	Amref-GF
		4. Conduct data quality audit	X	X	X	DNTLD-P	-
		6. Conduct supervision and OJT	X	X	X	DNTLD-P	-
Diagnostic Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	1. Develop a TB diagnostics mapping tool	1. Mapping of Chemisits laboratories and workplaces	X	-	-	DNTLD-P	Amref-GF
	3. Strengthen collaboration between the private laboratories, radiology units and the County Health Management Teams/ TB Program	Hold TB consultative/sensitization forums for diagnostic centres	X	-	-	DNTLD-P	-
		Establish a Public-Private TB Diagnostic (PP-TBD) steering committee to coordinate and support implementation of TB diagnostic services within the private sector	X	X	-	DNTLD-P	NTP-GF
		Support riders to provide sample transport services to diagnostic sites	X	X	X	DNTLD-P	-
2. Optimise delivery of people centred TB services across all provider types	1. Strengthening sample networking and linkage to TB treatment services	1. Link the chemists to the existing (County/Partner's/Integrated) sample referral mechanism in the county.	X	X	-	DNTLD-P	-
		2. Link radiology centre to the existing (County/Partner's/ Integrated) referral mechanism in the county.	X	X	-	DNTLD-P	-

Diagnostic Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
	2. Build capacity of stand alone laboratory and radiology centres to screen for TB, collect and test/ refer samples for TB testing	1. Train / sensitize stand alone labs and radiology centres personnel on different aspects of TB	X	X	-	DNTLD-P	NTP-GF
		2. Develop/ review and distribute guidelines and SOPs for use by laboratories and radiology centres	-	X	-	DNTLD-P	NTP-GF
	3. Streamline commodities management	1. Sensitize the laboratory personnel on commodity forecasting and quantification	X	X	-	DNTLD-P	NTP-GF
		2. Link private laboratories to lab commodity supply chain (AAFB reagents, falcon tubes and Xpert).	X	X	-	DNTLD-P	NTP-GF
	4. Improve access to diagnostics - new TB diagnostics technology and CXR services	1. Link all Xpert machines to GXLIMs for realtime reporting of results	X	X	X	DNTLD-P	CHS
		2. Sensitize stand alone laboratories and radiology centres on the available recommended TB diagnostic technologies for adoption	X	X	-	DNTLD-P	NTP-GF
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Build capacity for recording and reporting by private laboratories and radiology centres	1. Customize, print and distribute recording and reporting tools to stand alone labs and radiology centres	-	X	-	DNTLD-P	NTP-GF
		2. Provide technical assitance/OJT to stand alone Laboratories and radiology centres through the county TB coordinators	X	X	X	DNTLD-P	NTP-GF
Workplace Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	1. Engage the leadership of different work places and associations	1. Customize workplace mapping tool	X	-	-	DNTLD-P	Amref
		2. Map all workplaces for engagement in TB prevention and care	X	X	-	DNTLD-P	Amref
		3. Engage the leadership of prioritized work places and relevant associations	X	X	-	DNTLD-P	CHS
		4. Disseminate workplace policy documents to the stakeholders	X	X	-	DNTLD-P	CHS

Workplace Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
2. Optimise delivery of people centred TB services across all provider types	1. Promote TB screening in work places	Conduct bi-annual TB screening at workplaces	X	X	X	DNTLD-P	TBD
		Conduct TB screening as part of prescribed medical certification requirement for the workplace	X	X	X	DNTLD-P	TBD
		Hold targeted TB screening outreaches at the workplace	X	X	X	DNTLD-P	TBD
	2. Strengthen linkage and/ or referral to TB services/ integrate TB services into the service package for companies with Staff Medical Clinics	Link all workplaces to TB diagnostic and treatment services	X	X	-	DNTLD-P	TBD
		Conduct capacity building for TB for health care workers in Company Medical Clinics	X	X	X	DNTLD-P	TBD
		Develop, print and distribute a directory of TB diagnostic and treatment sites to workplaces	X	X	-	DNTLD-P	TBD
		Support sample transportation	X	X	X	DNTLD-P	TBD
		Contact management (Contact invitation and tracing)	X	X	X	DNTLD-P	TBD
	3. Awareness creation/ Sensitization - Stigma reduction	Identify workplace TB champions to create demand creation in the workplace	X	X	X	DNTLD-P	TBD
		Sensitize workplace TB champions	X	X	X	DNTLD-P	TBD
		Develop IEC materials for use at the various workplaces	-	X	-	DNTLD-P	TBD
		Print and distribute IEC materials to workplaces	-	X	-	DNTLD-P	TBD
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Build capacity for recording and reporting	Customize, print and distribute recording and reporting tools	-	X	-	DNTLD-P	TBD
		Provide technical assitance/trainings to workplace through the county TB coordinators	X	X	X	DNTLD-P	TBD
ISP Model							
		-					
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Coordination of ISPs: Identify, sensitize and engage ISP group leaders for PPM activities among their membership	Mapping of ISPs and their leaders	X	-	-	DNTLD-P	-
		Sensitize ISP leaders	-	X	-	DNTLD-P	-
		Annual ISP leaders coordination forums	-	X	X	DNTLD-P	-
2. Optimise delivery of people centred TB services across all provider types	Engagement of ISPs	Engagement of ISPs to provide TB services	-	X	X	DNTLD-P	-
		Biannual review meetings for the ISPs; 1 virtual and 1 physical	-	X	X	DNTLD-P	-
	Capacity Building ISPs	Continuous OJT and CMEs on different aspects of TB prevention and care to ISPs : 6 physical and 6 virtual	-	X	X	DNTLD-P	-
		Print and disseminate IEC material with targeted messaging for ISPs and their clients	-	X	X	DNTLD-P	-

ISP Model							
Strategic objective	Intervention	Activity	Yr 2021	Yr 2022	Yr 2023	Lead Organization	Source of Funds
	Strengthen community, facility and diagnostic linkages	Develop,print and distribute tailored ISP referral materials	-	X	-	DNTLD-P	-
		Link ISPs to community health units	X	X	-	DNTLD-P	-
		Biannual support supervision to the ISPs	-	X	X	DNTLD-P	-
	Advocacy and Demand Creation	Identify and capacitate ISP champions to advocate for TB issues among peers	-	X	-	DNTLD-P	-
-3. Promote effective and efficient monitoring and evaluation of PPM interventions	Recording and Reporting	Develop, print and disseminate recording and reporting tools: Roll out and sensitization of ISPs on t-bu lite	X	X	X	DNTLD-P	-

11.

BUDGET AND COSTED ACTIVITIES

US$13,114,583.97

Total budget for costed TB PPM Action Plan activities for 2021 to 2023, the yearly being US$1,675,794.24, US$ 4,644,782.36, US$ 3,484,237.94, and US$3,309,769.43 for 2021, 2022, 2023 and 2024 respectively

The costed TB PPM Action Plan activities for 2021 to 2023 are shown in Table 15. The yearly total budget is US$1,675,794.24, US$ 4,644,782.36, US$3,484,237.94 and US$3,309,769.43 for 2021, 2022, 2023 and 2024 respectively. The year 2024 costed activities appear in this action plan because of the activities done under Global Fund mechanism. The detailed budget can be found in the Annex 6. TB PPM activities are funded through different funding mechanisms including the GoK, Global Fund and USAID.

Table 15. *TB PPM Action Plan 2021-2023 Budget Summarized by Interventions.*

Policy and Coordination		**Year**			
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Strengthen leadership and coordination	144,732.84	152,624.87	33,683.07	33,683.07
2. Optimise delivery of people centred TB services across all provider types	Creating awareness and dissemination of Program guidelines and policies among private players	-	-	-	-

Policy and Coordination		Year			
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Strengthen TB reporting in private facilities				
	Promote data use for decision making and OR to generate evidence	-	94,919.02	94,919.02	94,919.02
	Sub-Total	**144,732.84**	**247,543.89**	**128,602.09**	**128,602.09**

Private Facilities Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Strengthen coordination of PPM activities at National and sub national levels	133,912.36	309,198.05	248,505.97	248,505.97
	Improve capacity of administration and HCWs in private facilities and associations	298,981.97	830,455.64	527,220.87	527,220.87
	Improve contact management among private facilities	72,637.89	290,551.57	290,551.57	290,551.57
2. Optimise delivery of people centred TB services across all provider types	Develop a network to support sample networking and referral	131,220.54	726,588.04	357,778.31	357,778.31
	Streamline supply chain management for lab commodities in the private sector	-	2,586.35	2,586.35	2,586.35

Private Facilities Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
	Increase TB treatment coverage	25,680.06	34,668.09	-	-
	To improve treatment outcomes among patients taking medication at the private facilities.	-	-	-	-
	Strengthen screening, diagnosis and referral of pediatric TB among the private providers				
	Dissemination of electronic reporting mechanisms (TIBU, t-bu lite etc.)				
	Sub-Total	**662,432.82**	**2,194,047.73**	**1,426,643.07**	**1,426,643.07**

Pharmacist/Chemist Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Engage proffesional associations -KPA,PSK in TB activities trainings, sensitization and policy review - KPA and PSK	29,715.50	116,936.00	93,181.94	93,181.94
2. Optimise delivery of people centred TB services across all provider types	Engament of the chemist owners	59,649.28	63,822.29	-	-
	Capacity building of the private providers on TB				
	Strengthening Linkage/ Referral	12,031.11	-	-	-
	Experience sharing meetings with the private providers				

Pharmacist/Chemist Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
	Demand creation and Visibility	108,727.55	51,864.56	51,726.98	51,726.98
	Support Supervision, Mentorship and OJT				
	Strengthen screening, diagnosis and referral of pediatric TB among the private providers				
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Stregthen MEAL in chemists-lab and workplaces to ensure M&E functions are conducted (R&Rtools are available, EMR are in use and data quality audits are conducted)	16,692.04	56,806.13	51,726.98	51,726.98
	Sub-Total	**226,815.49**	**289,428.99**	**196,635.91**	**196,635.91**

Diagnostic Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Develop a TB diagnostics mapping tool				
	Strengthen collaboration between the private laboratories, radiology units and the County Health Management Teams/ TB Program	75,779.11	25,794.71	4,127.15	4,127.15

Diagnostic Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
2. Optimise delivery of people centred TB services across all provider types	Strengthening sample networking and linkage to TB treatment services				
	Build capacity of stand alone laboratory and radiology centres to screen for TB, collect and test/ refer samples for TB testing	37,566.26	64,888.02	-	-
	Streamline commodities management	58,513.86	78,993.71	-	-
	Improve access to diagnostics - new TB diagnostics technology and CXR services	5,557.90	16,641.60	13,793.86	13,793.86
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Build capacity for recording and reporting by private laboratories and radiology centres	25,863.49	117,339.55	103,453.97	103,453.97
	Sub-Total	**203,280.63**	**303,657.57**	**121,374.98**	**121,374.98**

Workplace Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	1. Engage the leadership of different work places and associations	157,050.09	185,207.37	-	-
2. Optimise delivery of people centred TB services across all provider types	1. Promote TB screening in work places	153,530.09	307,060.18	307,060.18	307,060.18

Workplace Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
	2. Strengthen linkage and/ or referral to TB services/ integrate TB services into the service package for companies with Staff Medical Clinics	31,641.51	110,378.41	110,057.41	110,057.41
	3. Awareness creation/ Sensitization - Stigma reduction	33,030.98	121,026.47	75,485.63	33,622.54
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Build capacity for recording and reporting	43,105.82	207,004.24	172,423.28	172,423.28
	Sub-Total	**418,358.49**	**930,676.67**	**665,026.51**	**623,163.42**

ISP Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Coordination of ISPs: Identify, sensitize and engage ISP group leaders for PPM activities among their membership	20,173.98	133,239.17	89,630.76	49,514.83
2. Optimise delivery of people centred TB services across all provider types	Engagement of ISPs	-	82,726.49	169,644.33	136,214.39
	Capacity Building ISPs	-	137,938.62	303,978.58	276,739.37
	Strengthen community, facility and diagnostic linkages	-	289,487.68	327,384.12	299,154.39
	Advocacy and Demand Creation	-	11,364.35	-	-

ISP Model					
Strategic objective	**Intervention**	**2021**	**2022**	**2023**	**2024**
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Recording and Reporting	-	24,671.20	55,317.61	51,726.98
	Sub-total	**20,173.98**	**679,427.52**	**945,955.39**	**813,349.96**

	TOTAL	**1,675,794.24**	**4,644,782.36**	**3,484,237.94**	**3,309,769.43**

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ANNEXES

Annex 1: List of Contributors

S. No	Name	Institution
1.	Dr Waqo Ejersa	DNTLD-P-HoP
2.	Nkirote Mwirigi	DNTLD-P
3.	Dr Stephen Macharia	DNTLD-P
4.	Dr Kisia Jacque	DNTLD-P
5.	Dr Asin Carol	DNTLD-P
6.	Aiban Rono	DNTLD-P
7.	Dr Francis Mhimbira	Consultant
8.	Dr Jane Ong'ang'o	Consultant
9.	Dr Omesa Eunice	WHO Kenya
10.	Ann Masese	CHS - USAID TB ARC II
11.	Ng'ang'a JM	Amref Health Africa
12.	Dr Sam Muga	KCCB Komesha
13.	Dr Lorraine Mugambi-Nyaboga	CHS - USAID TB ARC II
14.	Stephen Wanjala	CHS - USAID TB ARC II
15.	Benson Ulo	Amref Health Africa
16.	Joshua Limo	PS Kenya
17.	Irene Mbithi	ReSoK
18.	Christine Mwamsidu	Amref Health Africa
19.	Martin Githiomi	DNTLD-P
20.	Lilian Kerubo	DNTLD-P
21.	Drusilla Nyaboke	DNTLD-P
22.	Nelly Mukiri	NPHL-NTRL
23.	Adano Godana	DNTLD-P
24.	Richard Kiplimo	DNTLD-P
25.	Evalyn Kibuchi	Stop TB Partnership
26.	Meshack Ndolo	IQVIA
27.	Walter Koech	Nyeri County-Private Practitioner
28.	Maerro Lutta	KCCB Komesha

29.	Mercy Nyangaresi	DNTLD-P
30.	Jeremiah Okari	DNTLD-P
31.	Wesley Tomno	DNTLD-P
32.	Joyce Kiarie	DNTLD-P
33.	Okado Duncan	KCCB Komesha
34.	Dr Elizabeth Gitau	KAPH
35.	Ann Kamau	Ganjoni Hospital Mombasa
36.	Lilian Omondi	MP Shah Hospital
37.	Peninah Makena	Nairobi Metropolitan Services-ScTLC
38.	James Akudian	Clinical Officers Council
39.	Omoro Blasio	Nairobi County-Private Chemist
40.	Steve Anguva	Network of TB Champions
41.	Winnie Mogusu	KCCB Komesha
42.	Felix Mbetera	DNTLD-P
43.	Josh Moturi	Siaya County-FBO
44.	Dr Lydia Matoke	Hearbalist Society of Kenya
45.	Lydiah Kamau	DNTLD-P
46.	Dr Winnie Kanyi	Muran'ga County-CDH
47.	Albert Taiti	Kenya Clinical Officers Association
48.	Timothy Malika	Kisumu County CTLC
49.	Dr Okemwa Job	Turkana County CTLC
50.	Dr Fred Olouch	Kisumu County -CDH
51.	Waithaka Samuel	Meru County ScTLC
52.	Elizabeth Mueni	Nairobi Metropolitan Services-CTLC
53.	Lucy Irungu	Muran'ga County CTLC
54.	Martin Mawira	Tharaka Nithi County SCTLC
55.	Dr Owino Lawrence	Kenya Peadiatric Association
56.	Sylvia Nyambeki	NTRL
57.	Ali Gathee	CHS - USAID TB ARC II
58.	Dr Esimiti Daniel	Turkana County CDH
59.	Peter Omware	Migori County-SCTLC
60.	Sarah Girma	DNTLD-P
61.	Dr Leon Ogoti	Kenya Medical Association
62.	Joshua Ojowi	DNTLD-P
63.	Agatha Wambugu	KCCB Komesha TB
64.	Dennis Oira	CHS - USAID TB ARC II

Annex 2: Facilities Engaged

Table 16. *Number of facilities engaged to provide TB services per county disaggregated by ownership in 2019 under TIBU.*

County	Proportion Private	Proportion FBO	Private for profit		FBO		MoH		NGOs		Grand Total
			Total	Engaged	Total	Engaged	Total	Engaged	Total	Engaged	
Tharaka Nithi	27%	18%	45	12	30	2	88	46	3		166
Narok	22%	17%	44	16	34	8	112	55	7		197
Turkana	13%	14%	32	12	37	10	179	37	8		256
Isiolo	23%	14%	16	6	10	0	44	27	1		71
Tana River	18%	13%	14	4	10	0	55	28	1		80
Muranga	44%	12%	146	14	39	0	147	91	1		333
Kirinyaga	59%	11%	154	13	30	1	73	55	5		262
Marsabit	22%	11%	27	7	14	6	83	41			124
West Pokot	9%	11%	14	6	17	0	121	47	2		154
Samburu	25%	11%	27	11	12	1	68	44	2		109
Meru	55%	11%	293	33	56	1	173	108	7		529
Uasin Gishu	32%	10%	76	14	25	4	134	51	5		240
Nairobi	65%	10%	654	107	104	11	139	116	109		1006
Embu	43%	10%	95	14	22	3	103	75	3		223
Homa Bay	25%	9%	83	27	31	1	189	135	27		330
Kiambu	71%	9%	478	46	60	10	118	77	14		670
Nyamira	31%	9%	54	20	15	2	102	77	2		173
Bungoma	31%	9%	75	16	21	8	144	121	3		243
Kisii	32%	9%	74	28	20	2	134	100	4		232
Migori	34%	8%	99	26	24	3	150	99	16		289
Nakuru	54%	8%	308	52	47	7	197	130	15		567
Busia	32%	8%	51	13	13	0	84	64	9		157
Makueni	22%	8%	74	12	27	8	238	133	4		343
Vihiga	34%	8%	39	15	9	0	64	40	3		115
Siaya	29%	8%	70	31	19	0	146	123	10		245
Nyeri	58%	8%	247	13	33	0	138	61	9		427
Kakamega	34%	8%	111	21	25	3	185	137	4		325
Taita Taveta	33%	8%	35	6	8	2	62	54	1		106
Elgeyo Marakwet	3%	7%	4	1	10	2	120	35			134
Kitui	20%	7%	78	25	29	2	293	152			400
Nyandarua	45%	7%	74	5	12	0	79	53	1		166
Machakos	48%	7%	197	19	29	0	180	125	4		410
Laikipia	47%	7%	96	12	14	0	88	35	5		203
Kisumu	40%	7%	115	45	19	1	134	95	21		289
Nandi	28%	6%	66	13	15	2	149	72	2		232
Kericho	27%	6%	62	7	14	5	153	57	4		233
Kwale	28%	6%	48	15	10	3	113	78	3		174
Kajiado	60%	6%	210	16	20	3	107	28	12		349

County	Proportion Private	Proportion FBO	Private for profit		FBO		MoH		NGOs		Grand Total
			Total	Engaged	Total	Engaged	Total	Engaged	Total	Engaged	
Kilifi	48%	5%	168	33	18	1	148	94	14		348
Baringo	13%	5%	33	6	13	1	205	85	2		253
Trans Nzoia	45%	5%	82	9	9	0	84	46	6		181
Bomet	18%	5%	34	2	9	2	144	55	1		188
Mombasa	74%	5%	230	67	14	0	55	40	11		310
Lamu	30%	4%	17	2	2	2	35	25	2		56
Garissa	46%	2%	87	4	3	0	91	34	7		188
Wajir	20%	1%	28	0	2	0	108	43	1		139
M&Era	45%	1%	69	1	1	0	85	37			155
Grand Total	**41%**	**8%**	**5,133**	**877**	**1,035**	**117**	**5,841**	**3,361**	**371**		**12,380**

Annex 3: Counties Supported with PPM Activities 2017-2020 Action Plan

1. Bungoma
2. Busia
3. Embu
4. Garisa
5. Homa Bay
6. Kajiado
7. Kakamega
8. Kiambu
9. Kilifi
10. Kirinyaga
11. Kisii
12. Kisumu
13. Machakos
14. Meru
15. Migori
16. Mombasa
17. Nairobi
18. Nakuru
19. Nyeri
20. Siaya
21. Tharaka Nithi
22. Trans Nzoia
23. Vihiga

Annex 4: County TWG Goal, Objectives and Membership

Goal

To enhance collaboration between the public and private sector for the delivery of people-centered, universally accessible, acceptable and affordable quality TB, Leprosy and lung disease services in Kenya

Mandate and scope

- The PPM sub TWG coordinates discussions and consultation including policy dialogue on engaging the private sector in the TB response, and specifically in the prevention, diagnosis, notification and treatment of TB.

Aims and objectives

- The overall objective of the sub TWG is to provide advisory support on matters TB PPM to the county health management team

Specifically, the sub TWG will provide:

- Overall coordination of the PPM strategies and stakeholders
- Provide technical advice and support to key players including the county and sub county teams, and private sector entities on the design of policies, strategies, plans and activities to ensure adequate engagement of the private sector
- Oversee implementation and monitoring of PPM policies, strategies/interventions, plans and activities
- Advocate for PPM with various entities both private and public
- Facilitate documentation and dissemination of information on PPM
- Identify knowledge gaps and research priorities to inform the design of more effective PPM interventions
- Form sub-groups under the sub TWG to address specific issues on an as need arises basis
- Strengthen multi-sectoral collaboration and propose partnerships towards PPM.

Membership

- The PPM Technical Working Group will have members from various stakeholders.
- Members will be nominated in writing through their organizations.
- The Technical Working Group will be led by the County Director for Health as the chairperson
- The secretary will be the County TB and Leprosy Coordinator (CTLC)

Frequency of Meetings

- The sub TWG will hold quarterly meetings. The dates will be determined by members.
- Extraordinary meetings may be convened as required.
- The secretary to the sub TWG will convene meetings
- Minutes will be prepared and shared with the county leadership

Proposed PPM Technical Working Group Membership

Chairperson – County Director for Health

Secretary – County TB and Leprosy Coordinator

Members:

1. CHMT – Relevant members
2. County partners' coordinator
3. Representative of private hospital association
4. Representative from a private health facility; Head of clinical service and proprietor
5. Representative from private institution: KMTC lecturer communicable diseases
6. Professional associations: KMA/Nurses/Clinical officers/Lab/pharmacy
7. Research institution/Academic
8. Civil Society Organizations
9. TB champion
10. Public sector – referral hospital
11. Community strategy focal person
12. Corporate sector representative
13. Ministry of education
14. Kenya health care associations – Representative from KMA, KPA, NNAK, KCO, AKMLSO
15. Representative from Media

Annex 5: Roles of Intermediary Organization

1. Providing technical support to the NTLD-P and counties on matters PPM; support review of guidelines, plans, tools, etc.
2. Engagement of various private provider types to implement PPM activities; health facilities, stand-alone consultants, chemists/pharmacies, laboratories and corporate sector
3. Strengthen diagnosis of TB in private facilities; Support linkage of private facilities to more sensitive diagnostic tests e.g gene xpert sites.
4. Link private facilities to the NTLD via county TB coordinators and program assistants. This facilitates the following:
    a. Mentorship, technical assistance and support supervision by the NTLD and county coordinators
    b. Providing of reporting and recording tools
    c. Notification of TB patients from private sector
    d. Provision of anti-TB medicines and laboratory supplies
5. Support private facilities to offer MDR-TB management, TB/HIV activities and Contact management
6. Support training and capacity building of frontline HCWs on TB; Provide CPD points to HCWs receiving any training on TB
7. Provide job aids and IEC material
8. Support referrals between facilities
9. Conduct Operation Research to inform PPM programming in the country.

Annex 6: The detailed budget of the TB PPM Action Plan 2021-2023

Table 17. *Detailed costed activities of TB PPM Action Plan 2021-2023 including source of funds*

Policy and Coordination									
		-							
Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	1.Strengthen leadership and coordination	Develop a PPM policy in a consultative manner with all policy stakeholders (The policy should include: TA policy statement, policy communication on the introduction of virtual training, verification of the policy on provision of commodities to the private providers by GoK,	5 days PPM policy development workshop		32,954.86	-	-		
			Stakeholders' forum to Endorse the PPM Policy		25,465.45	-	-		
			100 pax Breakfast meeting to disseminate the PPM policy (high level)		16,416.90	-	-	-	
			Virtual dissemination of the PPM Policy (target CTLCs, and key County stakeholders in preparation for the County level dissemination meetings)		554.87	-	-	-	
			Breakfast meeting to disseminate the PPM policy at County level		41,088.10	55,468.94	-	-	
		2.Revamp and expand the CoE, define participation and membership	1PPM CoE to Identify additional members from Private sector		0	0	0	0	
			Involvement of all identified members in quarterly CoEs		0	0	0	0	
		3. Involvement of private providers during development of guidelines and policies	Workshops, meetings and trainings cost -Already factored in individual activities costs		-	-	-	-	

Policy and Coordination									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		4. Update, disseminate and create awareness on patient charter	Workshop to update and dissemination meetings		-	-	-	-	
		5. In consultation with the HR department, develop an addendum to include TB-specific in the JDs for the staff deployed in the TB Program	3 meetings with MoH HR department to first share the intention and develop the addendum		825.43	-	-	-	
			Virtual meeting to sensitize staff deployed in the TB Program on the roles especially in coordination of PPM activities		554.87	-	-	-	
		6. Develop a circular from the national level to the County HMT on the roll out of TB PPM engagements	PPM CoE to draft the circular		-	-	-	-	
		7. Map Counties that have staff seconded from Public to private/ FBOs, draw lessons and strengthen the mechanism for secondment in consultation with the HR department	PPM CoE to develop a checklist		-	-	-	-	
			County level Virtual meeting with PPM stakeholders to sensitize on the checklist		11,097.46	14,981.57	-	-	
			Coordination of Checklist filling Exercise at County level		11,097.46	14,981.57	-	-	
			3 meetings with MoH HR department to develop a secondment mechanism		4,677.44	-	-	-	

Policy and Coordination									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		9. Development of the e learning modules and uploading them in a common platform with access guidelines	1 Workshop to customize content, develop access guidelines and upload		-	32,954.86	-	-	
			Sensitize Private providers on availability of e learning modules and access guidelines- Virtually		-	554.87	-	-	
		12. Conduct trainings that target the private sector that have flexy timings.	County level sensitizations, CMEs and OJTs		-	-	-	-	
		13. Develop evidence-based advocacy briefs and submit to the budget making processes in the ministry and Counties	PPM CoE to develop		-	-	-	-	
		14. Participation in the budget making processes at national and County level (MTEF among others)	Participation in annual budget making processes- MTEF National level		-	3,509.00	3,509.00	3,509.00	
			Participation in annual budget making processes- County level		-	30,174.07	30,174.07	30,174.07	
			SUB-TOTAL		**144,732.84**	**152,624.87**	**33,683.07**	**33,683.07**	
2. Optimize delivery of people centred TB services across all provider types	1. Creating awareness and dissemination of Program guidelines and policies among private players	1. Customize the integrated curriculum to be more responsive to the private sector	Workshops to customize and sensitizations		-	-	-	-	
		3. Involvement of private sectors representatives in PRM	Participation in PRM and AQI meetings		-	94,919.02	94,919.02	94,919.02	
		Sub-Total	**SUB-TOTAL**		**-**	**94,919.02**	**94,919.02**	**94,919.02**	

Private Facilities Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
	Strengthen coordination of PPM activities at National and sub national levels	Conduct a workshop to disseminate key documents (Action plan, Mapped facilities, reporting framework, SOPs etc) to all stakeholder	Half day meeting, 100 pax (high level): conference package		3,210.01	-	-	-	CHS
			One day meeting, 100 pax (County and stakeholders) CTLCs, CDH, 3 stakeholders reps		19,030.76	38,061.52	-	-	CHS
		To Establish PPM COEs at county and/or Sub-county level.	Workshop to develop/ review TORs, membership and formation of sub committees; conference package and transport refund		16,050.04	21,667.55	-	-	CHS
			Hold quarterly COEs meetings		17,242.33	68,969.31	68,969.31	68,969.31	AMREF, Komesha TB, CHS
		Develop a business case to encourage private sector to uptake TB services and invest in them.	5 days Workshop to develop business case content		22,699.34	-	-	-	NTP, Amref
		Support and facilitate implementation of policy and regulatory mechanisms through the county leadership and associations/ councils and refugee leadership	Meetings with county leadership, associations/ Councils and refugee leadership: County level		-	963.00	-	-	TBD
		Create engagement forums with associations leadership	Quarterly breakfast meetings: conference package		15,591.47	15,591.47	15,591.47	15,591.47	Amref
		NTP and counties to include TB symposia during professional associations conferences	Participation in annual professional association conferences to support TB symposium (KMA, KCOA, NAK, KPA, KAP, KMLTTA, Kenya pharmacists Associations)		-	3,591.54	3,591.54	3,591.54	NTP, Amref

Private Facilities Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		Provide regular technical assistance to the private facilities	Quarterly support visits by County/ Sub County teams to Private facilities PFP/PNFP (CTLC, CP, CMLT,CCO, Associations reps County level, SCTLC)		40,088.41	160,353.65	160,353.65	160,353.65	NTP, Amref, CHS, Komesha TB, Health IT, others
		Conduct regular technical site visits at national level	Integrate private health facilities TA with routine Tas		0	0	0	0	
			SUB-TOTAL		**133,912.36**	**309,198.05**	**248,505.97**	**248,505.97**	
	Improve capacity of administration and HCWs in private facilities and associations	Customization of training curriculum/ materials/ Programme for the various cadres (virtual trainings, media ie Print and digital, split CME sessions)	2 Workshops to review, customize and digitize training content		44,092.67	44,092.67	-	-	Health IT, Amref
			Breakfast meeting to launch the curriculum and digital training platform		-	7,795.73	-	-	Health IT, Amref
		Training of various cadres on different aspects of TB prevention and care	Refresher Training of 200 TOTs; County and sub county level in 47 Counties		24,572.15	73,716.46	-	-	TBD
			Sensitization of HCWs from private facilities in 47 Counties on TB prevention and care		62,420.90	84,268.21	-	-	TBD
		Continuous OJT and CMEs on different aspects of TB prevention and care	OJT conducted on monthly basis physically/virtually at health facility level		41,271.53	165,086.12	165,086.12	165,086.12	TBD
		Create a technical platform where HCWs in private facilities can share experiences and challenges e.g., WhatsApp, t-bu lite and other media platforms	Experience sharing workshop for private providers; annual coordination forums. 5pax per association		-	40,400.24	40,400.24	40,400.24	Health IT, Komesha TB, Amref, CHS
			Virtual annual experience sharing workshop for private providers		733.72	733.72	733.72	733.72	Health IT, Komesha TB, Amref, CHS

Private Facilities Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		Identification of technical experts to provide technical assistance to private provider in various platforms (Involve associations to support this)	Technical experts will be identified by the PPM COE		0	0	0	0	
		"Providing Enablers/ Incentive to the private providers - non-monetary incentives - Bonga points, CPD points, training, recognition and awards. Monetary incentives"	Monetary-Provide KES 1000 for every TB case diagnosed		75,664.47	302,657.89	302,657.89	302,657.89	Amref, Komesha TB, Health IT,
			Non-monetary incentives; including training certificates, CPD points, performance based/ innovations awards		18,342.90	18,342.90	18,342.90	18,342.90	Amref, Komesha TB, Health IT,
			Non-monetary: Identifying the basic minimum package of IEC materials		0	0	0	0	
			Sharing e-versions of the guidelines, SOPs and IEC materials		-	-	-	-	TBD
		Service provision mapping at county level	Workshop to develop the mapping tools and service provision matrix: Involve associations		-	9,418.16	-	-	Amref
			Virtual Training of research assistant on data collection tools		-	119.23	-	-	Amref
			Data collection exercise: To be done at County level		-	1,485.78	-	-	TBD
			Data synthesis and report writing workshop		-	23,863.20	-	-	TBD
			Dissemination of mapping report to stakeholders		-	-	-	-	TBD

Private Facilities Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		Decentralize ACF to all SDP	Sensitizations, provision of data collection e-tools and reporting		-	-	-	-	TBD
		Integrate screening questions into the existing facility EMRs and link to TIBU platform	Sensitize Private facilities HCWs on t-bu lite		75,976.30	102,568.01	-	-	Amref, CHS, Komesha TB, Others
			SUB-TOTAL		**343,074.64**	**874,548.31**	**527,220.87**	**527,220.87**	
	Improve contact management among private facilities	Counties to conduct OJT to HCWs to line list all contacts including social contacts	OJT conducted on monthly basis physically/virtually at health facility level		-	-	-	-	Amref, CHS, Komesha TB, Others
			Contact management for BC and children under 5; Transport reimbursement for patients (50% of the contacts will be traced by CHVs)		22,699.34	90,797.37	90,797.37	90,797.37	Amref, CHS, Komesha TB, Others
			Contact invitation for BC through index case; 1 index case 3 contacts		13,619.60	54,478.42	54,478.42	54,478.42	
		Counties to conduct OJT to HCWs to line list all contacts including social contacts	OJT conducted on monthly basis physically/virtually at health facility level		-	-	-	-	Amref, CHS, Komesha TB, Others
			Contact management for BC and children under 5; Transport reimbursement for patients (50% of the contacts will be traced by CHVs)		22,699.34	90,797.37	90,797.37	90,797.37	Amref, CHS, Komesha TB, Others
			Contact invitation for BC through index case; 1 index case 3 contacts		13,619.60	54,478.42	54,478.42	54,478.42	Amref, CHS, Komesha TB, Others
			SUB-TOTAL		**72,637.89**	**290,551.57**	**290,551.57**	**290,551.57**	
	Develop a network to support sample networking and referral	Counties to identify GeneXpert/ X-ray sites, negotiate/ draft MOUs to support diagnosis and create linkages with private facilities	Capacity assessment of identified diagnostic facilities by National level technical staff		33,420.77	45,118.04	-	-	NTP

Private Facilities Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
			Place diagnostic equipment in private facilities		8,355.19	25,065.58	-	-	NTP
			Training staff on use of diagnostic equipment including recording and reporting		-	20,593.58	-	-	NTP, Amref, CHS, Komesha TB, Other
		County TB coordinators to engage Associations to optimize sample networking	Hold engagement meetings with county leadership to engage in sample networking.		37,717.59	150,870.37	150,870.37	150,870.37	NTP, Amref, CHS, Komesha TB, Other
			Support sample referral network (engage 2 motorcycle riders per County)		51,726.98	206,907.94	206,907.94	206,907.94	Amref, CHS, Komesha TB, Other
			Provide starter pack (falcon tubes, cooler boxes, biohazard bags, lab coat) for all private providers		-	278,032.54	-	-	NTP, Amref, CHS, Other
			SUB-TOTAL		**131,220.54**	**726,588.04**	**357,778.31**	**357,778.31**	**-**
	Streamline supply chain management for lab commodities in the private sector	Streamline distribution of supplies to the private facilities - Include private providers in commodity security meetings	To be part of the supply chain management under NTP		0	0	0	0	NTP
		Sensitization on quantification, ordering, supply and reporting of commodities in private facilities	Virtual Sensitization of HCWs from private facilities on TB Commodities order management and action planning		-	2,586.35	2,586.35	2,586.35	NTP, Amref, CHS, Komesha TB, Othe
			SUB-TOTAL		**-**	**2,586.35**	**2,586.35**	**2,586.35**	
	Increase TB treatment coverage	Counties to engage more private facilities to be TB treatment sites.	Hold entry meetings with the private facility owners: Administrators, owners e.t.c		25,680.06	34,668.09	-	-	NTP, Amref, CHS, Komesha TB, Other
			Sensitization of HCWs on TB prevention and care		-	-	-	-	NTP, Amref, CHS, Komesha TB, Other

Private Facilities Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
			Provision of IEC materials, tools and commodities		-	-	-	-	NTP, Amref, CHS, Komesha TB, Other
		Counties to mobilize funds for support supervision and identification of treatment sites.	Support supervision, OJTs and CMEs		-	-	-	-	TBD
		Empower PPM providers to use TIBU at the SDP	0		-	-	-	-	NTP, Amref, CHS, Komesha TB, Other
		Use the existing structure to provide support to the private facilities - TOT/mentors to support expansion.	Identification and training of TOTs		-	-	-	-	NTP
			SUB-TOTAL		**25,680.06**	**34,668.09**	**-**	**-**	
	To improve treatment outcomes among patients taking medication at the private facilities.	NTP to source for child friendly formulations	Already included in the Forecasting and Quantification of TB commodities		0	0	0	0	NTP
	8. Strengthen screening, diagnosis and referral of pediatric TB among the private providers	1. Capacity building on pediatric TB	Trainings/ sensitizations/ CMEs/OJTs of Pediatric TB		-	-	-	-	NTP, Amref, CHS, Komesha TB, Other
		2. SOPs on pediatric TB	Printing and distribution of SOPs on Pediatric TB		-	-	-	-	NTP, Amref, CHS, Komesha TB, Other
		Skill development for collection of samples - Sputum induction/NPA/NGA	Will be integrated in the CMEs/ OJTs		-	-	-	-	NTP, Amref, CHS, Komesha TB, Other
	Dissemination of electronic reporting mechanisms (TIBU, t-bu lite etc.)	Scale up t-bu lite application to private providers	Roll out and sensitization of HCWs on t-bu lite		0	0	0	0	
			SUB-TOTAL		0	0	0	0	

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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	"1. Engage professional associations -KPA,PSK in TB activities trainings, sensitization and policy review - KPA and PSK	1. NTP and counties to include TB symposia during professional associations conferences	Participation in annual professional association conferences to support TB symposium (KMA, KCOA, NAK, KPA, KAP, KMLTTA, Kenya pharmacists Associations)		-	-	-	-	
		2. Train and sensitize association leaders on TB	Meetings with association leadership, associations/ Councils and refugee leadership: County level		6,420.02	23,754.06	-	-	
			Quarterly breakfast meetings: conference package		3,897.87	15,591.47	15,591.47	15,591.47	
		3. Use of local network of providers - WhatsApp groups,	Monthly engagement using social media platforms - 30 participants per county		19,397.62	77,590.48	77,590.48	77,590.48	
		4. Linkage of the chemists to county and sub county management	Engagement in monthly COEs; Costed under Private Sector model		-	-	-	-	
			SUB-TOTAL		**29,715.50**	**116,936.00**	**93,181.94**	**93,181.94**	
2. Optimize delivery of people centred TB services across all provider types	1. Engagement of the chemist owners	1. Develop/ Review mapping tool.	Workshop to develop the mapping tools and service provision matrix: Involve associations		23,863.20	23,863.20	-	-	
			Virtual Training of research assistant on data collection tools		2,384.58	3,219.18	-	-	
		2. Mapping of chemists	Data collection exercise: To be done at County level		9,538.31	12,876.72	-	-	
			Data synthesis and report writing workshop		23,863.20	23,863.20	-	-	

Pharmacist/Chemist Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		3. Engagement meetings/forums with the private providers	Dissemination of mapping report to stakeholders		-	-	-	-	
		4. Signing of MOUs with the private providers	During the engagement forum		-	-	-	-	
	3. Strengthening Linkage/ Referral	1. Customize, print and distribute referral forms	Workshop to customize the referral forms - National level workshop		12,031.11	-	-	-	
	6. Demand creation and Visibility	1. Workshop to development branding for private providers.	Conference package, consultancy, printing cost, per diems for national staff, transport allowances.		95,795.81	-	-	-	
		2. Print and distribute branding materials	Printing and distribution of IEC materials		-	137.57	-	-	
		3. Radio spots, TV shows, social media for TB screening demand creation	Cost of radio Spots - 2 radio spots per week for 1 month		12,931.75	51,726.98	51,726.98	51,726.98	
			SUB-TOTAL		**180,407.95**	**115,686.85**	**51,726.98**	**51,726.98**	
3. Promote effective and efficient monitoring and evaluation of PPM interventions	1. Strengthen MEAL in chemists-lab and workplaces to ensure M&E functions are conducted (R&R tools are available, EMR are in use and data quality audits are conducted)	1. Provide recording and reporting tools	print TB screening register - 3000 copies		-	2.75	-	-	
		2. Sensitization and onboarding of the chemists to the t-bu lite	Virtual sensitization meeting, 20 providers/county - Data bundles, facilitation fee		3,760.29	5,076.40	-	-	
		3. Provide monthly data bundles to providers to promote use of t-bu lite	Provider data bundle, monthly; 20 per county		12,931.75	51,726.98	51,726.98	51,726.98	
		4. Conduct data quality audit	Budgeted under PS model		-	-	-	-	
		6. Conduct supervision and OJT	Budgeted under PS model		-	-	-	-	
			SUB-TOTAL		**16,692.04**	**56,806.13**	**51,726.98**	**51,726.98**	

Diagnostic Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**						
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	1. Develop a TB diagnostics mapping tool	1. Mapping of Chemists laboratories and workplaces	Budgeted for under PS Model		0	0	0	0	
			Workshop to develop the mapping tools and service provision matrix: Involve associations		-	-	-	-	
			Virtual Training of research assistant on data collection tools		-	-	-	-	
			Data collection exercise: To be done at County level		-	-	-	-	
			Data synthesis and report writing workshop		-	-	-	-	
			Dissemination of mapping report to stakeholders		-	-	-	-	
			SUB-TOTAL		**0**	**0**	**0**	**0**	
	3. Strengthen collaboration between the private laboratories, radiology units and the County Health Management Teams/ TB Program	Hold TB consultative/ sensitization forums for diagnostic centres	One day consultative forum; 50 pax (high level): conference package		1,605.00	-	-	-	
			1 -day sensitization meeting, 100 pax (County and stakeholders) CMLCs, CDH, 3 stakeholders reps		57,092.28	-	-	-	
		Establish a Public-Private TB Diagnostic (PP-TBD) steering committee to coordinate and support implementation of TB diagnostic services within the private sector	Workshop to develop/ review TORs, membership and formation of steering committees; conference package and transport refund.		16,050.04	21,667.55	-	-	

Diagnostic Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**						
			Hold steering committee quarterly meetings		1,031.79	4,127.15	4,127.15	4,127.15	
		Support riders to provide sample transport services to diagnostic sites	Support sample referral network (engage 2 motorcycle riders per County) Budgeted under PS Model		-	-	-	-	
			SUB-TOTAL		**75,779.11**	**25,794.71**	**4,127.15**	**4,127.15**	
2. Optimize delivery of people centred TB services across all provider types	1. Strengthening sample networking and linkage to TB treatment services	1. Link the chemists to the existing (County/ Partner's/ Integrated) sample referral mechanism in the county.	Support sample referral network (engage 2 motorcycle riders per County) Budgeted under PS Model		-	-	-	-	
		2. Link radiology centre to the existing (County/ Partner's/ Integrated) referral mechanism in the county.	Support sample referral network (engage 2 motorcycle riders per County) Budgeted under PS Model		-	-	-	-	
			SUB-TOTAL		**-**	**-**	**-**	**-**	
	2. Build capacity of standalone laboratory and radiology centres to screen for TB, collect and test/ refer samples for TB testing	1. Train / sensitize standalone labs and radiology centres personnel on different aspects of TB	Sensitization of staff from Lab and radiology private facilities on different aspect of TB control; 1-day sensitization, 20 pax each county. Conference package, transport allowance of 100 pax and facilitation fee for 3 facilitators per day in every county		37,566.26	50,714.46	-	-	
		2. Develop/ review and distribute guidelines and SOPs for use by laboratories and radiology centres	Cost of Conference package, Accommodation, Meals and transport for 20 Pax for 5 days		-	14,173.56	-	-	
			SUB-TOTAL		**37,566.26**	**64,888.02**	**-**	**-**	

Diagnostic Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**						
	3. Streamline commodities management	1. Sensitize the laboratory personnel on commodity forecasting and quantification	Sensitize 20 pax per County: Conference package, Transport allowance; Facilitation fee for 3 facilitators per day		58,513.86	78,993.71	-	-	
		2. Link private laboratories to lab commodity supply chain (AAFB reagents, falcon tubes and GeneXpert).	link 20 labs per subcounty to Supply Chain Management No cost		-	-	-	-	
			SUB-TOTAL		**58,513.86**	**78,993.71**	**-**	**-**	
	4. Improve access to diagnostics - new TB diagnostics technology and CXR services	1. Link all GeneXpert machines to GXLIMs for real-time reporting of results	Cost of transport and lunch allowance for the County GeneXpert Super User/ CMLC - 2 days per quarter		3,448.47	13,793.86	13,793.86	13,793.86	
		2. Sensitize standalone laboratories and radiology centres on the available recommended TB diagnostic technologies for adoption	Sensitize 20 pax per County: Virtual Data bundles		2,109.43	2,847.74	-	-	
			SUB-TOTAL		**5,557.90**	**16,641.60**	**13,793.86**	**13,793.86**	
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Build capacity for recording and reporting by private laboratories and radiology centres	1. Customize, print and distribute recording and reporting tools to stand alone labs and radiology centres	Meetings to develop/ review current tools; Cost of Conference package, Accommodation, Meals and transport for 20 Pax for 5 days		-	13,885.58	-	-	
			Print of R&R tools		-	-	-	-	
		2. Provide technical assistance/OJT to stand alone Laboratories and radiology centres through the county TB coordinators	Cost of lunch and transport allowance for 2 sub county officers for 5 days per month		25,863.49	103,453.97	103,453.97	103,453.97	
			SUB-TOTAL		**25,863.49**	**117,339.55**	**103,453.97**	**103,453.97**	

Workplace Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	1. Engage the leadership of different work places and associations	1. Customize workplace mapping tool	Workshop to develop the mapping tools and service provision matrix: Involve associations		23,863.20	-	-	-	
		2. Map all workplaces for engagement in TB prevention and care	Virtual Training of research assistant on data collection tools		2,384.58	3,219.18	-	-	
			Data collection exercise: To be done at County level		29,715.50	40,115.93	-	-	
			Data synthesis and report writing workshop		23,863.20	23,863.20	-	-	
			Dissemination of mapping report to stakeholders		-	-	-	-	
		3. Engage the leadership of prioritized work places and relevant associations	Cost of 1 day conference package, transport allowance for 50 pax per county		33,200.65	44,820.88	-	-	
		4. Disseminate workplace policy documents to the stakeholders	Integrate TB into Occupational Safety and Health (OSH) structures: Cost of 1 day conference package, transport allowance for 50 pax per county		44,022.97	59,431.00	-	-	
			Print and distribute workplace policy documents to all stakeholders: Print 5000 poicy copies (100 copies per county)		-	13,757.18	-	-	
			SUB-TOTAL		**157,050.09**	**185,207.37**	**-**	**-**	
2. Optimize delivery of people centred TB services across all provider types	1. Promote TB screening in work places	Conduct bi-annual TB screening at workplaces	Conduct scheduled health education sessions at workplaces and screen the workers for TB; Cost of Fuel for 1 Vehicle; Lunch and transport allowances for 10 HCWs for 10 days per county every 6 months; 20 counties		102,353.39	102,353.39	102,353.39	102,353.39	

Workplace Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		Conduct TB screening as part of prescribed medical certification requirement for the workplace	Ride on existing medical assessments for certification to screen for TB in the workplace No additional costs		-	-	-	-	
		Hold targeted TB screening outreaches at the workplace	Conduct ad-hoc targeted TB screening outreaches in hot spot areas Cost of Fuel for 1 Vehicle; Lunch and transport allowances for 10 HCWs for 1 day (1 Outreach per county per quarter) - 20 counties		51,176.70	204,706.79	204,706.79	204,706.79	
			SUB-TOTAL		**153,530.09**	**307,060.18**	**307,060.18**	**307,060.18**	
	2. Strengthen linkage and/ or referral to TB services/ integrate TB services into the service package for companies with Staff Medical Clinics	Link all workplaces to TB diagnostic and treatment services	Create referral networks for TB services between the workplaces and health facilities; No costs		-	-	-	-	
		Conduct capacity building for TB for health care workers in Company Medical Clinics	County to work with workplaces to train Medical Clinic Staff on TB management (selected counties); "Train 30 pax per County: Conference package, Transport allowance; Facilitation fee for 3 facilitators for 5 days"		26,138.64	104,554.54	104,554.54	104,554.54	

Workplace Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		Develop, print and distribute a directory of TB diagnostic and treatment sites to workplaces	County and implementing partners to develop TB service directory with contacts, TB services offered and pricing; "Cost of 2 day conference package, transport allowance for 20 pax (National level activity)		-	-	-	-	
			Print 5000 copies of directories (100 copies per county)"		-	321.00	-	-	
		Support sample transportation	Adopt a suitable sample transport Mechanism (Courier, CHVs, HCWs, Riders, drones); Daily rate of 1000 per rider per sub county for 22 days a month Costed under PS Model		-	-	-	-	
		Contact management (Contact invitation and tracing)	Reimburse transport at the rate of ksh 200 per contact to contacts of TB index cases visiting the facility for TB screening and testing (Average three contacts per Index Case) - 50 index cases in 20 counties		5,502.87	5,502.87	5,502.87	5,502.87	
			SUB-TOTAL		**31,641.51**	**110,378.41**	**110,057.41**	**110,057.41**	
	3. Awareness creation/ Sensitization - Stigma reduction	Identify workplace TB champions to create demand creation in the workplace	Engage TB champions to spearhead TB services at workplaces; 1 TB champion engaged per sub county @ 6,500 per month		8,405.63	33,622.54	33,622.54	33,622.54	

Workplace Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		Sensitize workplace TB champions	Train 20 pax per county for 3days (conference package and transport reimbursement); County based trainings		24,625.35	49,250.69	41,863.09	-	
		Develop IEC materials for use at the various workplaces	Cost of 2 days workshop to develop IEC materials. Conference package, Transport, Meals and Accommodation for 30 pax		-	10,593.03	-	-	
		Print and distribute IEC materials to workplaces	Print IEC materials customized to target different clients at the workplace Cost of printing TB IEC materials for engaged workplaces (10,000 copies)		-	27,560.21	-	-	
			SUB-TOTAL		**33,030.98**	**121,026.47**	**75,485.63**	**33,622.54**	
3. Promote effective and efficient monitoring and evaluation of PPM interventions	Build capacity for recording and reporting	Customize, print and distribute recording and reporting tools	Meetings to review current tools to incorporate TB services "Cost of 2-day conference package, transport allowance for 20 pax		-	7,062.02	-	-	

Workplace Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
			Print 10,000 copies of assorted IEC materials"		-	27,518.94	-	-	
		Provide technical assistance/ trainings to workplace through the county TB coordinators	Provide technical support and On-Job-Training (on different aspects of TB and lung diseases including reporting) to private workplaces (County level) Cost of lunch and transport allowance for 2 sub county officers for 5 days per month		43,105.82	172,423.28	172,423.28	172,423.28	
			SUB-TOTAL		**43,105.82**	**207,004.24**	**172,423.28**	**172,423.28**	
ISP Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
1. Ensure effective leadership and stewardship of PPM for TB prevention and Care	Coordination of ISPs: Identify, sensitize and engage ISP group leaders for PPM activities among their membership	Mapping of ISPs and their leaders	Workshop to develop the mapping tools		20,079.98	-	-	-	
			Virtual Training of ISPs on data collection tools		47.00	2,384.58	-	-	
			Data collection exercise: To be done at County level		47.00	29,715.50	40,115.93	-	
			Data synthesis and report writing workshop		-	47,726.40	-	-	
		Sensitize ISP leaders	1 day breakfast meeting to sensitize ISP leaders on TB agenda		-	3,897.87	-	-	
		Annual ISP leaders' coordination forums	1 day breakfast meeting to sensitize ISP leaders on TB agenda		-	49,514.83	49,514.83	49,514.83	
			SUB-TOTAL		**20,173.98**	**133,239.17**	**89,630.76**	**49,514.83**	

ISP Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
2. Optimize delivery of people centred TB services across all provider types	Engagement of ISPs	Engagement of ISPs to provide TB services	Sensitization of ISPs in 47 Counties on TB prevention and care at County level		-	24,762.92	33,429.94	-	
		Biannual review meetings for the ISPs; 1 virtual and 1 physical	Virtual Biannual progress review meetings with ISPs at County level		-	8,437.74	19,828.68	19,828.68	
			Physical Biannual progress review meetings with ISPs at County level		-	49,525.84	116,385.71	116,385.71	
			SUB-TOTAL		**-**	**82,726.49**	**169,644.33**	**136,214.39**	
	Capacity Building ISPs	Continuous OJT and CMEs on different aspects of TB prevention and care to ISPs: 6 physical and 6 virtual	Physical OJT conducted on monthly basis at health facility level		-	117,761.43	276,739.37	276,739.37	
			Virtual OJT conducted on monthly basis at health facility level		-	-	-	-	
		Print and disseminate IEC material with targeted messaging for ISPs and their clients	Monetary: Printing and distribution of IEC materials		-	20,177.19	27,239.21	-	
			Non-monetary: Identifying the basic minimum package of IEC materials		0	0	0	0	
			Sharing e-versions of the guidelines, SOPs and IEC materials		0	0	0	0	
			SUB-TOTAL		**-**	**137,938.62**	**303,978.58**	**276,739.37**	
	Strengthen community, facility and diagnostic linkages	Develop, print and distribute tailored ISP referral materials	3 days Workshop to review existing ISP referral materials		-	13,179.38	-	-	
			Monetary: Printing and distribution of ISP referral materials		-	1,008.86	-	-	

ISP Model									
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Strategic objective	**Intervention**	**Activity**	**Sub-Act**		**Cost 2021**	**Cost 2022**	**Cost 2023**	**Cost 2024**	**Source of Funds**
		Link ISPs to community health units	Develop simplified ISP referral materials to facilitate linkages to the CHVs/ facilities		-	13,179.38	-	-	
			Identify and incentivize Linkage Assistants		-	42,922.39	100,867.62	100,867.62	
			Sensitize CU, Linkage assistants and ISPs on referrals.		-	20,910.91	28,229.73	-	
		Biannual support supervision to the ISPs	Biannual support supervision meetings with ISPs at County level		-	198,286.77	198,286.77	198,286.77	
	Advocacy and Demand Creation	Identify and capacitate ISP champions to advocate for TB issues among peers	1 day Sensitization of ISP Champions		-	11,364.35	-	-	
			SUB-TOTAL		**-**	**300,852.03**	**327,384.12**	**299,154.39**	
2. Promote effective and efficient monitoring and evaluation of PPM interventions	Recording and Reporting	Develop, print and disseminate recording and reporting tools: Roll out and sensitization of ISPs on t-bu lite	Review ISPs tools by PPM CoE		-	-	-	-	
			Printing and distribution of ISP recording and reporting materials		-	-	-	-	
			Virtual sensitization of ISPs on t-bu lite		-	2,659.72	3,590.62	-	
			Monthly data bundle to facilitate reporting		-	22,011.48	51,726.98	51,726.98	
			SUB-TOTAL		**-**	**24,671.20**	**55,317.61**	**51,726.98**	

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

National Tuberculosis, Leprosy and Lung Disease Program,

Afya House Annex 1st Floor | Kenyatta National Hospital Grounds
P.O. Box 20781-00202 Nairobi, Kenya | **Cell:** 0773 977 440
Website: www.nltp.co.ke | **Facebook:** NTLDKenya | **Twitter:** @NTLDKenya