GUIDE

TO DEVELOP A NATIONAL ACTION PLAN ON PUBLIC-PRIVATE MIX

FOR TUBERCULOSIS PREVENTION AND CARE

USAID
FROM THE AMERICAN PEOPLE

World Health Organization

Guide to develop a national action plan on public-private mix for tuberculosis prevention and care

ISBN 978-92-4-151351-7

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Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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ACKNOWLEDGEMENTS

This document was drafted by William Wells from USAID, with inputs from Mukund Uplekar and Hannah Monica Dias from the World Health Organization (WHO). It was based on an exercise undertaken in Bangladesh by Rebecca Furth and Zacharoula Srimuangboon (both from Initiatives Inc.), in collaboration with the National TB Programme of Bangladesh. Additional review and inputs were provided by Rebecca Furth, Khurshid Alam Hyder (Regional Advisor, WHO South East Asia Regional Office), Vishnu Kamineni (Consultant) and Joshua Obasanya (Consultant). WHO would also like to acknowledge the support received from the Lilly Global Health Partnership.

Guide to develop a national action plan on public-private mix (PPM) for TB prevention and care

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Introduction and context

The importance of engaging all providers in tuberculosis (TB) care and prevention has been recognized for well over a decade. Over 4 million people with TB are missed each year by health systems and therefore do not get the care they need and deserve. A large proportion of these patients, especially in Asia, are diagnosed and managed in the private sector or unengaged public sector, but not notified to national health systems. Multiple studies have shown extensive use of the private sector, with an average of 50% (in Sub-Saharan Africa) to 80% (in South Asia) of initial visits being in the private sector[1]. Failure to engage with these providers can result in long delays in diagnosis and treatment, resulting in further TB transmission, and poor quality diagnosis and treatment, leading to the development of multidrug-resistant TB (MDR-TB).

The programmatic response to this need has been public-private mix (PPM) for TB prevention and care[2,3]. Engaging all relevant health care providers in TB prevention and care through PPM approaches is an essential component of WHO's End TB Strategy. PPM for TB prevention and care represents a comprehensive approach for systematic involvement of all relevant health care providers in TB control to promote the use of International Standards for TB Care and achieve national and global targets to end TB. PPM encompasses diverse collaborative strategies such as public-private (between NTP and the private sector), public-public (between NTP and other public sector care providers such as general hospitals, prison or military health services and social security organizations), and private-private (between an NGO or a private hospital and the neighborhood private providers) collaboration. The aims of this work are to identify people with TB symptoms as soon as possible, no matter where in the health system they first present, and to establish mechanisms that allow for efficient and high quality diagnosis and treatment.

In 2007, WHO and stakeholders developed a guide for PPM national situation assessments (NSA)[4], which allows a review of engagement of both private providers (public-private contributions) and of public providers who are not under the direct purview of the NTP (public-public contributions). The subsequent PPM toolkit outlines the various domains in which

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[1] Private Sector for Health. Private healthcare in developing countries. http://www.ps4h.org/globalhealthdata.html.

[2] Wells WA, Uplekar M, Pai M (2015) Achieving Systemic and Scalable Private Sector Engagement in Tuberculosis Care and Prevention in Asia. PLoS Med. 12(6):e1001842.

[3] Uplekar M (2016) Public-private mix for TB care and prevention: what progress? what prospects? Int J Tuberc Lung Dis. 2016 Nov;20(11):1424-1429.

[4] WHO (2007) PPM for TB care and control: a tool for national situation assessment. http://www.who.int/tb/publications/2007/who_htm_tb_2007_391/en/

engagement is needed[5]. By now, almost all high burden countries have developed a number of PPM models, adapted to local contextual needs, that allow engagement of certain types of healthcare facilities or providers.

The new document outlined here – the guide to develop a national TB PPM action plan – builds on these earlier documents. To be successful, necessary inputs include the extensive background information collected during a PPM NSA (or NSA-like process as outlined below), including a detailed understanding of the current PPM models in the country, and consideration of all the facility and provider categories outlined in the PPM tool kit.

The difference with the current action plan concept, however, is the greater emphasis on planning the overall PPM response. The resulting plan should have national scope, a pathway to achieve national coverage using existing models and/or newly proposed models of care, and details about targets, costing, and assigned manpower and funding, broken down by PPM areas (e.g., hospitals, general practitioners (GPs), pharmacists, regulation, etc).

The action plan document is not intended to be a standalone plan for PPM in a country. It is a planning document designed to facilitate the integration of strong PPM components into national TB strategic plans that are supposed to be the basis for Global Fund proposals and national budgeting processes, and will help drive a more comprehensive approach to provider engagement in TB care and prevention.

The process highlighted in this document has already been adopted and used in over ten countries, including Bangladesh, Ethiopia, Ghana, Kenya, Malawi, Namibia, Nigeria, Philippines, Tanzania, Uganda and Zambia. PPM action plans were developed in these countries by the national TB programme and key partners on the ground, with the support of a PPM consultant. Some of these plans have been incorporated into national strategic plans and Global Fund proposals already.

[5] WHO, Stop TB Partnership (2010) Public-private mix for TB care and control: a toolkit. http://www.who.int/tb/careproviders/ppm/PPMToolkit.pdf

Goal and objectives of this document

This document has one simple goal: to guide national programmes in developing an action plan for PPM that will close the gap in reaching the missed cases using PPM approaches. Such plans should, in turn, fulfill four objectives:

1. Provide an easy reference to keep track of need versus coverage in all the distinct elements of PPM (e.g., hospitals, GPs, pharmacies, etc), as outlined in the NSA guide.
2. Review the regulatory environment for PPM, while defining the implementation arrangements
3. Provide a clear roadmap for national level planning of PPM, reflecting more ambitious PPM plans with broad coverage and allocated resources.
4. Build high-level commitment at the national level to build or strengthen linkages with the private sector.

Target Audience

This document is targeted for use by national TB programmes, partners and consultants supporting countries in developing proposals or providing technical assistance in scaling up PPM approaches in the country.

Process considerations

Since the action plan is a national document, it is critical that the process for developing the document be:

1. Under the leadership of the NTP;
2. Participatory and inclusive with the involvement of key PPM stakeholders in the country;
3. Reflective of inputs from private sector providers including through associations of these providers, and with feedback from civil society.

To facilitate NTP leadership of the process, there should be an NTP staff designated for PPM activities who is responsible for overall coordination. It will typically be useful to have one or more consultants who are responsible for the actions below, in collaboration with the NTP and partners on the ground:

1. Gathering and summarizing background information on the current health system situation, provider numbers, and PPM coverage and policies (see next section on "situation analysis" – this analysis should generally be done by the consultant(s) prior to the national consultations, with inputs from all major stakeholders including civil society organizations (CSOs), and the outcomes summarized for consultation participants);
2. Structuring and driving the process of the NTP-led national consultations;
3. Capturing the outcomes of the initial consultations, and summarizing them for further discussion by participants (at least two rounds of consultation should be scheduled, with a break in between to organize the outputs from the first consultation);
4. Drafting the text of the national action plan; and
5. Finalizing the text of the national action plan, in response to feedback from participants.

The planning process is structured around a number of standard Tables. These Tables are reproduced in this document but are also available in Excel format at http://www.who.int/tb/areas-of-work/public-private-mix/actionplanguide. The suggested order of activities are as follows:

1. Consultant(s), with NTP support, gather information for the situation analysis (section 4) via desk review and informal discussions, and prepare a draft report and presentation of this information. The development of a detailed NSA in advance may be possible in certain countries which have robust documentation on PPM. However, in other settings it may only be possible to put together a draft outline of the NSA, which could then be finalized after the country mission, following site visits and meetings with stakeholders.
2. Consultant(s) prepare the templates required for group work during the consultation (e.g., local adaptations of Table 1, Table 2, Table 3, Table 4, Table 5 and Table 8).

3. Convene first national consultation of ~2 days (see draft agenda in Annex 1) to:
    a. Review and improve the situation analysis
    b. Agree on a goal, strategic objectives and timeline for the national action plan
    c. Define task mix and referral pathways (Table 1 (useful for providing a snap shot for the first consultation), Table 2 (useful for more detailed mapping of individual PPM models)
    d. Define targets (Table 3)
    e. Define sub-objectives and activities (Table 4)
    f. Start the costing process (Table 5), and set timelines for partners to provide further cost and coverage information. NOTE: if possible, partners should come to this first consultation with basic costing, coverage, and outcome data about their existing PPM efforts. If this is not possible, the consultant will need to follow up with key stakeholders to set appropriate targets and to cost sub-objectives.
4. Consultant(s) write up the outcomes from the first consultations with inputs from NTP and partners, collect any further coverage and cost data required from partners, submit to NTP and partners for review and comment, and prepare the format for the second consultation.
5. Convene second national consultation of ~1 day to review and improve the draft outcomes, including the final costing (Table 5) and estimation of cost per case found (Table 8).
6. Based on the second consultation, consultant(s), with NTP, revise the national PPM action plan, send it around for any additional comments, and then finalize the report (in Word) and master Excel costing for dissemination.

If time is limited, the sequence may be altered as follows:

1. Initially focus more on collecting information from individual stakeholders, with the consultant filling out the first draft of these tables based on these individual consultations.
2. Consolidate the two national consultations into a single meeting towards the later part of the consultancy, which will cover all of the consultation topics in a single consultation.

Situation analysis

The situation analysis builds on the general template of the National Situation Assessment (NSA) tool, and users of this guide on PPM action plans should consult the earlier guidance document for further advice on data sources and process considerations, and read any available country-specific NSAs for background information.

In brief, the situation assessment should first use reviews of formal and grey literature, and then individual and group discussions, to provide a summary of findings for each of the following areas:

1. Basic TB epidemiology, including gaps in national TB case finding. This could include PPM and health system data collected in previous epi reviews for NSP development, and an analysis of whether case finding shortfalls are driven more by under-diagnosis, under-notification, or both;
2. Any major initiatives in the country to engage or structure the work of private healthcare providers (not specific to TB), e.g, major franchising or insurance initiatives that include private providers (for TB-specific PPM models/initiatives, see # 9 below). Published success stories and programme review reports may be typical data sources. In particular, the assessment should describe any private sector engagement by other vertical programs (such as HIV, malaria, family planning, and maternal and child health), as it will be easier to add to these efforts rather than starting TB-only efforts;
3. Sources of current TB notifications to the NTP (i.e., what proportion of TB notifications come from different sources such as public hospitals, private hospitals, etc);
4. Causes and average duration of TB diagnostic delays;
5. Availability and sales volumes of TB drugs in the private sector, if known;
6. Patterns of health seeking behaviors by people with TB symptoms: both the proportion of people first seeking treatment at different types of providers; and the typical pathways that those individuals take before reaching quality TB diagnosis and treatment. Such data can be sourced from special studies, patient pathway analyses[6,7](and the studies they cite), and also from most TB prevalence surveys;
7. The total numbers of each health facility or provider type in the country (e.g., public hospitals, private hospitals, specialists (pulmonologists, pediatricians, etc), general practitioners, pharmacists, laboratories, informal providers, large workplaces, and public

[6] Hanson C, Osberg M, et al. Conducting Patient-Pathway Analysis to Inform Programming of Tuberculosis Services: Methods The Journal of Infectious Diseases, Volume 216, Issue suppl_7, 6 November 2017, Pages S679–S685

[7] Hanson C, Osberg M, et al. Finding the Missing Patients With Tuberculosis: Lessons Learned From Patient-Pathway Analyses in 5 Countries. The Journal of Infectious Diseases, Volume 216, Issue suppl_7, 6 November 2017, Pages S686–S695

sector health facilities overseen by other ministries such as in prisons, armed forces, etc). In large countries, the action plan process may be undertaken for individual states or provinces, in which case the provider numbers should reflect only the numbers in that selected area;

8. The number of each of these provider types that are already engaged in quality TB diagnosis and treatment and are contributing referrals or notifications to the National TB Program;
9. The mechanics and outcomes of the models used for PPM engagement in the country: what methods each engagement model uses for provider engagement, provider education, monitoring, and support; the personnel and financial requirements for each model; and the referral, case finding and treatment success outcomes from each of the models;
10. Sources and amounts of current funding (from both national and donor sources) for TB PPM;
11. Current mechanisms for collecting data on private provider numbers, their engagement by the TB program, and their contributions to TB notifications, including any mHealth applications being used or developed;
12. The major professional associations in the country, including indicators of their institutional capacity such as yearly budget, number of paid staff, number of members, and any involvement in and outcomes of TB PPM;
13. The current situation with regulations such as provider licensing, facility accreditation, mandatory TB notification, and dispensing antibiotics (and specifically TB drugs) with prescriptions: the details of existing regulations; the extent to which these regulations are or are not enforced; and the mechanism of enforcement;
14. PPM-related actions and operational gaps identified in the TB national strategic plan (NSP); and
15. Current status of universal health coverage (UHC) in the country and social protection schemes for TB patients, and any considerations for coverage of private patients under both.

Many of the above points will have to be probed in detail during the field visits and consultations, followed by systematic collation of this information. The field visits also need to be planned in a manner to ensure interactions with the diverse actors relevant to facilitate PPM in the country context, including both public and private managers and implementers at all levels of the health system.

Defining a goal, strategic objectives, and a timeline for the action plan

An early step in the consultations should be to define an overall goal for the national PPM action plan, and a limited number of strategic objectives. The goal should indicate the level of the ambition of the action plan, and give some indication of which thematic areas are being emphasized more or less in the country (e.g., case finding, referral vs case holding by the private sector, certain provider types who are expected to contribute most strongly).

All specific sub-objectives and activities will be placed under one of the plan's strategic objectives. These strategic objectives can be grouped in various ways, but typically there will be objectives covering:

1. PPM leadership and stewardship (e.g. oversight, management, regulation and resource mobilization), including the role of medical associations.
2. PPM mapping, data collection systems, databases and supervision tools to standardize and enhance monitoring, recording, reporting and analysis of PPM results.
3. Efforts to engage specific facility and provider types. This will likely be spread over several strategic objectives, e.g., by having distinct strategic objectives for hospitals, specialists, individual general practitioners, pharmacists, laboratories, and workplaces, or for different models that link these providers in distinct ways (e.g., one objective for comprehensive PPM at the primary healthcare level, and one for comprehensive PPM care at the secondary level).
4. PPM financing. This should include themes such as increased domestic financing for PPM, an increased share of donor TB financing for PPM, and increased reach of insurance initiatives and reimbursements for TB to more private providers.

Efforts to strengthen regulatory approaches can be included as part of the first strategic objective (on leadership and stewardship) or considered separately if there is a more developed or complex regulatory legislative framework. Another potentially important strategic objective could outline plans to strengthen UHC and/or social protection mechanisms that do or could cover the clients of private providers.

The grouping of provider types into several individual strategic objectives will depend on how current engagement is structured in the country, e.g., whether current engagement efforts effectively group together certain types of providers. One important outcome of PPM efforts is

to increase the organization and structure of the private health system, so models that link together different types of providers should be strongly considered.
These "engagement" objectives should also distinguish between areas where there are existing, proven models that require expansion, versus areas where innovation is needed to establish one or more new models. The alignment of ongoing community engagement models with PPM efforts can be considered (e.g., community workers who direct clients to private providers), but in general this PPM exercise should not attempt to capture or analyze the large universe of community TB initiatives.

The strategic objectives should also align well with the overall National TB Strategic Plan in the country and complement other objectives/activities in the plan.

Finally, the time period to be covered by the action plan should be defined. Typically, this would cover a 5-year period, starting from the current year.

Defining the task mix and referral pathways

The concept of the task mix – which outlines the provider types that will undertake each task in TB care and prevention – remains central to all PPM efforts. Early in the consultative discussion, a draft task mix for the country should be discussed, revised based on inputs from participants, and finalized. The possible role of intermediary agencies to facilitate PPM efforts should be considered based on the country context. See Annex 2 of the NSA guidance and Table 1 for the structure of a simple task mix table that can be helpful in early discussions. The structure for a more detailed task mix is presented on page 19 of WHO guidance on engaging all care providers, and in a slightly modified form below in Table 2. This latter table elaborates, in more detail, the tasks undertaken by providers as part of existing PPM models in countries, or proposes tasks for providers under new models proposed for PPM implementation and scale up.

Table 1: Simple task mix for TB PPM

	Provider type #1	Provider type #2	Etc.
Refer (identify and refer symptomatics)			
Diagnose (identify symptomatics, request and interpret diagnostic tests and prescribe treatment)			
Treat (periodically check on patient progress and re-supply drugs)			
Follow-up (adherence monitoring, and recording and reporting)			

Table 2 below can be used in a number of different ways. One recommendation is to develop one task mix table for an individual provider model, with one column for each staff or provider type in that model, and another task mix table for an institutional (e.g., hospital) provider model. Individual partner organizations can also develop their own version of this table to describe the specific designs of their PPM models.

In addition, stakeholders should consider and sketch out referral pathways. From a patient's first encounter with the health system, what are the most preferred referral pathways? Which pathways are most likely to be reflect client preferences (e.g., to be cheap, simple, fast, and to a preferred provider type), and thus be more successful? How can such pathways be supported by existing or new PPM efforts?

Table 2: Expanded task mix for TB PPM

	Task title/ Model or Position Type	PPM Model #1 (e.g. indiv PP), Staff type A	PPM Model #1, Staff type B	…	PPM model #2 (e.g, hospital), Staff type A	PPM model #2, Staff type B	…
SERVICE DELIVERY TASKS	Identify TB symptomatics						
	Refer symptomatics						
	Request diagnostic tests						
	Run diagnostic tests						
	Prescribe treatment and counsel/inform patients						
	Supervise treatment (dispense drugs)						
	Patient follow-up visits						
	MDR-TB treatment supervision						
	TB/HIV diagnostic and treatment linkages						
	Contact investigation						
	Loss to follow-up tracing						
	Recording and reporting, including notification						
PUBLIC HEALTH TASKS	Stewardship, financial management						
	Drugs and Supply Management						
	Monitoring and Evaluation						
	Laboratory Quality Assurance						
	Supervision or quality improvement						
	Training, Orientation or Sensitization						
	CME contributions and knowledge dissemination to providers						
	Mapping and enrollment of private providers						
	Organizing quarterly programme oversight						

Defining targets

The next step is to build on the background information and, in consultation with all stakeholders, decide on specific targets. The discussion should be based around a table similar to Table 3 below. As much as possible, the structure of this table, and columns 1, 2, 3 and 6, should be completed by the consultant(s), in collaboration with the NTP, prior to the first national consultation. The target setting should take into account baseline levels of engagement and contribution by various care providers, and map the potential contribution expected from scaling up engagement of providers, using different operational models.

Table 3: Target setting for the national PPM action plan

Type of non-NTP provider or facility	Total number of providers or facilities in country	Number currently engaged	Target number engaged by 20xx	Total target as % of total provider or facility number	Number currently notified in a year	Target number notified yearly by 20xx	Total new yearly notifications
Provider or facility type #1		By model (a): xx	By model (a): ##		By model (a): xx	By model (a): ##	
		By model (b): yy	By model (b): **		By model (b): yy	By model (b): **	
		…..etc.	….etc.		…..etc.	….etc.	
		Total: ….	Total: ….		Total: ….	Total: ….	
Provider or facility type #2							
Provider or facility type #3 …..etc.							
TOTAL	**xxxx**	**xxxxx**	**xxxx**	**xxxx**	**xxxx**	**xxxxx**	**xxxx**

Defining sub-objectives and activities under each strategic objective

A series of defined sub-objectives and activities should be outlined for each strategic objective. Using the structure of the strategic objectives outlined above, a number of questions to consider for each strategic objective are outlined below.

1. **PPM leadership and stewardship:**
   a. Which groups should meet, and at which levels? Note that almost all PPM implementation occurs at sub-national levels, so governance at these lower levels, including from civil society organizations, should not be neglected.
   b. For each such group, what are the core responsibilities and actions required, the membership, the frequency of meetings, and the expected outcomes?
   c. What capacity building efforts are required? There should be specific consideration of pre-service training of providers, in-service training of providers, and institutional capacity building of organizations delivering PPM services (such as professional associations and NGOs). The capacity building of the local PPM leadership group should also not be neglected, so that these groups can create local roadmaps for PPM.
   d. What actions will be taken to increase resource mobilization for PPM?

2. **PPM regulation:**
   a. What human resources and mechanisms can be used to strengthen the various regulatory mechanisms such as:
      i. facility licensing
      ii. provider certification;
      iii. facility accreditation;
      iv. mandatory TB notification;
      v. prohibiting or regulating the dispensing of TB antibiotics for TB and/or for other diseases; and
      vi. mandatory use of prescriptions before dispensing antibiotics.
   b. Can medical councils or provider associations be used to facilitate dissemination and enforcement of regulations?

3. **Engaging specific facility and provider types (outlined in multiple strategic objectives, organized by facility/provider types or by distinct engagement models):**
   a. How will provider mapping be carried out, documented, and updated at the local level? Will this include GPS mapping of facilities and, if so, how will this be achieved?

b. How will provider referrals and notifications be recorded and reported?
c. Is there a simple electronic method for private providers to record and report? If not, what are the actions to develop one under this plan?
d. What are the expansion plans for specific models, as outlined in Table 3? For the larger models, this should include more detailed tables that outline the sequence of steps necessary for expansion, and the timeline and targets for intermediate steps (e.g., number of facilities engaged, trained, and adopting key practices). The targets set in section 8 can be revisited, if necessary.
e. What institutional capacity building is needed for each implementing organization, including resource mobilization efforts?
f. What tool development, and monitoring and evaluation efforts, are needed for each implementing organization?
g. What incentives and enablers, if any, are required?

4. **PPM monitoring and evaluation:**
   a. How will the mapping and notification data be summarized to and captured by higher levels?
   b. What analyses of PPM data will be carried out at each level of the health system? Which organization has the capacity to analyze outcome measures (e.g., cost per case diagnosed in each of the different models), and how often will this be assessed?

5. **PPM financing**
   a. How can domestic financing for PPM be measured and increased?
   b. What strategies will help ensure an increased share of donor TB financing for PPM?
   c. How can TB be included in existing and new insurance initiatives, and how can these initiatives use reimbursements for TB to engage more private providers in providing quality TB care?

For each bullet point above, the consultation group should discuss:

1. What actions are needed?
2. Is the next step:
   a. a detailed assessment to determine the way forward; or
   b. development of a new system, pilot, or methodology; or
   c. immediate rollout of an existing model?
3. What human and financial resources would be necessary for the agreed actions, and where could those resources come from? The details of this will come later (see Table 5), but high level ideas can be discussed here.

It is critical that there is a realistic "owner" organization for each major area of work – meaning that TB stakeholders believe that this organization has the ability to recruit and organize the staffing needed to implement the outlined activities and reach the expansion targets.

As this discussion is progressing, the consultants should be filling out the following table (Table 4 - a single example of the type of content for each column is given in the top row). Each activity and target should be **SMART** (specific, measurable, achievable, relevant, and time-bound). Targets are included for each level (strategic objective, sub-objective, and activity), and an indicator column may also be useful.

Table 4: Log frame for the national PPM action plan

PPM Strategic Goal: xxxxx.										
Strategic Objective	**Sub-Objective**	**Activity Description**	**Activity Timeframe**					**Lead / support orgn**	**Funder**	**Target**
			Y1	**Y2**	**Y3**	**Y4**	**Y5**			
1. Ensure effective leadership and stewardship of PPM through resource mobilization, active oversight and management, and fulfilment and coordination of PPM roles, and responsibilities among NTP and partners.	**1.1** Ensure the effective functioning of the PPM Committee and TWG in PPM representation and implementation by the end of 2016 (NTP).	1.1.1 Review and update ToR for PPM Committee	x							- Consistent commitment and attention by stakeholders to PPM - TOR for PPM Committee revised
		1.1.2 Conduct bi-annual PPM Committee meetings and PPM TWG quarterly meeting	x	x	x	x	x			- 2 Semi-annual Committee meetings held and minutes shared with partners (2/Y = 10 total) - 4 quarterly TWG meetings held per year
	1.2 …..	1.2.1 ….								
	1.3 …..	1.3.1 …								
	1.4 …	1.4.1 …								
		1.4.2 …								
2. …..	**2.1** …..	2.1 1 …								

Costing the national action plan for PPM

Once decisions have been made about strategic objectives, sub-objectives, activities, and targets, the group should develop a costed version of the plan. The WHO planning and budgeting tool may be used to support this exercise.

The suggested approach is as follows:

1. For each cross-cutting strategic objective (e.g., the governance, data management and regulatory strategic objectives listed above), pull out the "activity description" column from Table 4 to create Table 5. Group together all of the activities with the same lead organization, and task this organization with costing out each of the activities, or the package of activities (depending on how their own activities and budgets are organized). The organizations may wish to expand each activity into a series of budget lines to come up with a more robust costing; if so, they should consider using the standard cost categories in Table 6. However, in many countries it may be more practical to estimate costs per model rather than costs per activity.

Table 5: Costing framework for the national PPM action plan

Sub-Objective	Activity Description	Budget					Lead / support organization	Funder
		Y1	Y2	Y3	Y4	Y5		
1.1	1.1.1 Review and update ToR for PPM Committee							
	1.1.2 Conduct bi-annual PPM Committee meetings and PPM TWG quarterly meeting							
	1.2.1 ….							
	1.3.1 …							
	1.3.2 …							
	1.4.1 …							
2.1…	2.1 1 …							

2. For each PPM model represented in the subsequent strategic objectives, the lead organization should calculate the costs of expansion to reach the targets decided in Table 3. This process can be standardized by using the cost categories from Table 6; the results are then transferred to Table 5. Funding gaps can be noted by inserting "n/a" in the final column of Table 5. If it is not politically acceptable to designate the "lead organization" for each area of work in a national plan, this column can be deleted from Table 5.

Table 6: Cost categories for the national PPM action plan

Cost grouping
1.0 Human Resources (HR)
2.0 Travel related costs (TRC)
3.0 External Professional services (EPS)
4.0 Health Products - Pharmaceutical Products (HPPP)
5.0 Health Products - Non-Pharmaceuticals (HPNP)
6.0 Health Products - Equipment (HPE)
7.0 Procurement and Supply-Chain Management costs (PSM)
8.0 Infrastructure (INF)
9.0 Non-health equipment (NHP)
10.0 Communication Material and Publications (CMP)
11.0 Programme Administration costs (PA)
12.0 Living support to client/ target population (LSCTP)
13.0 Results-based financing (RBF)
Sub total
Overhead xx% of subtotal cost
Grand total

3. If HR requirements are complex, Table 7 may be useful. Note the existing positions, their numbers, rank, location, salary, and funding source. Then fill out Table 7 to figure the number of new staff needed. Transfer the summary results to Table 5.
4. The consultant(s) should consolidate all of this information in a single master Excel sheet. The first tab of this Excel should be a master budget using the structure outlined in Table 5. The individual contributions from partners (which may have more detailed breakdowns of the costing process for their particular activities) can be inserted into the same document as back-up tabs.

Table 7: HR worksheet

A	B	C	D	E	F	G	H	I	J	K	L
Staff Title	Employed by (NTP, NGO, Gov Hosp, Prison, etc.)	Level (national, prov, district, etc)	Qualif-ication	FT/ INT PT*		Staffing Assessment (complete either column G or H and I)					
					Target # of providers to be reached in the model	# of providers to cover /staff member	Number of sites	Number of staff / Site	Estimated No of staff required (F/G or H*I)	Average expected Salary	Total HR cost (J*K)

* FT= full time, INT = integrated (working full time but on PPM only part-time) and PT = part time.

In projecting the later years, this costing should take into account inflation, salary increases, and expansion of targets.

Once the costing is complete, the participants should review the cost per case for each of the models by filling out Table 8. In Table 8, columns A and B come directly from the corresponding columns in Table 3, and column C comes from the costing exercise outlined above. It can also be useful to compare cost per case in Year 1 for new implementation sites or models versus Year 5, since initial investments can inflate costs, but these may reduce over time.

It may be justifiable to allocate money even to "expensive" models that cost more than the average for each case found, especially if those mechanisms are locating distinct or harder to reach populations, or offer greater scope for scale or sustainability. In addition, the cost of different models will vary depending on which cost categories they include or do not include (e.g., some models will include budget for diagnostics and/or drugs, whereas other models will rely on actors outside the models for these resources). While considering these caveats, this simple costing exercise should be carried out so that efficiency and program reach are discussed and maximized.

Table 8: Cost per case notified, by model

A: Type of non-NTP provider or facility	B: Target number notified yearly by 20xx	C: Budget required for one year of notifications	Cost per case identified (= B/C)
Provider or facility type #1	By model (a): ##	By model (a): ##	By model (a): ##
	By model (b): **	By model (b): **	By model (b): **
	….etc.	….etc.	….etc.
	Total: ….	Total: ….	Total: ….
Provider or facility type #2			
Provider or facility type #3 …..etc.			
TOTAL	**xxxxx**		

Finalizing the national PPM action plan

Once both sets of consultations are completed, and stakeholders are in agreement on task mixes (Table 2), targets (Table 3), strategic objectives, sub-objectives, and activities (Table 4), costing (Table 5), and cost per case (Table 8), the written report should be finalized. This report should include these five key tables (plus explanatory text), and follow the same structure as this guidance document, i.e. the suggested sections are:

1. Introduction and context
2. Objectives of this document
3. Process considerations
4. Situation analysis: data and findings
5. Defining a goal, strategic objectives, and a timeline for the action plan
6. Defining the task mix and referral pathways
7. Defining targets
8. Defining sub-objectives and activities under each strategic objective
9. Costing the national action plan for PPM
10. Annex 1. Agenda for national consultations
11. Annex 2. Detailed budgets for cross-cutting activities and individual models, organized by strategic objective number (it may be easier to present this as a separate master Excel document summarizing the costing outcomes, as described above).

In summarizing this document, there should be an analysis of how much the plan will contribute to closing the national gap in case detection or reaching the people with TB who are missed by the health system. This is an important step in assessing if the plan is ambitious enough or if it will make the contribution needed.

Adopting the PPM national action plan

The PPM national action plan process provides an opportunity to engage multisectoral stakeholders and raise awareness and commitment about the need to leverage the entire health system in order to reach public health goals in TB and beyond. Once the PPM national action plan is finalized, countries should get high-level clearance/commitment for the plan by getting sign-off from the leadership of the NTP, Director of Disease Control, and if possible the Health Secretary or Minister of Health. The strategies and financial tables from the PPM national action plan should be incorporated into the country's TB national strategic plan, GF concept notes and other donor proposals, and national budgeting processes.

ANNEX 1.

Draft agenda for national consultations

The example agenda below is a simple and condensed format for a PPM action plan meeting. Depending on the size and complexity of the country's health system, this process may take multiple days, with a break in between to consolidate the data collected. This abbreviated format is presented here only as a starting point. Whatever the length of the consultation process, the consultant will need to come to the meeting prepared with draft documents, as described in the guidance above.

Template:

WORKSHOP TO DEVELOP A PPM ACTION PLAN

LOCATION:
DATE:

Goal: Develop the 5-year PPM National Action Plan

Objectives:

- Introduce PPM Action Planning Steps.
- Review current PPM situation, gaps and recommendations.
- Develop PPM strategic goals and objectives.
- Prioritize models for expansion or addition and determine opportunities and threats.
- Identify PPM providers, structures and support systems needed to implement the models.
- Develop targets and indicators for M+E.
- Map HR and other cost requirements to implement models.

Expected outcomes:

1. First draft of the plan ready for dissemination to key stakeholders for feedback

Workshop methodologies:

1. Power Point Presentations
2. Small and large group work and group presentations
3. Group discussions and brainstorming exercises

Proposed Agenda

TIME	TOPIC	
800-0830	Registration	
0830-0900	Opening Remarks, introductions, workshop introduction, and agenda	Honored guests, ALL
0900-0930	Steps in the PPM action planning process	Lead consultant PPT
0930-1030	Situation analysis, including overview of current PPM models (successes, gaps and recommendations)	Lead consultant, NTP and partner PPTs
1030-1100	Coffee	
1100-1130	Define PPM action plan's goal, strategic objectives (including prioritized models) and timeline	Lead consultant PPT and facilitated discussion
1130-1200	Discuss draft task mixes (drafted beforehand by consultant, working with partners)	Group Discussion
1200-1300	Lunch	
1300-1400	Define targets	Group discussion or small group work
1400-1500	Define HR and budget requirements for different strategic objectives	Facilitated small group work
1500-1520	Coffee	
1520-1600	Continue costing	Facilitated small group work
1600-1630	Summary of outcomes, key points for follow-up	Lead consultant, NTP, all

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