Global Coalition of TB Advocates

TRAINING MANUAL

MEANINGFUL ENGAGEMENT IN NATIONAL STRATEGIC PLAN AND PROGRAM REVIEW

CONTENT

BACKGROUND

Nearly 5 million new TB cases emerged in the SEA Region and an estimated more than 780 000 died due to the disease in 2021 (WHO Global TB Report 2022). COVID-19 pandemic has reversed the progress towards ending TB in past two years. There is an urgent need to plug the gaps in TB services not just to recover the lost ground but also make them resilient to cope with future disruptions.

Community engagement in health care delivery and monitoring, specifically in TB has long been identified as a priority need in the SE Asia Region. However, for meaningful engagement of communities, there is a need to build their capacity to participate in programme reviews as well as development of national strategic plans. Communities add value to these processes as:

1. Communities have a unique vantage point to provide valuable insights and bring the lived perspective to the forefront
2. Communities are best placed to identify and propose solutions for any programme implementation gaps
3. Community members have first-hand understanding of the challenges in service delivery
4. Meaningful community engagement strengthens community buy-in and creates a strong partnership between the people and the programme
5. Community experience can inform research and development of new tools and can steer path to a successful outcome for all

Therefore, community capacity building will go a long way towards filling the gaps in community engagement in the Region.

Several Member States will be updating National Strategic Plans and applying for Global Fund (GF) proposal, this exercise will support NTP planning process and ensure appropriate space for community engagement. While community engagement is also important for implementation, this training will be focused on planning and monitoring only. WHO has been working to strengthen collaboration with communities and civil society through ENGAGE TB approach and establishing a Civil Society Task Force.

The GF strategy document for 2023-2028 has “Promote enabling environments, in collaboration with partners and affected communities, to reduce TB-related stigma, discrimination, human rights and gender-related barriers to care; and advance approaches to address catastrophic cost due to TB.” as one of the key strategic priorities. The interventions specifically promoted by the GF include:

1. Integrate the development of comprehensive community health strategies into national disease responses and grant implementation
2. Scale up enhanced CLM approaches

Strengthening community engagement also came up strongly during the NTP managers’ meeting held in August 2022. Therefore, this workshop will also support development of funding proposals in alignment with the donor requirements.

General Objective

To strengthen community engagement in planning and monitoring of TB programmes in close collaboration with national programmes in the South-East Asia Region

Specific Objectives:

Develop capacity of community members in 3 main areas

1. Participate and contribute to country TB programme reviews
2. Development of National Strategic Plans, ensuring adequate space and budgeting for community led activities
3. Advocacy for use of newer tools in TB Diagnosis, treatment and care, as per WHO

Guidelines Output

1. Roster of community experts who can participate in programme planning and review, as well as train other community members
2. Trainees enabled to include community perspective/engagement in their national strategic plan and thereby include budgetary requirement for future funding proposal
3. The trained personal envisaged to advocate with their national programme and community to use new tools for diagnosis and treatment

STRUCTURE OF THE MANUAL

This manual has been designed as a complete package for three-days training. As an alternative, individual modules addressing a particular thematic area, or a combination of selected modules, may also be used for specific contexts.

How to use this Manual

The facilitator(s) are required to read all the topics covered in these modules before commencement of the training in order to have a comprehensive understanding of the scope of each topic and its relevance, besides the sessions that they will be facilitating.

Prior to the training, the facilitators will need to consider and discuss how they will use these modules to develop the knowledge and capacity of the participants. The sessions are meant to engage the participants in a participatory learning process based on adult learning principles. Facilitators are encouraged to:

- Identify the participants' needs and what is important to them
- Provide real-life situations and emphasize the application of learning to real problems
- Provide activities that require active participation of the participants
- Use a variety of training techniques
- Establish an atmosphere of respect and understanding of differences
- Provide opportunities for sharing information
- Discuss and analyze the participants' experiences
- Engage participants as valued resources and encourage them to participate and share their experiences

Each session has the following arrangement, although facilitators may choose to adapt the sequences and timings as per the requirements of the training.

Time: duration of the session

Materials required: A suggested list of materials required during the training including audio-visual equipment, stationery, handouts, reference materials, pre and post training assessment forms and feedback forms

Learning objective(s): Describes the desired learning outcome to be achieved by the participants at the end of the session

Methodology: Describes step-by-step participatory methods that will be employed to engage participants in the learning process

Facilitator's notes: Notes to provide the facilitator with useful information on the topic or tips for facilitating an activity

Tips for Facilitators

- Before each day's training, it is recommended that the facilitators familiarize themselves with the topics to be covered for that day, by carefully reading the relevant materials. This will enhance their understanding of the concepts and points raised on each slide and its correlation to the accompanying text. Depending on the skills of the facilitator and their background, they may wish to include examples or case studies to bring further depth and clarity to the topic being presented.
- Most modules require more than one facilitator. In such cases, it ensures that the co-facilitators have read all the training materials in this package and that they feel comfortable facilitating the selected topics from the training manual. A meeting of the facilitators should ideally be conducted before the training to agree on the agenda and to decide who is going to teach which topic. Some facilitators feel more comfortable presenting certain topics and, for the benefit of the facilitator and the participants, this should be taken into consideration.
- Understand the profile of participants attending the training so that the training can be tailored to suit their requirements. For example, if it is a Hindi-speaking audience, then the training can be conducted in Hindi and the PPT, along with other handouts, can be translated in Hindi. If the participants are a mix of new and senior staff, then ensure there is space for the senior staff to share their experience with the new staff.

How to Facilitate

- The facilitators should be familiar with participatory forms of learning.
- They should have the ability to ask exploratory open-ended questions and should make it a point to involve all the participants.
- The facilitators should be technically competent to answer intervention-related questions. The topics included may be adapted to suit local needs and priorities.
- While presenting, it is suggested to take the centre stage – not to hide behind a podium or desk. do not to hide behind a podium or a desk. Face the audience when speaking, not the board or screen. Make eye contact with people in all sections of the audience and speak slowly, clearly and loudly enough for everyone to hear and understand you. Use natural gestures and facial expressions and avoid blocking the participants' view.
- During discussions, involve all participants. Ask direct questions to the quiet ones. Reel in the talkative ones. Move around the room - approach people to get their attention. Use the participants' names.
- Repeat responses from participants when it is likely that not everyone heard it. Respond encouragingly and positively to all answers - correct errors gently. Reinforce participants by thanking them for their comments and praising good ideas. Respond adequately to questions - offer to seek answers if not known.
- Handle incorrect or off-the-subject comments tactfully.
- During group work, explain clearly the purpose of the activity, the role of the participants, and the time limit.

Key Things to Remember as Facilitator

Do

1. Be flexible. Scheduling may have to change depending on the need of the participants
2. Use different teaching methods to enhance participation and retain interest
3. Ensure that teaching materials like hand-outs; charts, etc. are available before the beginning of the session
4. Respect the participants' local knowledge
5. Encourage participants to make presentations

Don't

1. Let any one person dominate the discussion
2. Speak more than the participants – let the participants brainstorm and discuss
3. Allow distractions like mobile phones and chatting among participants
4. Make the training a boring experience – intersperse the sessions with energizers/ games
5. Read out from the PowerPoint presentations – prepare well and use the presentation slides as cue cards to elaborate on the relevant points

SESSIONS

SETTING THE CONTEXT

Duration: 50 mins

Materials Required:

Post-its	Pre-training assessment forms
Whiteboard for sticking post-its	Laptop
Flipchart	LCD Projector

Learning Objective: For the participants to introduce themselves to each other.

Methodology

1. Introductions (15 mins): Conduct an icebreaker to learn about your group of participants
    a. Have a ball ready and pass it to the first participant. They should share their name, the region they come from and their designation. Then, the participant should answer “Who is my dream celebrity dinner guest and why?”
    b. After answering the question, the ball is passed to someone else in the group to answer the same questions

2. Expectations from the training (10 mins)
    a. Each participant is to be given a post-it note
    b. In one sentence, they are to write their expectations from the training program and stick their post-it on a board

c. The trainer can group the answers into major themes or simply read out the post-its

d. The expectations that do not match the agenda of the training can be kept under a spot titled “parking lot”. You can address this later or state that it is outside the scope of this training

e. Be sure to check the expectations board at the end of your training program to see if you have covered the expectations

3. Training objectives and overview (5 mins): Use the PPT to highlight the objectives and overview of the training

   a. To increase the capacity of the participants in 3 specific areas:

      - National Strategic Plan (NSP)- understanding it and interacting with it
      - National review and monitoring of the NSP
      - Advancement of TB diagnosis and care

4. Ground rules (5 mins)

   a. Interact with the participants to list down the ground rules that will be followed during the training to ensure maximum learning

   b. Note their suggestions on a flipchart chart and put it up on one side of the hall

5. Pre-Training Self-Assessment (15 mins)

   a. Request participants to complete a pre-training self-assessment questionnaire

   b. Note that this is not an examination. It is conducted to measure the effectiveness of the training

   c. Inform them that a similar post-training assessment will also be administered after the last session of this training

TUBERCULOSIS 101 & LATEST INFORMATION

Duration: 1 hour 30 mins

Materials Required:

Chocolates as rewards	LCD projector
Handout A: All about Tuberculosis	Flipchart
Laptop	Coloured markers

Learning Objective: To have an overview of tuberculosis, its transmission, diagnosis and treatment, and to update the participants on the latest in TB diagnostics and treatment.

Methodology

1. Introduction (20 mins)
   a. Game to stimulate a mutual understanding of TB within the group and to provide more information as needed. This game is intended to be a quick revision of known facts of TB.
   b. Prepare 8 to 10 questions on simple facts about tuberculosis in advance. Ask the participants to provide answers to these questions. The participant with the greatest number of correct answers receives a reward.

      Sample Questions:

      - What is TB?
      - What are some of the symptoms of TB?

- What types of support do TB patients require?
- What is the difference between pulmonary and extra pulmonary TB?
- What are the latest WHO guidelines on TB treatment?
- How can TB be prevented?
- What is dormant TB?
- What is drug resistant TB?
- What is TB infection?

2. With the aid of the PPT (available with GCTA), discuss the basics of tuberculosis on the topics below. Facilitator can also have participants call out responses after passing out Handout A: All about Tuberculosis at this point (45 mins)
   a. Definition of TB
   b. Pulmonary TB and Extra Pulmonary TB (EPTB)
   c. Dormant TB
   d. Difference between latent TB and TB disease
   e. Symptoms of TB
   f. Diagnosing TB infection
   g. Diagnosing EPTB
   h. TB Preventive Treatment
   i. TB Vaccine
   j. How is TB treated?
   k. Childhood TB
   l. Common Adverse Events (AEs) and how doctors should respond
   m. Latest WHO guidelines on TB treatment (conventional and moving forward)
   n. New and upcoming TB treatments and diagnostics
3. Facilitator to take time to answer any questions, give out any latest information and encourage discussions about this topic before proceeding (15 mins)

ROLE OF STRATEGIC PLANNING IN NATIONAL EFFORTS TO END TB

Duration: 2 hours

Materials Required:

Laptop	Flipchart
LCD projector	Coloured markers

Learning Objective: To understand strategic planning, elements of a good strategic plan and why it is required in the effort to end tuberculosis.

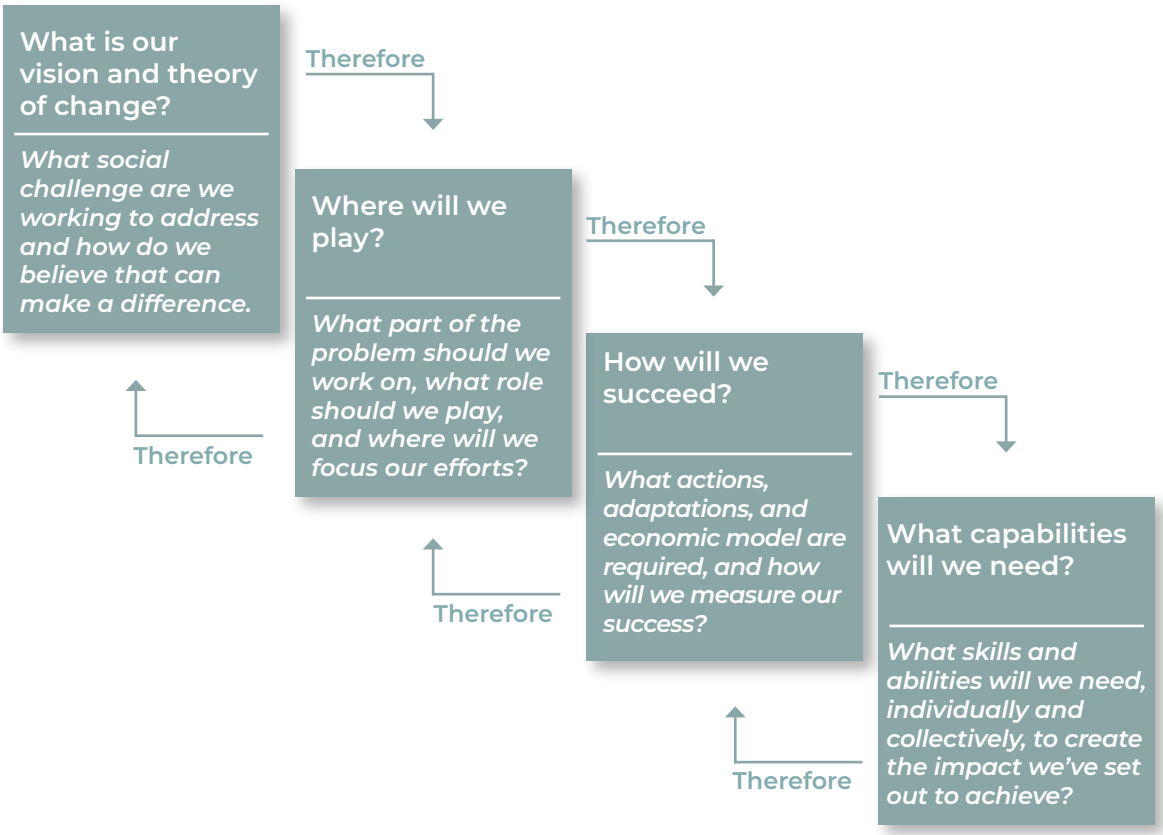
Methodology

1. Introduction: What is strategic planning? (PPT; 5 mins)
    a. A strategic plan is a process of setting goals that outlines the direction and future of an organization
    b. The components of this plan involve strategies, implementation processes and evaluation of the results
2. For instance: what is the end TB strategy endorsed by the WHO[1]? (PPT; 10 mins)
    a. The End TB Strategy, endorsed by the World Health Assembly in May 2014, provides strategic direction for the achievement of the TB targets within the United Nations (UN) Sustainable Development Goals (SDGs), including the provision of universal health coverage (UHC) to all people affected by TB
    b. The strategy outlines a range of medical and socioeconomic interventions to

1. Guidance for National strategic planning for tuberculosis, Pg 2-4, ©WHO, 2022

address TB morbidity and mortality, and to facilitate the provision of people-centred services and the elimination of TB-related catastrophic costs

3. Showcase a sample strategic plan over PPT as shown below. This slide is just to help the audience understand the components involved in a strategic plan (PPT; 15 mins)
   a. The cascade of strategic choices:



4. A National Strategic Plan (NSP) for TB care constitutes the key instrument to efficiently implement the defined policies for TB in a country (PPT; 5 mins)

Facilitator's Notes: *It must reflect the vision of the national TB programme (NTP) and must be in line with the national health policies and strategies as well as with the general health plan for the country. For global public health problems such as TB, development of national strategic plans should be guided by a national adaptation of the global strategy. The development of a NSP should be based on an in-depth analysis of TB epidemiology and in order to rely on a clear understanding of the TB control situation and follow a rational process of development.*

5. WHO states the role of strategic planning in national efforts to end TB (PPT; 15 mins)
   a. TB is a disease of poverty and inequity. Therefore, addressing TB is critical for the attainment of equity in health
   b. A TB National Strategic Plan (NSP) provides medium-term direction for the country's efforts to end TB. It outlines the overall goal, strategies and interventions prioritized by the national health authorities and stakeholders

and provide guidance on how these are coordinated across various sectors

c. The NSP translates global, regional and national commitments into national and sub-national targets and activities to be implemented to achieve these targets and provides the basis for mobilization of domestic and external resources for the TB response.

6. WHO provides a picture of what a well-planned, coordinated strategic planning process will look like (PPT; 30 mins)

Facilitator's Notes: *Please engage the participants in a discussions or Q & A related to these points.*

a. Provides an opportunity to assess the country's situation, and adopt and adapt international commitments and recommendations to the local context

b. Facilitates the identification of relevant stakeholders and their engagement to comprehensively identify the needs of people affected by TB and address TB using a multi-sectoral approach (biomedical, medical, social, economic determinants and consequences)

c. Builds capacity of TB-affected communities, nongovernmental organizations (NGOs) and other stakeholders on planning for TB, and strengthens their meaningful engagement in the TB response

d. Facilitates critical interdisciplinary and multi-sectoral review of the country's TB situation, contributing to a shared understanding of the burden, distribution and determinants of the disease

e. Facilitates collective exploration of the underlying causes and system factors that need to be addressed to end the TB epidemic, facilitates holistic planning, ensuring linkage with other national strategies, and correct placement of the TB response in the context of a broader human rights agenda

f. Provides a platform for collectively identifying and building consensus on the NSP interventions, and differentiation of services according to the needs and preferences of people affected by TB

g. Provides an opportunity to increase awareness and strengthen the commitment of political and other leaders to the TB response, and to mobilize the required resources

7. The good practices for TB strategic planning according to the WHO (PPT; 30 mins)

Facilitator's Notes: *This section describes good practices for developing a TB NSP. These practices are relevant for national and sub-national levels.*

a. Government stewardship and ownership

Facilitator's Notes: *National strategic planning should be led and coordinated by the highest level of leadership possible within the Ministry of Health, at national and subnational levels, to ensure alignment with national and subnational health priorities, and to facilitate adequate engagement and participation of other key institutions and agencies within and beyond the health sector. This will also foster high-level leadership awareness of the country's TB situation and buy-in from key stakeholders, to facilitate resource allocation and leadership support for strategic plan implementation.*

b. Alignment with the End TB Strategy and other relevant global and regional strategies

Facilitator's Notes: *The End TB Strategy guides the global effort to end TB. The NSP development process should consider all components of the End TB Strategy, adapted to the local context, and the NSP should be aligned with other relevant global and regional strategies.*

c. Alignment with the national health strategy and other health programmes

Facilitator's Notes: *It must be noted that a TB strategic plan should be in line with the national health strategy and should complement plans for programmes responsible for addressing TB co morbidities, disability and social protection, and other relevant programmes. The strategic planning cycle for TB should be synchronized with the health sector planning cycle. This is critical for multisectoral planning and domestic resource mobilization that aligns with the country's financial planning cycle, and for optimizing synergies across programmes. In situations where the TB NSP is not aligned with the national health sector plans, efforts should be made to re-align these.*

d. Multisectoral and multistakeholder engagement at national and subnational levels

Facilitator's Notes: *The success of the NSP largely depends on buy-in by all government authorities and public and private stakeholders involved in its development and implementation, within and beyond the health sector. Sensitization and orientation of agencies across government and other stakeholders may be required early in the process, especially for stakeholders who have not previously been actively engaged in the country's TB response. Deliberate efforts should be made to engage affected communities and civil society, both during the planning process and throughout the implementation phase of an NSP.*

e. Adapting the NSP at subnational level

Facilitator's Notes: *Implementation of interventions included in the NSP mainly occurs at community and facility levels. Lessons learned from implementation of previous plans can also help to inform the administrative levels of the health system which should participate in the planning process.*

f. Promoting quality care that is effective, safe and people centred

Facilitator's Notes: *Data suggest that inadequate quality of care is responsible for significant mortality in low- and middle-income countries. The WHO handbook for national quality policy and strategy highlights the need to address quality in disease programmes.*

8. End this session with a time of questions, answers and comments on what has been discussed so far (10 mins)

COMPONENTS OF A TB NATIONAL STRATEGIC PLAN (NSP)

Duration: 1 hour 30 mins

Materials Required:

Chocolates as rewards

Handout B: Process of developing a TB NSP

Laptop

LCD projector

Flipchart

Coloured markers

Learning Objective: To understand the various components of an NSP and the process involved in developing it.

Methodology

1. Optional: Start the session with a game to break monotony (15 mins)
   a. Game suggestion: My superpower
   b. Each participant will state their name and then share what their "superpower" is. This can be a special skill, a curious fact about their lives, valuable knowledge they can share, etc. You can choose to make it more professional or keep things more personal as a way of getting to know each other better.
2. Recap last session if required
3. Use of case studies to understand the components of NSP
   a. Participants will be divided in 4 groups and given a case study each (2 groups get Country Study X and 2 groups get Country Study Y)

Country study 1: Country X accounts for more than 20% of the world's TB burden, averaging an incidence rate of 189 per 100,000 population in the year 2021. TB continues to be a major public health emergency in this country of over 1 billion people. The Ministry of Health has a comprehensive national strategic plan and programme which provides numerous facilities with free treatment to all citizens. However, more than 1000 people die every day from TB, only 22% of people notified were tested with rapid diagnosis, only 24% of children (aged < 5 years) household contacts of bacteriologically-confirmed TB patients were started on preventive treatment, people aged 15-24 years carry the highest burden of the disease, undernutrition continues to be the most likely attributable risk factor.

Q: What components must be incorporated into the planning of the revised NSP for country X?

Country Study 2: Country Y is a has a high TB burden. In 2016, it had an incidence rate of 500 per 100,000, TB case detection rate was 60% and the TB treatment success rate was 85%. The high prevalence of TB was thought to be a combination of high poverty, low levels of literacy, low community awareness, insufficient access and poor health seeking with relatively poor use of health facilities and limited knowledge among the health staff for screening of TB. In Country Y, TB was the second most common cause of death in hospitals.

A five-year NSP was launched on January 2016, including training health workers on drug regimens and treatment of TB and a focus on strengthening diagnosis by improving the quality of laboratories and human resource capacity. In addition, TB advocacy, communication, and social mobilization activities were included, such as dissemination through mass media, billboards, sensitization events involving village councils, providing TB information in secondary schools, and training community volunteers on identifying individuals who may have TB. In 2022, Country Y has an incidence rate of 300 per 100,000, TB case detection rate of 80% and the TB treatment success rate is 90%.

Q: What can we learn from Country Y and its approach to widespread tuberculosis amongst its citizens?

b. Discuss and present findings

4. Components of a National strategic plan[2] (PPT; 15 mins)
   a. A TB NSP comprises the key components outlined below. These components are interconnected parts of a single plan and should be collectively developed as part of the overall strategic planning process
   b. Situation analysis

Facilitator's Notes: *this includes an analysis of all key socio-demographic, cultural, economic, epidemiological, political, institutional and governance aspects that have implications for the country's TB epidemic and response.*

   c. Goal(s), objectives and strategic interventions
   d. Activities and sub-activities

2. Guidance for National strategic planning for tuberculosis, Pg 5 onwards, ©WHO, 2022

Facilitator's Notes: *These include the key actions, and they should reflect the inputs and technical expertise required for implementation of these actions.*

e. Contingency measures

Facilitator's Notes: *These are measures to be activated in case of major disruption to service provision.*

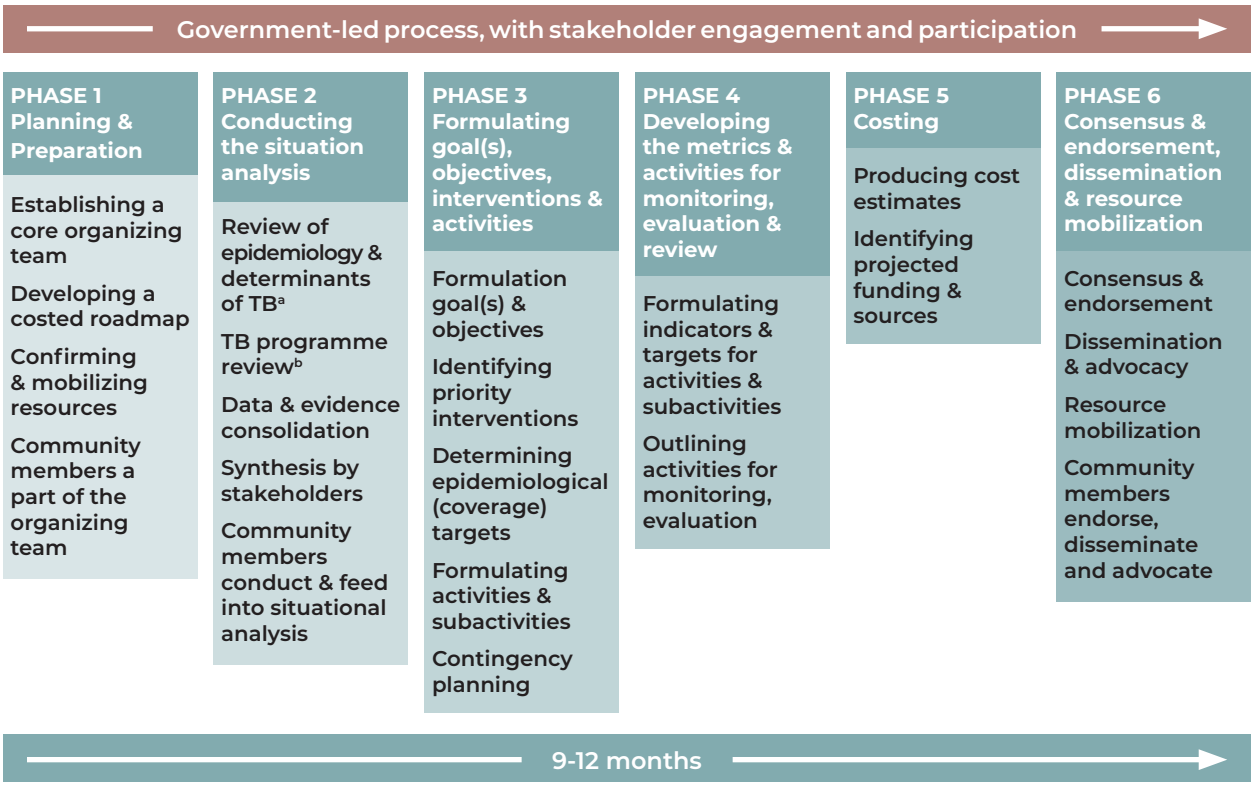
f. Monitoring and evaluation

Facilitator's Notes: *This includes indicators to track the goal(s), strategic objectives, interventions and key activities, to inform improvement in coverage and quality of services.*

g. Costing and resource mapping

Facilitator's Notes: *this includes the costs for each intervention, activity and subactivity, and other inputs needed to implement the NSP.*

5. A brief summary of the process of developing a TB NSP (15 mins)
   a. Project Handout B: Process of developing a TB NSP and pass around to participants for them to get an idea of the components involved



MOH: Ministry of Health; NSP: National Strategic Plan, TB: tuberculosis
[a] This includes review of social determinants
[b] This includes review of aspects of the health system as well as other sectors that are relevant to the country's TB response. This can be primarily informed by a desk review of the relevant reports, as well as inclusion of the most pertinent aspects in the TB programme review

Facilitator's Notes: *Handout B is taken from the WHO Guidance for National Strategic planning for TB, Chapter 2, page 7.*

6. End this session with any questions, comments or deliberation.

STRUCTURE OF NATIONAL STRATEGIC PLAN AND REVIEW OF COUNTRY SPECIFIC NSP

Duration: 2 hours

Materials Required:

Print the NSP of each country that is represented

Handout C: Programmatic Gap Analysis

Laptop

LCD projector

Flipchart

Coloured markers

Learning Objective: For the participants to understand the NSP of their country, evaluate its strength against the template given by WHO and provide suggestions to strengthen it.

Facilitator's Notes: *If a participant's country does not have an NSP, they must join with a participant whose country has an NSP.*

Methodology

1. Introduction to the components of a strong national strategic plan (NSP)[3] (5 mins)

Facilitator's Notes: *This section presents the proposed structure of the national TB strategic plan. If the country has a standard format for NSPs, it is recommended to use that format, to ensure alignment with other health sector plans as far as possible. The following session can be printed and handed out to participants as the facilitator runs through the elements in detail. The headers of this section can be projected over a PPT as the session is information heavy.*

3. Guidance for National strategic planning for tuberculosis, Pg 34 onwards , ©WHO, 2022

2. A proper numbering system for a strategic plan (10 mins): It is important to maintain coherence and consistency across different sections and components of the NSP, and a standardized numbering system can help to facilitate this. A numbering system will also help with cross-referencing and linkages of the elements throughout the plan, including the linkage of goals, objectives and strategic interventions with their inherent activities and sub-activities and indicators

    a. Sample of a numbering system for a strategic plan (on PPT)

EXAMPLE OF A NUMBERING SYSTEM FOR THE STRATEGIC PLAN
Goal: Reduce the incidence of TB to less than 55 per 100 000 per year by 2025
Objective 1: Increase TB treatment coverage from 50% in 2020 to 90% in 2025
Strategic intervention 1.1 Scale-up WHO-recommended rapid diagnostic test as an initial diagnostic test for TB and detection of rifampicin resistance, including in children with signs and symptoms of TB
Activity 1.1.1 Develop a costed implementation plan to improve the specimen transportation system
Subactivity 1.1.1.1 Assess the capacity of the programme's diagnostic network relative to testing demand to meet they country's TB targets
Subactivity 1.1.1.2 Develop a costed implementation plan for expansion of the specimen transport system
Subactivity 1.1.1.3 Establish agreements with local courier service providers for the transport of the specimens
Activity 1.1.2 Accelerate expansion of rapid molecular diagnostic equipment
Subactivity 1.1.2.1 Conduct a readiness assessment at new targeted health facilities or testing sites
Subactivity 1.1.2.2 Organize training for health workers at new targeted health facilities or testing sites on the use of rapid molecular diagnostics
Strategic intervention 1.2 Introduce and scale up targeted measures to find and treat people with TB among high-risk groups
Activity 1.2.1 [Specify first activity]
Activity 1.2.2 [Specify second activity]
Objective 2: [Specify second objective]
Strategic intervention 2.1 [Specify first strategic intervention for Objective 2]
Activity 2.1.1 [Specify first activity]
Activity 2.1.2 [Specify second activity]
If subactivities are needed, use the same numbering system
Subactivity 2.1.2.1 [Specify first subactivity of second activity]
Subactivity 2.1.2.2 [Specify second subactivity of second activity]

Facilitator's Notes: *From WHO Guidance for National Strategic Planning for tuberculosis, Chapter 3, Pg 33.*

3. Summary of findings from the situation analysis (30 mins; headers of this section can be on PPT): The situation analysis outlines the country context and profile; it covers demographic information as well as key cultural, social, economic and political characteristics that are relevant for the health status of the population or have implications for the delivery of health services. The analysis also includes a

brief description of the structure of the health system and its referral system, the TB epidemiological profile, the TB social determinants and multi-sectoral elements (e.g., social protection and legislation) relevant to the TB response

Facilitator's Notes: *The situation analysis should be succinct and focused, and only include information that is directly relevant to the interventions in the NSP, or to the implementation modalities for those interventions. The suggested content given here is indicative – some aspects may not be relevant in specific country contexts.*

a. **Country context (Indicative: 3 pages):** It must include geographical and demographic characteristics, political and socioeconomic context, vulnerable populations and ethics, equity and human rights
b. **The national health and social care system (Indicative: 3-5 pages):** This section should briefly describe relevant aspects of the health and social care system as it relates to the provision of TB services. They can include organization of the health and social care delivery system, health and social protection governance, health and social service providers, linkages with services provided to potentially vulnerable populations, financing for health and TB services, human resources for health, pharmaceuticals and other medical products, physical infrastructure for the provision of TB services, the diagnostic network and the status of relevant health technologies, the TB surveillance system and its linkage with the national health information system and other relevant information systems and outlining of the social protection schemes and the linkages and eligibility of people affected by TB to access this support, and how the implementation and coverage are coordinated. This section could also cover institutional research and innovations being done in the field of TB
c. **Epidemiology of tuberculosis (Indicative 3-5 pages):** This section should provide an overview of the epidemiology of TB in the country, based on the latest available data. The data should be disaggregated as much as possible – for example, by gender, age, areas (e.g. states, provinces, regions or districts) – to facilitate the identification of populations and population groups requiring focus. This section should also cover trends of TB, HIV and other determinants, the burden of TB among vulnerable population, TB infection prevention and control which includes preventive treatment and TB screenings
d. **Summary of the review of the previous TB strategic plan:** This section should summarize progress made in implementing the interventions and activities of the previous strategic plan, including key achievements and enabling factors, and challenges and recommendations
e. **Programmatic gap analysis:** This section should include gaps in TB service delivery across the care cascade, and in the delivery and coordination of these services within the health sector and in other relevant sectors. A sample of what this can include is contained in Handout C: Programmatic Gap Analysis

Facilitator's Notes: *From WHO Guidance for National Strategic Planning for tuberculosis, Chapter 3, Pg 40 onwards. Three image composite on the following pages.*

EXAMPLE OF AN OUTLINE FOR SUMMARIZING THE PROGRAMMATIC GAP ANALYSIS				
Programme Area			**Key gaps (to be quantified) where possible with appropriate references for the data sources**	**Identified root or contribute causes**
The national health and social care system	**Organization of the health and social care delivery system**	**Health and social protection governance**	TB is not included among the criteria for social assistance grants	Inadequate awareness of the social consequences of TB Disproportionate focus on biomedical interventions in the TB training curricula and other strategic documents
			50% of people with TB who are eligible for social assistance for other conditions do not access social assistance	10% of people with TB do not have national identification documents required to access social services
		Health and social service providers	30% of public sector health facilities do not provide TB services	Historical designation of sites as DOTS centres with inadequate decentralization Inadequate health worker capacity to manage TB
		Other sectors	60% of health facilities operated by mining companies do not provide TB diagnostic services	Inadequate awareness of senior management in mining companies regarding the local TB situation and required services
	Financing for health and TB services		30% of the national TB budget required to implement the TB NSP was unfunded TB was not included in the district action plan in 7 of the 24 districts	Low awareness of TB among key decision-makers at national and subnational levels
			The share for health in some of the district budgets is very low (<5%)	Overreliance on external funding to address TB
	Human resources for health		Insufficient programmatic and clinical staff for the management of TB	TB-related stigma and fear of infection among health workers Inadequate incentives and infection control provisions for health workers Insufficient opportunities, including training for staff at all levels
	Pharmaceutical and other medical products		Inadequate supplies of ancillary medicines for people with TB	Ancillary medicines not included in the procurement for anti-TB medicines
			Frequent stock-outs of anti-TB medicines at facility level	Inadequate monitoring and reporting of stock status at facility level
	Infrastructure and health technologies	**Physical infrastructure**	Inadequate airborne infection control at health facilities	Infrastructure design and renovations not in line with infection control standards Health facility infrastructure not adequately maintained
		Diagnostic network	Inadequate converage of rapid diagnostics for TB (only 70% of health facilities)	Limited funding for expansion of laboratory diagnostics Frequent machine breakdown Frequent power outages
		Health technologies	30% of health facilities do not have reliable internet access	Low penetration of internet services outside urban centres
	Surveillance system for TB		High (41%) level of TB underreporting as reported by the TB inventory study	Private sector facilities and some hospitals are not linked to the national TB surveillance system High workload and reporting burden on staff Multiple systems in place (paper-based and electronic), making harmonization of data difficult

	Social protection		Unknown coverage of social assistance services for TB-affected families	Unclear eligibility of people with TB for social assistance grants No systematic social needs assessment of people with TB Recording and reporting systems does not include social protection indicators
	Research and innovation		National research agenda does not include TB-specific research	Inadequate engagement of researchers in the national TB response
The NTP	**Organization of the NTP**		Inadequate staff for coordination of TB services at national and subnational levels	Key staff positions for the TB programme are not filled Inadequate funding for human resources for the TB programme Perception among key decision-makers that TB is no longer a major problem in the country
	Organization of services along the TB care cascade	**TB prevention**	Low coverage of core elements of airborne infection control (focal person, infection control committee and infection control plans) Low (25%) coverage of TPT among eligible household contacts of people with TB	Low awareness of infection control among facility managers No national guidelines or SOPs for airborne infection control Health worker reluctance to provide TPT (concerns about resistance, side effects, effectiveness and workload) Inadequate supplies of TPT medicines (funding, TPT perceived as low priority)
		TB screening and diagnosis	Only 63% of people with DR-TB had second-line DST	Second-line DST is only performed at the national reference laboratory There is no nationwide specimen transport system to facilitate second-line DST
		TB treatment and care	24% of people diagnosed with MDR/RR-TB were not started on treatment	Limited number of health facilities providing DR-TB treatment Long waiting time for results of baseline examinations required before DR-TB treatment initiation
		Screening and management of comorbidities	Low (20%) coverage of nutrition assessment among people with TB	Inadequate health worker capacity and tools on nutrition assessment No system in place for addressing nutrition needs of TB patients
		Addressing TB in vulnerable populations	No data on TB burden in key vulnerable populations	Recording and reporting system does not collect key data on vulnerability No targeted interventions for TB vulnerable populations in the previous NSP
Implementation of previous strategic plan			Inadequate awareness of the NSP at district level	Inadequate involvement of the district level staff in the development of the NSP
			Inadequate engagement of other sectors in strategic plan implementation	Suboptimal engagement of leadership in key sectors for the TB response

DOTS: directly observed treatment course

DR-TB: drug-resistant TB

DST: drug susceptibility testing

MDR/RR-TB: multidrug-resistant or rifampicin-resistant TB

NSP: national strategic plan

NTP: national TB programme

SOP: standard operating procedure

TB: tuberculosis

TPT: TB preventive treatment

4. Goals, objectives and interventions: This section presents the goals, objectives and interventions for the NSP. (20mins; headers of this section can be on PPT)

   a. **Goals:** A strategic plan should have one or more specific goals. Usually, these goals will have a broad perspective and will be defined within the national vision for ending TB, aligned with the End TB Strategy and in the context of the national development and health sector plans. It is recommended that each goal be defined in line with SMART (specific, measurable, attainable, realistic and time-bound) criteria

   b. **Objectives and strategic interventions:** Each objective is a clear statement that is logically related to the goals and rationally linked to one or more gaps that are to be addressed through the implementation of the strategic interventions specified in the plan. As with the goals, the strategic objectives should also be SMART, as far as possible

   c. **Activities and sub-activities:** Activities and sub activities to be implemented for each intervention to achieve the objectives and goals of the strategic plan should be itemized. This will facilitate appropriate costing (especially if the bottom-up costing approach is used), and inform implementation of the plan. The activities and sub-activities should be listed by year, with quarterly breakdown for at least the first 2 years, and clear assignment of responsibilities among all key actors. Key elements to be added in this section are clear time frame with a quarterly break-down, roles, responsibilities and details to make the implementation successful, potential sources of funding for implementation, any additional needs for success of plan. Example shown in insert below

Facilitator's Notes: *From WHO Guidance for National strategic planning for tuberculosis, Chapter 3, Page 44.*

EXAMPLE OF STRATEGIC PLAN GOALS, OBJECTIVES AND INTERVENTIONS
Goal: **Reduce the incidence of TB to less than 77 per 100 000 per year by 2025**
Objective 1: **Increase TB treatment coverage from 50% in 2020 to 75% in 2025**
Interventions: **1.1** Scale up WRD as an initial diagnostic test for TB and detection of rifampicin resistance in all people with signs and symptoms of TB **1.2** Introduce and scale up targeted measures to find and treat people with TB among high-risk groups **1.3** Strengthen systematic engagement of private and other unlinked public health care providers in the deivery of TB services **1.4** Expand free-of-charge or highly subsidized TB service packages, including diagnosis of TB, and provision of all TB medicines and ancillary drugs

   d. An example of a strategic plan matrix

Facilitator's Notes: *From WHO Guidance for National strategic planning for tuberculosis Chapter 3 "Structure and components of a TB NSP" page 45.*

EXAMPLE OF A STRATEGIC PLAN MATRIX FOR ONE GOAL, OUTLINING THE OBJECTIVES, STRATEGIC INTERVENTIONS, ACTIVITIES AND SUBACTIVITIES							
Goal: Accelerate reduction of TB incidence to 10% per year by 2025 and then to an average of 17% per year from 2025 onwards							
	Date	**Location**	**Imple-menter**	**Costs in USD**	**Source of funding**	**Process indicator**	**Additional technical assistance needs**
Objectictive 1: Increase the proportion of people with presumptive TB tested with rapid diagnostics at diagnosis from 50% in 2020 to 90% in 2025							
Strategic intervation 1.1 Scale-up WRD as an initial diagnostic test for TB and detection of rifampicin resistance, including in children with signs and symptoms of TB							
Activity 1.1.1 Develop a costed implementation plan to improve the specimen transportation system							
Subactivity 1.1.1.1 Assess the capacity of the programme's diagnostic network relative to testing demand to meet the country's TB targets	Q1/Y1	National & subnational levels	NTP	80 000	MOH	Assessment report available	Diagnostic network assessment
Subactivity 1.1.1.2 Develop a costed implementation plan for expansion of the speciman transport system	Q2/Y1	National & subnational levels	NTP		MOH	Costed plan for specimen transport system available	Costing of the plan for the specimen trasport system
Subactibity 1.1.1.3 Establish agreements with local courier serevice providers for the transport of specimens	Q2-3/ Y1	Subnational level	NTP		MOH		
Activity 1.1.2 Accelerate expansion of rapid molecular diagnostic testing for TB							
Subactivity 1.1.2.1 Conduct a readiness assessment at new targeted health facilities or testing sites	Q2/Y1	Subnational level	NTP		MOH	Report of readiness assessment available	
Subactivity 1.1.2.2 Organize training for health workers at new targeted health facilities or testing sites on the use of rapid molecular diagnostics	Q2/Y1	Subnational level	NTP		MOH	Number and proportion of health facilities or laboratories with trained health workers	
Subactivity 1.1.2.3 Procure additional equipment for rapid molecular diagnostic testing (based on assessment of diagnostic network [subactivity 1.1.1.1])	Q2-3/ Y1	National level	NTP	12 500	MOH	Number of health facilities or laboratories with capacity for rapid molecular diagnosis of TB	

5. Take to answer any questions participants may have so far

6. Hand the participants their country's NSP (60 mins)
    a. Break the large group into country-wise or smaller region-wise groups
    b. Ensure tables and chairs are placed so that discussions, reading and evaluation of the plans can take place
    c. The objective of this time is to look over their own country's NSP and evaluate it against the structure and components given in this session
    d. Facilitator is to be taking time in each group to guide discussions and answers questions as needed
    e. At the end of this time the participants are to present in a chart what they feel is missing in their own country's NSP
7. End this session giving any closing thoughts and tying up loose ends

MONITORING AND EVALUATION FOR THE NATIONAL STRATEGIC PLAN

Duration: 2 hours

Materials Required:

Handout D: Sample M&E component of the NSP

Laptop

LCD projector

Flipchart

Coloured markers

Learning Objective: To understand the fundamentals of monitoring and evaluation (M&E), and specifically the M&E components of the National Strategic Plan (NSP).

Methodology

1. Introduction to Monitoring (PPT; 20 mins)[4]: Monitoring is an ongoing process of collecting and analyzing data to check a program's efficiency. This data is used to plan, monitor and improve programs. Typically monitoring answers these three questions
   a. Did the programme reach the target group?
   b. Was the programme implemented effectively? Was the programme able to achieve its objectives in the given budget.
   c. Was the programme implemented differently at different sites? If so, why and how did the implementation differ at different program sites.

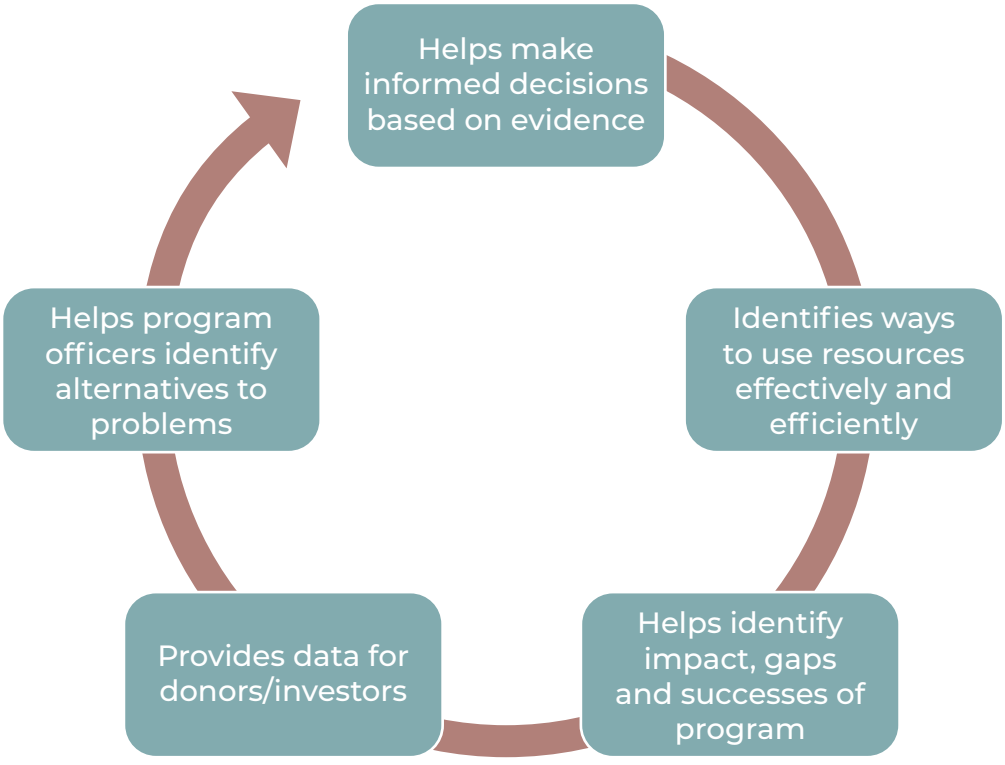
4. Material from this chapter is sourced from: https://humansofdata.atlan.com/2018/07/what-is-monitoring-and-evaluation/

2. There are 3 key elements of monitoring
    a. Continuous process: it is a continuous process that runs through the entire programme
    b. Regular data collection: Data is collected at regular intervals (monthly, bi-monthly, or quarterly, for example) using a preset questionnaire, which has metrics that are decided at the beginning of the programme
    c. Identify gaps in implementation: It helps the programme make changes during the implementation phase. Monitoring helps identify gaps that keep the programme from making maximum impact
3. What is Evaluation? (PPT; 20mins): Evaluation is the process to check whether a program has met its objectives. The 3 key features of evaluation are
    a. Regular data collection: Data is collected at the beginning and end of the programme to see how the important indicators have changed
    b. Robust methodology: Data is collected using a questionnaire designed at the beginning of the programme
    c. Control group: Evaluation includes a control group which doesn't participate in the programme to measure any changes were solely caused by the programme
    d. Evaluation is a critical component for any program, as it allows program designers to identify gaps, strengths, best practices, and learning's that can help them improve implementation in the future
4. How to create an M&E plan (PPT; 20 mins)
    a. Monitoring and evaluation (M&E) is monitoring followed by evaluation
    b. It involves collecting data, monitoring key indicators of a program, and evaluating whether it has met its objectives
    c. M&E is not possible without a monitoring and evaluation plan
    d. This is a document that includes the objectives of the program and the activities designed to achieve them
    e. An M&E plan outlines the procedure that will be used to evaluate whether or not the objectives have been met
    f. It should include the data that will be collected, the method of collection and analysis, how the data will be used, and the resources that will be required to implement this plan
    g. A M&E plan is most effective when it is designed at the beginning of the programme. This helps scope and allocate the required resources right at the start
    h. Here are some key components of Monitoring and Evaluation[5]

5. Source: https://humansofdata.atlan.com/2018/07/what-is-monitoring-and-evaluation/

Program details	Introduces the program, its need, its objectives, any resources required, and details of the activities to be implemented
Data collection plan	Includes data sources and methods for data collection, analysis and reporting. It may also include possible challenges
Monitoring plan	Includes the components that will be measured, frequency of data collection, and the indicators that will be used to measure results
Evaluation plan	Includes the research design - i.e. how the program will be evaluated and the indicators that will be used to measure the program's outcomes
How the plan will be used	Includes all stakeholders who will access the plan and use the collected data. Also includes where and how the data and findings will be stored

5. The importance of an M&E plan (PPT; 15 mins)



6. Guiding principles for M&E (PPT; 15 mins)

Focused	Data collected should focus on the goals of the program
Timely	Data should be shared at the relevant time else it is unless
Usable	Data should be easy for all stakeholders to use
Credible	All techniques for data collection and analysis should be credible and standardized
Ethical	All data should be collected and analysed ethically with informed consent

7. The M&E component of the NSP (PPT; 5 mins)
    a. This outlines the indicators to track progress of implementation of the NSP
    b. The achievement of the targets
    c. The coordination of M&E activities included in the NSP
8. Continuous M&E of the NSP (10 mins)
    a. The NSP should include a description of the frequency of regular review meetings (e.g. quarterly, semesterly or annually) at various levels, and which stakeholders should be involved in the collection, analysis, sharing and discussion of data.
    b. These review meetings enable early identification of implementation challenges and bottlenecks, which in turn can facilitate timely intervention to improve programme implementation.
    c. Data should be analysed and presented in a way that facilitates appropriate interpretation by all relevant stakeholders in these meetings.
9. Mid-term strategic plan review (10 mins)
    a. It is recommended that a comprehensive mid-term review of the implementation of the strategic plan be implemented; this is particularly relevant for strategic plans covering periods of about 5 years or more.
    b. The objective of the review is to determine if the country is on track to achieve the strategic plan targets, identify bottlenecks, identify good practices that can be scaled up, identify emerging challenges, threats and opportunities and update if necessary.
10. End term strategic review plan (10mins)
    a. An end term review is performed during the final year of implementation of the strategic plan, primarily to serve as a baseline for the preparation of the successor strategic plan
    b. This is a comprehensive exercise that should be conducted with the participation of all stakeholders involved in the implementation of the plan, and it should be planned, costed and budgeted for as part of the strategic plan

c. It is also good practice for end-term reviews to include external experts who can provide an independent perspective on the country's progress with implementing the NSP.

11. Sample of the M&E component of the NSP[6] (10 mins)

Facilitator's Notes: *Please go through WHO Guidance for National strategic planning for tuberculosis, Chapter 3, Pg 49 onwards for detailed information on the tabulation of information for your own understanding. Detailed information about tabulation to the participants may not be necessary in the session but may be useful for your own understanding.*

Item	Indicator	Purpose	Calculation[a]	Source of information	Periodicity	Who will collect the information	Level of information collection	Baseline (2020)	Target (2025)
Goal	TB incidence	Impact	WHO estimates	Global TB report (baseline); Modelling (target)	Annually; once	NA	NA	100 per 100 000	77 per 100 000[b]
Goal	Number of TB deaths	Impact	WHO estimates	Global TB report; modelling	Annually; once	NA	NA	1 000	680[c]
Goal	TB-affected families facing costs >20% of household income or expenditure due to TB (%)	Impact	Survey results	TB patient cost survey	At the end of the NSP period	M&E focal point	National	47%	10%
	Proportion of annual budget defined in TB strategic plan that is funded	Input	Available domestic and international funding each year divided by the estimated NSP funding needs for the same year	NTP, finance department	Annually	Finance focal point	National	75%	100%
Objective 1	TB treatment coverage	Outcomes	Number of new and relapse cases that were notified and treated, divided by the estimated number of incident TB cases in the same year, expressed as a percentage	Surveillance system	Quarterly	M&E focal point at relevant levels	Facility, district, province, national	50%	75%[d]
	Number of people diagnosed with TB	Outputs	Number of new and relapse cases that were notified and treated	Surveillance system	Quarterly	M&E focal point at relevant levels	Facility, district, province, national	5 000	6 380
	Costed implementation plan to improve specimen transportation system	Process	NA	NTP	Once off (2023)	NA	NA	Implementation plan not available	Implementation plan developed and costed

Take time to review and dialogue with participants regarding questions, comments or discussions they may have from the session so far.

6. WHO Guidance for National strategic planning for tuberculosis, Chapter 3, Pg 49 onwards

GUIDELINES FOR CONDUCTING A REVIEW

Duration: 4 hours

Materials Required:

Handout E: Checklist

Laptop

LCD projector

Flipchart

Coloured markers

Learning Objective: To understand guidelines that are necessary to conduct a review of a national strategic plan (NSP) for TB which includes understanding objectives, target audiences, checklists, conducting de-briefs and presentation to stakeholders involved in decision-making.

Methodology

1. Introduction to defining a review: Reviewing the work of a national TB programme provides an important opportunity to assess the implementation of interventions to fight TB that have been defined in national policies, the quality of TB care and preventive services, and the progress that has been made towards reaching the programme's targets. The review should assess the appropriateness of the strategies and interventions being used. Reviews of national TB programmes are external evaluations that are conducted periodically and that aim at improving the managerial and technical performance of the programme in order to reduce morbidity and mortality from TB.

2. Benefits of a review (PPT; 10 mins)

a. Improve the effectiveness of the national TB programme and share with the international community the positive experiences of the review
b. Strengthen national political commitments to TB-preventive efforts
c. Strengthen the engagement of key stakeholders
d. Improve and strengthen strategic planning for TB prevention, and mobilize resources

3. Purpose of a review (PPT; 10 mins)
   a. The overall purpose of reviewing the activities of a national TB programme is to evaluate progress in the response to TB in the context of the goals, objectives and targets that have been specified in the national strategic plan to control TB
   b. The review should assess programme outputs, outcomes and impact, including the quality of TB care in terms of access, quality, effectiveness and responsiveness
   c. The review may also significantly contribute to identifying best practices, challenges to implementation, and potential solutions to any problems that have been identified
   d. The review should provide recommendations for improving TB prevention, care and preventive activities

4. Objectives of a review (PPT; 15 mins)
   a. Assess the structure, organization and management for TB policy
   b. Assess the financial situation and human resources considering the programme's performance and demands
   c. Assess whether progress has been made towards achieving targets
   d. Assess the performance of the programme, how well services are delivered, and assess any inequities in access to and quality of care
   e. Identify obstacles to meeting the objectives of the national TB programme in a specific area
   f. Define the steps to be taken to improve the programme's performance

5. Target audiences of a review: This is a list of all stakeholders that might be involved in the review process. A more detailed version of the review is provided in the WHO manual titled "Framework for conducting reviews of TB programmes" These stakeholders usually include (PPT; 10 mins)
   a. Staff of the national TB programme and the relevant departments of ministries of health
   b. Staff of other ministries, such as the ministry of planning, finance, justice or social welfare/social protection, and staff of governmental organizations
   c. Institutions that provide health training
   d. Civil society organizations, including patient organizations
   e. Technical agencies and technical consultants
   f. Donors
   g. Implementing partners

h. Professional health associations
i. Local government agencies

6. Process of reviewing a TB National Strategic Plan (PPT; 5 mins)
   a. Planning and preparing for the review
   b. Conducting the review in the field
   c. Writing and finalizing the report of the review and recommending steps that need to be taken to improve the national TB NSP

7. Planning and preparing for the review (checklist material below; 30 mins)

PLANNING

a. Reviews of national TB programmes should be planned well in advance. Planning is the first phase of a review and is critical to its success. This phase should be fully owned by the national programme and its partners
b. The budget needed to carry out the review should be highlighted in the budgetary component of the plan
c. Check-lists for the review must be thoroughly revised
d. Local festivals, national holidays, religious feasts, elections and the time of year may influence the timing, duration and impact of the review; these issues should be considered when scheduling the review

SKILLS & RESPONSIBILITIES

a. A writer must be appointed to take detailed notes during the review
b. Set a date for the review
c. A sample review calendar could include: arrival date, field visits with check-list, de-briefing day, preparation of reports, prepare to present the findings to relevant stakeholders
d. Team members should have a variety of competencies, including critical thinking and problem solving skills, communication skills that enable them to discuss the status and performance of the programme with staff at different levels of the health-care system, and the ability to write clearly
e. A writer must be identified to prepare the final review report

SELECTION OF INFORMATION FOR REVIEW

a. The programme review should also include visits to facilities to the area's health infrastructure. The purpose of these visits is to observe how well the health infrastructure functions
b. Sites should be selected randomly to reduce bias in the results. The team should try to obtain a balance between urban and rural locations, and between districts that are performing well and those that are performing poorly
c. Specific efforts should be made to visit areas where there are large populations of persons at high risk of developing TB, such as urban slums

a. Remuneration or per diem for members involved
b. Travel costs for local transportation
c. Communication costs - prints, photocopying, etc.
d. Refreshments for de-brief meetings
e. Translation and printing of final report
f. Fund mobilization through the ministry of health, donors and partners

8. Conducting the review in the field (checklist material below; 30 mins)
   a. If the review is being done with a team, then briefing the review teams is a critical step in conducting the review, and a briefing session must be organized for all team members. The aim of the briefing is to ensure a common understanding of and consensus among teams' members about the review's objectives, processes and methods.
   b. An explanation of the purpose of the review; and fully describes how the review will take place. Reviewers may volunteer or be appointed to take on specific tasks, according to their expertise and their expected roles and responsibilities.
   c. The briefing session should provide the following information:

No.	Items	Status
A	Introduce team members	
B	Background information on the demographic area	
C	General information on health within the area to be reviewed	
D	Structure of the TB programme within the area	
E	The rationale for and objectives of the review to be explained to all participating team members	
F	Assignments for field visits for members participating in the review; roles and responsibilities	
G	Review assessment checklists	
H	Present and discuss the template that will be used to report findings from the field visits	
I	Logistics discussion	
J	Tasks to be undertaken upon return from field visits	

   d. Tips to making a field visit successful must include (PPT; 10 mins)
      - Full cooperation of health workers practicing in the health facilities visited. The health workers practicing in the health facilities that are visited should not feel that the review is an audit intended to punish poor performance
      - The reviewers must emphasize that the review is being undertaken to identify (a) where the TB prevention and services are doing well (b) any bottlenecks that impair the services (c) possible solutions to overcome the bottlenecks mentioned

- Each team should check the consistency and credibility of the data they are collecting

e. Field visits should include
   - The unit that deals with the TB programme in that area
   - District health offices and hospitals
   - Implementing health partners in that area
   - Key NGOs and civil society in the area
   - Medical schools or nursing schools in the area

f. The agenda (PPT; 15 mins) An agenda for each stakeholder which could include
   - Strategy to prevent and control TB in the area
   - Guidelines on TB prevention and care
   - Discussion around the TB NSP
   - Human-resource capacity
   - Benefits for TB patients under the social security policy
   - Plans for training staff, materials and methods
   - Co-ordination mechanisms
   - Platforms for participation in activities related to the TB NSP

g. Key areas of assessment (PPT; 20 mins): Assess the managerial capacities of the coordination unit in charge of the TB programme. For example, how capable the unit is in training and supervising staff, how well it manages the anti-TB medicines, coordinates with local stakeholders, and investigates the contacts of TB index cases.

h. Check list for assessment (Checklist material below; 20 mins)

No.	Assessment Items	Status
A	The number of trained staff and the availability of training opportunities	
B	The process for identifying and managing patients suspected to have TB	
C	The efforts made in implementing TB screening activities	
D	The procedures used to diagnose TB and the quality of diagnosis	
E	The procedures and approaches to addressing comorbidities (e.g., HIV/AIDS or diabetes) as well as risk factors such as smoking or malnutrition that may influence the effectiveness of care	
F	The appropriateness of the TB treatment provided	
G	The monitoring of and support provided to patients receiving treatment, and any related human rights concerns on access, discrimination or provision of care	
H	The recording and reporting systems, the completeness of registration, the availability of quarterly reports, and whether there is consistency between the registers and reported data	
I	How the implementation and provision of TB prevention and care services are supervised, and whether supervisory visits are recorded	

J	The supplies of anti-TB medicines, including buffer stock, and laboratory consumables and equipment	
K	Whether informational, educational and communication materials are available to promote TB prevention and care within the community	
L	Whether mechanisms are in place to overcome access barriers related to stigma, discrimination, gender norms or other factors such as migrant status	
M	Whether link person with TB to social protection mechanisms to ensure access to relevant benefits	
N	The level of involvement in identifying and managing patients with MDR-TB	
O	The links with community-based organizations and volunteers	
P	Collaboration between the national TB programme and the national HIV/AIDS programme and/or other national programmes addressing important comorbidities or risk factors	
Q	When acceptable and feasible, discussions should be arranged with small groups of patients as well as with a small group of community workers and volunteers to elicit their perspectives on access to care and treatment	
R	Interviews with individual patients should be also organized	
S	The team should schedule appointments with the respective authorities (such as the provincial or district health director, the hospital director and relevant stakeholders) to provide feedback on their findings and to make recommendations for improvements, if necessary	
T	Individual team members should be given responsibility for making specific observations as well as for specific places to visit and people to meet	
U	The designated recorder should note the key points of the discussion, and these should be included in the field report	

i. Presenting the review findings to the entire review team involved (Checklist material below; 15 mins)
   - Following the field visits, each team must prepare a presentation about their observations
   - Team members can propose preliminary recommendations
   - It is necessary to provide a list of places visited and persons met
   - Ideally the team should prepare their report on a computer
   - The information to be presented may include background information, findings, strengths of the programme, weaknesses of or challenges to the programme, and conclusions and recommendations
   - The teams should compare the information gathered and the interpretations of it before reaching consensus on the findings and recommendations
   - The review team should ensure that the national TB programme takes ownership of the actions required to follow-up on the recommendations that have been made

j. Eventually the review findings and recommendations must be presented and debriefed to the authorities at the next level.

9. Writing the report and recommendations (checklist material below; 15 mins). Here

are some key steps in finalizing the report of the TB programme review

a. Compile the different sections of the report such as summary, introduction, background information, include policies, structure and organization of services, methods used, main findings, strengths, weaknesses, challenges, recommendation for improvement, any reports to be included in annexure
b. Check for consistency of language
c. Check for consistency of findings
d. Ensure that all the recommendations made by the review teams have been vetted by review coordinators?

10. Conclude the session by passing out a review checklist and going through the review checklist with timelines for execution, roles, responsibilities and answering questions of participants. (30 mins)

GUIDANCE ON COMMUNITY AND CIVIL SOCIETY ENGAGEMENT TO END TB

Duration: 2 hours 30 mins

Materials Required:

Handout F: Actions Before and After TB
Laptop
LCD projector
Flipchart
Coloured markers

Lesson Objective: By the end of the session the participants will understand more about meaningful community and civil society engagement to end TB, practical suggestion for engagement and how to implement them.

Methodology

1. Why communities? (PPT; 5 mins)
    a. Are at the core of society
    b. They bring the ground realities and lived experiences
    c. They advocate based on lived experiences
    d. Their voices are powerful
    e. It ensures the people centered approach becomes a reality and human rights upheld
    f. They give a human face to TB
2. Introduction to community engagement (PPT; 10 mins)
    a. Community engagement is defined as the process of working collaboratively

with and through communities to address issues affecting their well-being

b. Community-based TB activities are conducted outside the premises of formal health facilities (e.g., hospitals, health centers and clinics) in community-based structures (e.g. schools, places of worship, congregate settings) and homesteads

c. Community health workers (CHWs) and community volunteers (CVs) carry out community-based TB activities

d. A CHW is a person with some formal education who is trained to contribute to community-based health services, including TB prevention and patient care and support

e. A CV is a community member who has been systematically sensitized about TB prevention and care, either through a short specific training scheme or through repeated contact with professional health workers

f. Both can be supported by nongovernmental organizations (NGOs), faith-based organizations (FBOs), other civil society organizations (CSOs) and/or the government

3. Information related to Community & Civil Society Engagement to end TB (PPT; 20 mins)

   a. TB continues to kill over 1.5 million people every year and is one of the deadliest infectious diseases

   b. The 2022 World Health Organization (WHO) TB report described rates of finding people with TB falling and deaths rising for the first time in 10 years, as a result of COVID 19[7]

   c. To address the current losses in progress and reduce the burden of TB towards the achievement of the targets set in the WHO's End TB Strategy, it is essential to work with civil society and affected communities

   d. These targets include an 80% drop in new cases, a 90% drop in people dying of TB, and 100% of TB-affected families protected from catastrophic costs by 2030 compared to 2015[8]

   e. "Building a strong coalition with civil society and community" is one of the core principles of the End TB strategy, and is included in Pillar 2 (Figure: WHO end TB strategy). The political declaration of the 2018 United Nations High Level Meeting on TB includes pledges by member states for "ensuring strong and meaningful engagement of civil society and affected communities in the planning, implementation, monitoring and evaluation of the tuberculosis response, within and beyond the health sector"[9]

7. Tuberculosis - Key Facts. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/tuberculosis#:~:text=Eight%20countries%20account%20for%20two,Nigeria%2C%20Bangladesh%20and%20South%20Africa (accessed May 31, 2022)
8. Global Tuberculosis Programme -the End TB Strategy. World Health Organization. https://www.who.int/teams/global-tuberculosis-programme/the-end-tb-strategy (accessed May 31, 2022)
9. https://www.un.org/en/ga/73/resolutions.shtml

Figure 1: WHO End TB Strategy

f. The WHO defines community engagement as, 'a process of developing relationships that enable people of a community and organizations to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes'[10]

g. Community and civil society engagement to end TB requires the TB-affected communities to be equal partners in a health systems TB response. As equal partners, community members are empowered as experts on local needs and priorities

4. Community and civil society as equal partners (PPT; 10 mins)

a. Equal partnership requires all stakeholders in the TB response to recognize people with TB or people who have had TB as experts of the lived experience

b. In the context of this session, "community engagement to end TB" refers to communities and CSOs within the health system (e.g., community health workers), individuals, groups and informal networks that 'interact, coordinate, and deliver responses to the challenges and needs affecting their communities[11]

c. This includes people with TB and their families, those who have recovered, advocates, religious and opinion leaders, local individuals, families and communities, community advisory boards for TB/HIV, and civil society organizations

5. What does meaningful community engagement look like: (PPT; 30mins)

Facilitator's Notes: *The WHO also has resources to provide guidance for how programs and communities can understand meaningful engagement. Meaningful engagement keeps people at the center of the health system response to TB. Such as the WHO guidance on community and civil society engagement to end TB.*

10. WHO community engagement framework for quality, people-centered and resilient health services. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/handle/10665/259280)
11. The Global Fund: Community Systems Strengthening Framework. 2014. https://www.theglobalfund.org/media/6428/core_css_framework_en.pdf (accessed June 29, 2022)

a. Start with Learning: As highlighted earlier, community engagement has a long history in responding to TB, with established expertise in context-specific needs and resources for TB prevention and care. Meaningful engagement begins with learning from and listening to community members and representatives, and people who have had or have TB to understand their lived experience

b. Lessons from COVID-19: COVID-19 has demonstrated the importance and feasibility of communities and civil society playing central role in effective responses[12]. Community engagement was critical for keeping local systems running during lockdowns. It was also noted that recovery from COVID-19 will require engaging with communities and CSOs, to rebound from the huge number of 'missing' TB cases due to COVID disruptions, with the expectation that just over half of all TB cases were actually notified in 2020

c. Stakeholders in community engagement to end TB: To help map community concerns and alliances, ministries of health (MOH), through their National TB Programmes (NTPs), or other programmes and implementation partners, can provide forums (local and national) for sharing information and strategies with TB affected communities and civil society. A stakeholder mapping system can be found in the WHO guidance on community and civil society engagement to end TB, Annex 1

d. Civil Society as a Bridge: CSOs often can and do play multiple roles. At the global level, they can also advocate for commitment to meaningful engagement at the highest level

e. Reaching Key and Vulnerable Populations: Vulnerable populations may lack access to health services provided by the formal health system, and therefore, community systems can play a vital role in identifying who the most vulnerable groups are, and the barriers they may face in accessing care. Health system and community partnership can work together to identify context-specific vulnerable populations who require additional support as part of their TB responses

6. Types of community engagement themes and activities (PPT; 30 mins)

a.

Theme	Activities
Prevention	Awareness-raising, information, education and communication (IEC), behaviour change communication (BCC), infection control, training of providers
Diagnosis	Screening, contact tracing, sputum collection and transport, providers training
Referral	Linking with clinics, transport support and facilitation, accompaniment, referral forms, providers training
Treatment adherence support	Home-based supervision and patient support, adherence counseling, stigma reduction, pill counting, training of providers, home-based care and support

12 Gilmore B, Ndejjo R, Tchetchia A, et al. Community engagement for COVID-19 prevention and control: a rapid evidence synthesis. Bmj Global Heal 2020; 5: e003188 and Pai M, Kasaeva T, Swaminathan S. Covid-19's Devastating Effect on Tuberculosis Care — A Path to Recovery. New Engl J Med 2022; 386: 1490–3.

Social and livelihood support	Cash transfers, insurance schemes, nutrition support and supplementation, voluntary savings and loans, inclusive markets that extend choices and opportunities to the poor, training of providers, income generation
Stigma reduction	Community theatre/drama groups, testimonials, patient/peer support groups, community champions, sensitizing and training facility and CHWs and leaders
Advocacy	Ensuring availability of supplies, equipment and services, training of providers, addressing governance and policy issues, working with community leaders

b. Additional community-based TB activities that can be considered
   - Awareness-raising, behaviour change communication and community mobilization
   - Reducing stigma and discrimination
   - Screening and testing for TB and TB-related morbidity (e.g., HIV counselling and testing; diabetes screening) including through home visits
   - Facilitating access to diagnostic services (e.g., sputum or specimen collection and transport)
   - Initiation and provision of TB prevention measures (e.g., Isoniazid preventive therapy, TB infection control)
   - Referral of community members for diagnosis of TB and related diseases
   - Treatment initiation, provision and observation for TB and co-morbidities
   - Treatment adherence support through peer support and education and individual follow-up
   - Social and livelihood support (e.g., food supplementation, income-generation activities)
   - Home-based palliative care for TB and related diseases
   - Community-led local advocacy activities

7. What are some practical suggestions for meaningful engagement? (PPT; 60 mins)

a.

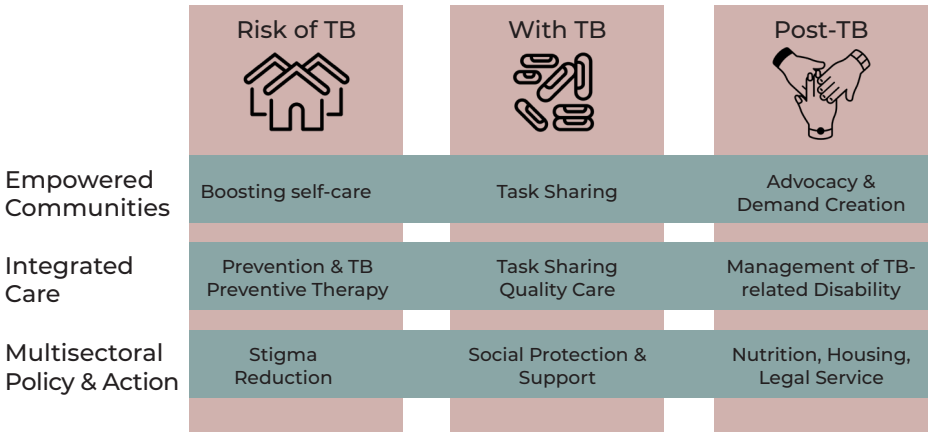


Figure 2: Spectrum of community engagement to end TB

Facilitator's Notes: *Actions that can occur before and after TB diagnosis and treatment need to be considered, and include different types of services, including promotive, preventive, curative, rehabilitative and palliative care. Facilitator can take time to explain the figure and go through it in detail. The following table can also be handed to the participants.*

	RISK OF TB	WITH TB	POST TB
Empowered people and communities	Health literacy and promotion for communities to understand risk factors for TB, prevention options, and when to access care Building capacity of health systems, community systems and networks to measure TPT, and other indicators that are important Stigma reduction in important community fora, such as schools, places of worship, markets, sports halls, starting with measurement Awareness raising through community systems to train people affected by TB on prevention, screening, and early treatment Safeguarding health as a human right by facilitating access to legal aid and using commitments to the primary care concept as a mechanism for government advocacy Planning for prevention, in partnership with National TB Programme, especially around vaccine preparedness and TPT; providing treatment support for preventive treatment Support for research that advances implementation of End TB strategies Community-led monitoring for evidence-based advocacy, action, and advancement of programmatic goals.	Promoting a human-rights-based approach to end TB through use and understanding of the Declaration of the Rights of People Affected by TB Finding missing people with TB through accessible care pathways, especially for vulnerable populations and families of people with TB Providing home-based care, including boosting TB and health literacy, diagnostic access, referrals for families of affected household members, treatment adherence support, psychosocial counseling, and interventions to reduce stigma Advocacy for access to medicines and quality care as the first step for successful treatment of TB Community-led monitoring of service needs and deficits, as identified by community members, to create demand for quality care and ensuring continuous access	Awareness raising as experts of the lived experience Community-led monitoring, utilizing digital technologies where possible Complete recovery and community integration for those who faced stigma or ostracization during TB

Integrated care & health services	Screening for TB that respects autonomy and privacy, especially for stigmatized communities Utilizing digital technologies for information sharing, community mobilization and diagnosis Providing access to diagnostic tools and protocols for linking people to care without economic consequences to affected people and their families Capacity building and training for peer groups, champions, and advocates to reduce stigmatization and discrimination; use of the TB stigma index TB Preventive Treatment for all people who are eligible and who agree to treatment; support for completing a full course of preventive treatment Vaccination preparedness, utilizing learnings from COVID-19 to prepare messaging and systems for vaccine deployment Assessment and evaluation of systems for sensitizing populations and preparing them to enter care Infection control practices at the health center and community	Task sharing between NTPs and communities for referral mechanisms, sputum transport and collection, and engagement with traditional healers and private providers Screening and care for comorbidities, including HIV, diabetes, COVID-19, etc., and risk factors such as smoking and heavy alcohol use Utilizing digital technology to facilitate adherence to treatment and referral pathways for receiving integrated care Household contact triaging and prevention, including testing for TB infection and TB preventive treatment Protection from economic consequences for services and treatment needed to recover from TB; free care and access for everyone	Management of TB-related disability, including persistent pulmonary dysfunction Quality follow up to prevent relapse and re-infection

Multi-sectoral policy and action	Infection prevention in the workplace and public gathering points; promotion of ventilation, cough hygiene, and other lessons learned from COVID-19 Resource mobilization for fair financing for community and civil society engagement to end TB Transport services for connecting people with TB symptoms and community health workers to facilities with diagnostic tools Social determinants of TB interventions to prevent TB, including nutrition support, housing, education, and poverty reduction Strengthen community legal empowerment	Social protection and support through holistic health service that addresses employment status, housing, nutrition support, prevention for affected families Legal services for people affected by TB who need support accessing treatment, employment protection, housing protection, etc.	Income generation and vocational training, and recovery from catastrophic costs

8. End the session by taking any further questions and comments

Community Led Monitoring

Duration: 60 mins

Materials Required:

Laptop
LCD projector
Flipchart
Coloured markers

Learning Objective: To define and explain CLM (Community Led Monitoring).

Methodology

1. The facilitator will start the session by asking the following questions. The facilitator notes down the responses from the participants (20 mins)
   a. What is CLM?
   b. Why CLM?
   c. How to conduct CLM?
   d. Where to conduct CLM?
2. The facilitator explained and summarized the above discussion through power point presentation (30 mins)
   a. What is CLM
      - Monitoring of services **by communities**, where they are the end-user
      - Monitoring is **routine**
      - Monitoring is of **indicators that are relevant** to that community in order to improve services (quality, type of service etc.)

- Monitoring provides an evidence-informed platform for the all-too-often **missing voice** in the response to **advocate** for change
- CLM is a process where communities take the lead to **routinely monitor issues that matter to them.** Communities then work alongside policymakers to co-create solutions to the problems they have identified. When problems uncovered through CLM aren't resolved, communities escalate with evidence-based advocacy and campaigning until they achieve implementation of corrective actions by duty bearers

b. CLM is not

- Monitoring people by governments or any other group
- Providers carrying out monitoring projects with the recipients of care
- A parallel M & E system to the routine government monitoring and evaluation
- Communities covering data collection gaps for donor M&E
- Only data collection
- A snapshot of data to understand recipient of care experiences
- A quality improvement initiative

Facilitator's Notes: *CLM is focused on fact-finding, not fault-finding – building trusting and effective relationships for meaningful change is fundamental to the ethos of CLM. It is a powerful model for improving the quality of healthcare services, by empowering communities with data to advocate for change. What differentiates CLM from typical efforts to improve health service quality is its accountability function: CLM is developed by and for communities using the services being monitored in order to uncover and correct problems undermining access to quality health services. In the CLM model, service users and directly-impacted communities lead a systematic data collection effort, in which the community itself decides which issues should be tracked, creates indicators, and collects facility- and community-level data. These data are then analyzed and used to support advocacy directed at government and donors, with the aim of improving accountability and improving the quality of healthcare services.*[13]

c. Key methods or approaches

- Mixed method design - Qualitative and Quantitative - is increasingly being applied in community-led monitoring
- Mixed methods design is when a CLM implementer collects qualitative and quantitative data, analyze it, integrates the findings, and draws conclusions
- A key component of mixed methods design is the integration of the quantitative and qualitative findings/results in drawing conclusion about an issue or problem

d. Why both qualitative & quantitative data in CLM

- Qualitative data provided a detailed understanding of a problem while quantitive data provides a more general understanding. Facilitates the identification of relevant stakeholders

13. http://clm.itpcglobal.org/

- Qualitative understanding arising out of studying a few individuals and exploring their perspectives in great depth whereas quantitative arises from examining a large number of people
- Both provide different perspectives and each has its limitations
- A combination of both data provides a more complete understanding of the issue than either approach by itself
- Strong evidence for a conclusion
- Words and narratives will add more meaning to numbers

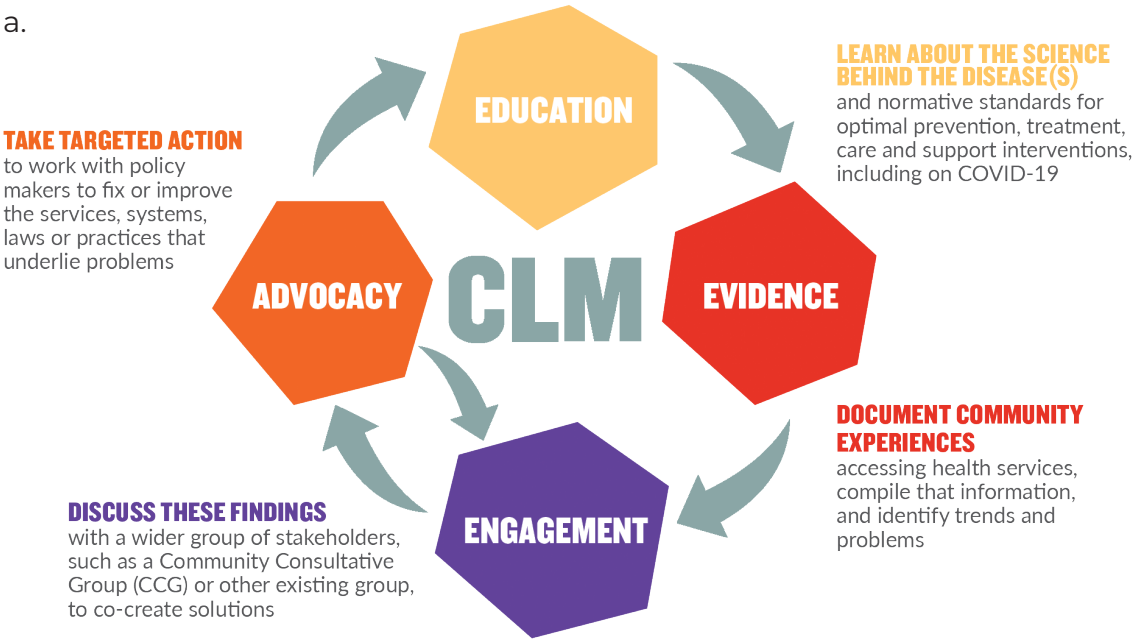
e. What to consider before planning for mixed method

- Is there sufficient time to collect and analyze two different types of data?
- Are there sufficient resources to collect and analyze both data?
- Skills to collect both the data
- Mixed method design involves collecting more types of data and analyzing and interpreting more datas
- Time and resources are important issues to consider

Facilitator's Notes: *After the data collection tools have been developed, the next phase is data collection. Depending on the program's priorities and focus, this can involve any combination of surveys, individual interviews, and focus groups, collected in clinics, the surrounding communities, and/or in respondents' homes. These data are then analyzed by the implementation team. Finally, meetings with both the CLM implementer, civil society organizations, and the broader community are held to analyze the information and translate data into actionable insights and advocacy priorities.*

3. ITPC conceptual model of CLM

a.



b. EGS - ITPC West Africa, GCTA (India)
    - Cote d'Ivorie - Eliminating user fees: 17% of the ROC indentified payment/ out-of-pocket expenditure as a reason for not accessing ART. ART was free, but fees for diagnostics, consultations, and medicines for OI were charged. The data was used to pressure the MoH to sign a by-law that from now on, onsite treatment would be free (April 2019)
    - HCW findings: GCTA
        - Delay in testing
        - Increased loss to follow up
        - No provision of PPE initially
        - Referral centres were closed (HIV and diabetes)
    - Over the course of the project, the number of new ART initiations among key populations increased more than 17-fold at RCTO-monitored sites
    - *"I cannot trust anyone but the community to lead such a study. We need to expand the scope of the study. We need such a survey with the IDU community and where the HIV burden is very high. Also, we need to raise questions like 'Are TB patients being tested for COVID?' and 'What kind of testing set-ups are there?'"* - Prashant, Sikkim Drug User Forum, TB Survivor

Facilitator's Notes: *International Treatment Preparedness Coalition (ITPC) CLM model is a process where communities take the lead to routinely monitor an issue that matters to them. Communities then work alongside policymakers to co-create solutions to the problems they have identified. When problems uncovered through CLM aren't resolved, communities escalate with evidence-based advocacy and campaigning until they achieve implementation of corrective actions by duty bearers*[14].

c. Global Coalition of TB Advocates (GCTA) in partnership with ITPC conducted the first pilot study of a TB CLM in Delhi, India in order to ensure adherence, to track TB care and to gather evidence to support and plan advocacy. The objective of the study was to understand the availability, accessibility, acceptability, affordability and appropriateness of TB services

4. Donor landscape
    a. Greater recognition by the donors of the CLM
    b. CLM is now a funded priority
    c. The Global Fund - supporting effective implementation of CLM in HIV, TB, malaria, RSSH and C19RM grants.
    d. The PEPFAR COP Guidance recognizes the importance of engaging with communities in the development and implementation of HIV programming. Operating Units (OUs) are required to fund the development and implementation of community-led monitoring activities.
    e. Stop TB Partnership – CFCS Grant

14. http://clm.itpcglobal.org/

Facilitator's Notes: *In February 2020, the Global Fund held a global meeting in Geneva, entitled "Towards a Common Understanding of Community-based Monitoring and Advocacy"[15].This meeting brought together implementers, donors, and other stakeholders to review the current understanding of CLM. Several key findings from this convening were summarized in a white paper that created a first definition of the CLM model[16].Two years since this convening, CLM implementation has expanded dramatically. COP20, PEPFAR has required all programs to develop and support a CLM program and the Global Fund Strategy has signaled a strong commitment to "putting the community at the center," in part through scaling up investments in CLM [17].*

5. In August 2022, a second global convening on CLM was held by Global Fund in Bangkok, with the aim of working "Towards a Global Agenda for Community-Led Monitoring". During this meeting, 66 CLM implementers and technical assistance providers7 were invited to a three-day meeting to review the findings, experiences, and lessons learned from CLM implementation. This report presents a global consensus that emerged from the meeting, including the fundamental stages of the CLM cycle, the core principles of CLM, and recommendations for strengthening CLM[18]

6. End the session with any questions, comments or deliberation (10 minutes)

15 The Global Fund. Towards a Common Understanding of Community-based Monitoring and Advocacy. February 2020. Geneva Switzerland.
16 Health GAP, HEPS-Uganda (the Coalition for Health Promotion and Social Development), ICWEA(The International Community of Women Living with HIV Eastern Africa), ITCP (International Treatment Preparedness Coalition), O'Neill Institute for National and Global Health Law, SMUG (Sexual Minorities Uganda), TAC (Treatment Action Campaign). Community-Led Monitoring of Health Services: Building Accountability for HIV Service Quality (White Paper).
17 The Global Fund. Fighting Pandemics and Building a Healthier and More Equitable World. Global Fund Strategy (2023-2028).
18 The Global Fund. Towards a Global Agenda for Community-Led Monitoring. Meeting Report. 29 August - 1 September 2022. Bangkok, Thailand

APPENDIX

PRE AND POST ASSESSMENT FOR FACILITATING A STRONG NSP REVIEW

1. TB is an infectious disease caused by a germ called 'Mycobacterium Tuberculosis'
   a. True
   b. False

2. TB only affects people belonging to a specific age group and economic strata.
   a. True
   b. False

3. What is the full form of TB NSP?

4. This is a part of the process of NSP development:
   a. Thinking and discussions
   b. Planning and preparation
   c. Protesting

5. Choose which components below are a part of strategic planning:
   a. Goals
   b. Objectives
   c. Interventions
   d. Activities
   e. All of the above
   f. None of the above

6. An ongoing process of collecting and analyzing data to check a program's efficiency, is the definition of
   a. Supervision
   b. Observation
   c. Monitoring

7. "Building a strong coalition with civil society and community" is one of the core principles of the WHO end TB strategy
   a. True
   b. False

8. Who is best placed to be a member of a joint monitoring mission?
   a. Doctors
   b. Lab Specialist
   c. Program Director
   d. Community Members
   e. All of the above

ANSWER KEY

PRE AND POST ASSESSMENT FOR FACILITATING A STRONG NSP REVIEW

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   Tuberculosis National Strategic Plan

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HANDOUT A: ALL ABOUT TUBERCULOSIS

What is TB? How does it spread?

- TB is an infectious disease caused by a germ called 'Mycobacterium Tuberculosis'
- TB mostly affects the lungs (causing pulmonary TB) but can also affect other organs, including bones and joints, kidneys, brain, genitals, urinary tract, spine, lymphatic system, intestines, etc.
- When TB affects any organ other than the lungs, it is called extra-pulmonary TB
- TB spreads through air. When someone with pulmonary TB coughs, spits or sneezes, droplets of mucous carrying TB germs may be expelled into the air. Anyone who inhales these droplets could develop an active TB infection
- A person with pulmonary TB disease could infect in a year, 10-15 other persons who are in close contact with the person
- TB can affect people belonging to any age group or economic strata
- Since TB is an airborne disease, anyone who inhales the bacteria can get infected with TB
- When someone inhales the TB bacteria, it could settle in the lungs and cause pulmonary TB. However, it could also spread to other organs via the blood stream and lymph system and cause an infection in whichever part of the body it settles in
- Many of us have already inhaled the TB bacteria and carry it within our bodies, often without our knowledge. All of us who inhale the TB bacteria do not become ill with the disease. In most people, the normal immune system of the body is able to keep the bacteria well under control. In about 10% of the people who harbour the bacteria, the germs multiply and cause TB disease
- A person with TB infection usually develops TB disease when his or her immunity is lowered
- Poor nutrition, diabetes, old age and HIV are some of the risk factors for TB, as they all lower a person's immunity
- Use of tobacco is also a risk factor as it weakens the lungs
- Anyone in close contact with someone who has pulmonary TB is also at a greater risk of catching the infection and developing the disease

Diagnosing TB

The symptoms of pulmonary or lung TB may include:

- Persistent cough
- Cough of any duration in people who are living with HIV
- Blood in the phlegm (haemoptysis)
- Fever
- Chest pain
- Loss of appetite
- Loss of weight
- Breathlessness
- In children, specific symptoms such as falling off growth curve, reduced playfulness

TB Infection (TBI) and TB disease

- If someone has had a persistent cough, it's important to consult a doctor and get tested for TB
- Pulmonary TB is diagnosed by testing the sputum sample by microscope, any rapid molecular tests such as Cartridge Based Nucleic Acid Amplification Test (CBNAAT) or by sputum culture
- Extra-pulmonary TB is ideally diagnosed by examining the affected organ or site, eg. Lymph node. This is done by a FNAC or a biopsy, in which a small bit of the tissue or fluid from the affected part is removed through a surgical procedure and examined under the microscope. Alternatively, the sample can be tested by CBNAAT. CBNAAT is increasingly becoming tool of first choice for diagnosis. Sometimes the diagnosis, for instance in the case of the spine, is made with a combination of X-rays, CT or MRI scans and symptoms. A genotypic test would be the preferred test over microscopy especially in PLHIV and children
- Serological tests (blood tests) are not recommended by WHO for the diagnosis of TB disease but they may be used to detect TB infection. IA blood test will not distinguish if a person has TB infection or TB disease
- The Mantoux test is a skin test. It checks to see if the immune system of the body recognizes TB, which is a sign that someone may have TB in the system. However, the Mantoux test cannot be used to determine active TB disease but only the presence of the bacteria in the system. A Mantoux test cannot definitively tell if someone has TB disease or not, particularly in the case of adults. However, in children, the Mantoux test is often used to diagnose TB disease, in combination with other signs and symptoms
- Screening is sometimes done prior to referring an individual for diagnosis. Symptom screening, for example, means assessing whether a person has any of the TB symptoms and is often used as a tool for finding missed people with TB

Treating TB

- TB is a curable disease
- The course of the TB treatment is 4-6 months for drug sensitive TB and 6-18 months for drug resistant form of TB (DR TB)
- TB is treated with a combination of drugs. These drugs are given daily and sometimes as fixed dosed combinations (FDC)
- Every person diagnosed with TB is assigned a treatment supporter (follow national TB guidelines in country) who will be responsible for ensuring that medicines are taken as required, updating the treatment cards, reminders to go for reviews on time, follow-up if there are any side effects and ensuring that the entire course of treatment is completed
- It is very important to complete the full course of treatment. It is likely that someone with TB will feel better in a few weeks after starting treatment but that does not mean s/he is cured. It is essential to complete the course of medicines to ensure that one does not have a recurrence of TB and that the body does not become resistant to the anti-TB drugs (and cause a more serious complication, i.e drug-resistant TB)

- TB can easily be treated on an outpatient basis. Only severe cases and complicated TB treatment require hospitalisation
- TB treatment is available free of cost at all government centres. However, costs in the private sector vary tremendously
- For most people TB treatment is safe and does not cause side effects. However, some people may develop side effects and they should be evaluated by the doctor and offered testing to see if one of the TB medicines is the cause of the problem
- Some side effects that can be seen with TB treatment include vomiting, nausea, problems with the liver, and problems with the nerves in the hands or feet. Early identification of these side effects is important to make sure they do not cause permanent damage. People on TB treatment experiencing side effects should talk to their doctors right away

Drug-resistance

- Drug resistance means that the TB medicines are not able to kill the bacteria causing TB in a person. The bacteria have become resistant to some specific drugs, which are therefore no longer effective
- When someone with TB develops resistance to two of the most important drugs used in the treatment (Isoniazid and Rifampicin), with/without resistance to other drugs, the person is said to have multi-drug-resistant (MDR) TB
- Drug-resistant forms of TB spread through the air just like other forms of TB
- In some cases, people directly get MDR-TB by inhaling MDR-TB infected droplets
- The symptoms of MDR-TB are the same as 'ordinary' TB – a persistent cough, chest pain, fever, loss of appetite and weight
- Those who come into frequent contact with someone who already has MDR-TB or a TB patient whose treatment has been interrupted, are at a higher risk of developing MDR-TB
- MDR TB is diagnosed by CBNAAT, LPA, MGIT and conventional culture methods. However, it takes anywhere from three to twelve weeks to get results from culture tests
- In 2012 and 2014, two new drugs: Bedaquiline and Delamanid , were approved for treating MDR-TB and WHO has issued guidelines for their usage.
- Everyone has a right to the best possible treatment free of charge and people also have a right to know about the side effects before starting on treatment (people-centered, rights-based TB response)

TB and Co-infections

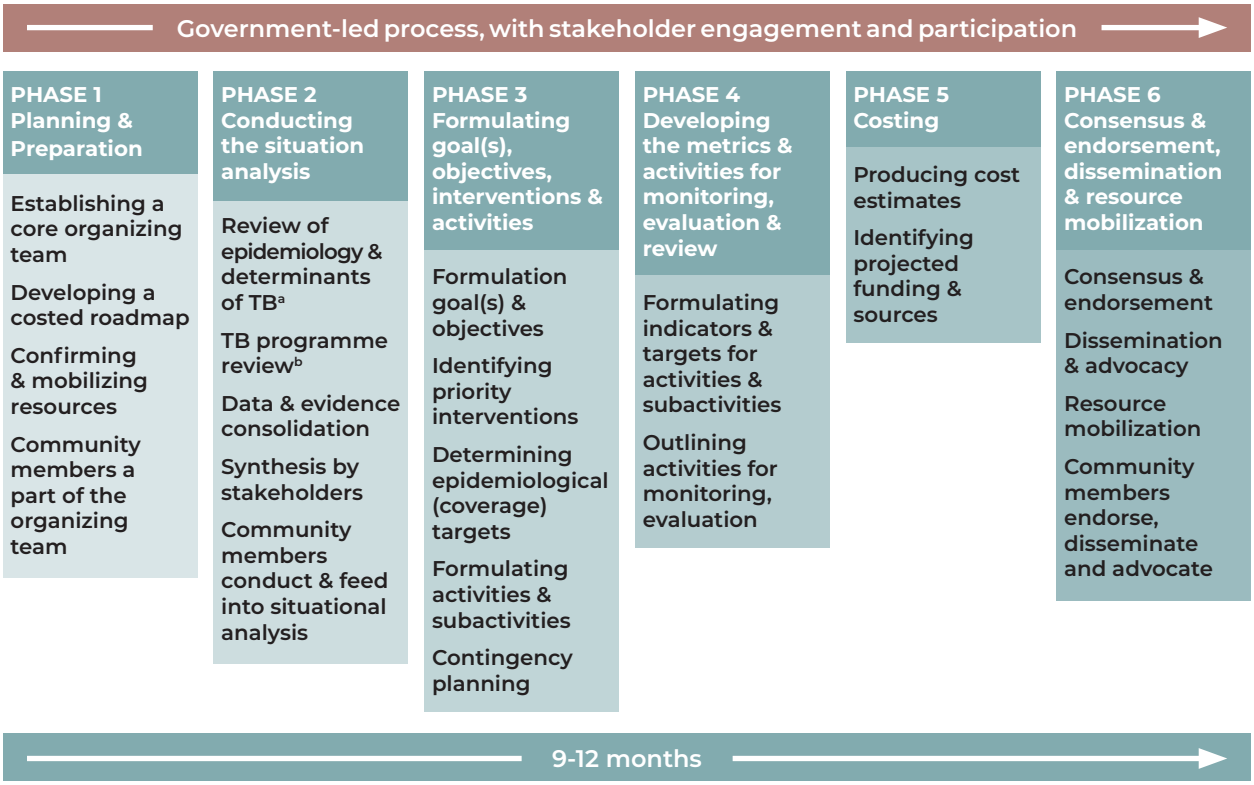
- People living with HIV are up to 20 times more likely to fall ill with TB. TB is the commonest opportunistic infection for people living with HIV. This means that those with HIV are at increased risk of TB and considered vulnerable to TB on account of their lowered immunity
- This co-infection also contributes to the increased mortality, with almost a quarter of deaths among PLHIV on account of TB
- The programme mandates that people with HIV should be regularly tested for TB and all people diagnosed with TB should be tested for HIV

- People with diabetes have an increased risk of active TB or TB disease (2-3 times higher than people without diabetes)
- For these reasons, it is essential that anyone diagnosed with TB is tested for diabetes regularly and vice-versa
- There is some preliminary evidence to show that diabetes worsens TB treatment outcomes – increased deaths and relapse rates
- For these reasons, it is essential that anyone diagnosed with TB is tested for diabetes regularly and vice-versa
- For the affected individual, managing two infections can be difficult, and support from families and communities is essential

Support required:

- Like other long-drawn out illnesses, TB affects an individual in multiple ways. Apart from the physical symptoms, TB also has an effect on the earning capacity of an individual and patients are often not able to support their family
- People affected by TB face a certain amount of stigma and risk being isolated or ostracised. Everyone should have access to diagnostic and treatment for free
- Psycho-social support
  - Counselling: Peer-counselling from TB survivors and/or people affected by TB can be very effective in providing support. Channels for open communication that allows information sharing, peer support, undertaking collective activities and problem-sharing should be established. This can be through meetings, app-based groups, phone calls or other preferred means. Peer counsellors need to keep in mind that issues that fall beyond their scope should be referred to professional counsellors and experts (for example: potential mental health issues, suicidal ideation, serious unaddressed medical complications, etc.)
  - Social support: During the course of treatment persons affected by TB need the support of family, friends, well-wishers and community members. A good support system can help prevent the patient from spiraling into depression and giving up the treatment. To avoid catastrophic costs, adequate financial support is essential for people who are diagnosed and on treatment for TB
- Access to good nutritious food is also important during TB treatment, for TB patients and their families

HANDOUT B: PROCESS OF DEVELOPING A TB NSP



MOH: Ministry of Health
NSP: National Strategic Plan
TB: tuberculosis
[a] This includes review of social determinants
[b] This includes review of aspects of the health system as well as other sectors that are relevant to the country's TB response. This can be primarily informed by a desk review of the relevant reports, as well as inclusion of the most pertinent aspects in the TB programme review

HANDOUT C: PROGRAMMATIC GAP ANALYSIS

EXAMPLE OF AN OUTLINE FOR SUMMARIZING THE PROGRAMMATIC GAP ANALYSIS				
Programme Area			**Key gaps (to be quantified) where possible with appropriate references for the data sources**	**Identified root or contribute causes**
The national health and social care system	**Organization of the health and social care delivery system**	**Health and social protection governance**	TB is not included among the criteria for social assistance grants	Inadequate awareness of the social consequences of TB Disproportionate focus on biomedical interventions in the TB training curricula and other strategic documents
			50% of people with TB who are eligible for social assistance for other conditions do not access social assistance	10% of people with TB do not have national identification documents required to access social services
		Health and social service providers	30% of public sector health facilities do not provide TB services	Historical designation of sites as DOTS centres with inadequate decentralization Inadequate health worker capacity to manage TB
		Other sectors	60% of health facilities operated by mining companies do not provide TB diagnostic services	Inadequate awareness of senior management in mining companies regarding the local TB situation and required services
	Financing for health and TB services		30% of the national TB budget required to implement the TB NSP was unfunded TB was not included in the district action plan in 7 of the 24 districts	Low awareness of TB among key decision-makers at national and subnational levels
			The share for health in some of the district budgets is very low (<5%)	Overreliance on external funding to address TB
	Human resources for health		Insufficient programmatic and clinical staff for the management of TB	TB-related stigma and fear of infection among health workers Inadequate incentives and infection control provisions for health workers Insufficient opportunities, including training for staff at all levels
	Pharmaceutical and other medical products		Inadequate supplies of ancillary medicines for people with TB	Ancillary medicines not included in the procurement for anti-TB medicines
			Frequent stock-outs of anti-TB medicines at facility level	Inadequate monitoring and reporting of stock status at facility level
	Infrastructure and health technologies	**Physical infrastructure**	Inadequate airborne infection control at health facilities	Infrastructure design and renovations not in line with infection control standards Health facility infrastructure not adequately maintained
		Diagnostic network	Inadequate converage of rapid diagnostics for TB (only 70% of health facilities)	Limited funding for expansion of laboratory diagnostics Frequent machine breakdown Frequent power outages
		Health technologies	30% of health facilities do not have reliable internet access	Low penetration of internet services outside urban centres
	Surveillance system for TB		High (41%) level of TB underreporting as reported by the TB inventory study	Private sector facilities and some hospitals are not linked to the national TB surveillance system High workload and reporting burden on staff Multiple systems in place (paper-based and electronic), making harmonization of data difficult

	Social protection		Unknown coverage of social assistance services for TB-affected families	Unclear eligibility of people with TB for social assistance grants No systematic social needs assessment of people with TB Recording and reporting systems does not include social protection indicators
	Research and innovation		National research agenda does not include TB-specific research	Inadequate engagement of researchers in the national TB response
The NTP	**Organization of the NTP**		Inadequate staff for coordination of TB services at national and subnational levels	Key staff positions for the TB programme are not filled Inadequate funding for human resources for the TB programme Perception among key decision-makers that TB is no longer a major problem in the country
	Organization of services along the TB care cascade	**TB prevention**	Low coverage of core elements of airborne infection control (focal person, infection control committee and infection control plans) Low (25%) coverage of TPT among eligible household contacts of people with TB	Low awareness of infection control among facility managers No national guidelines or SOPs for airborne infection control Health worker reluctance to provide TPT (concerns about resistance, side effects, effectiveness and workload) Inadequate supplies of TPT medicines (funding, TPT perceived as low priority)
		TB screening and diagnosis	Only 63% of people with DR-TB had second-line DST	Second-line DST is only performed at the national reference laboratory There is no nationwide specimen transport system to facilitate second-line DST
		TB treatment and care	24% of people diagnosed with MDR/RR-TB were not started on treatment	Limited number of health facilities providing DR-TB treatment Long waiting time for results of baseline examinations required before DR-TB treatment initiation
		Screening and management of comorbidities	Low (20%) coverage of nutrition assessment among people with TB	Inadequate health worker capacity and tools on nutrition assessment No system in place for addressing nutrition needs of TB patients
		Addressing TB in vulnerable populations	No data on TB burden in key vulnerable populations	Recording and reporting system does not collect key data on vulnerability No targeted interventions for TB vulnerable populations in the previous NSP
Implementation of previous strategic plan			Inadequate awareness of the NSP at district level	Inadequate involvement of the district level staff in the development of the NSP
			Inadequate engagement of other sectors in strategic plan implementation	Suboptimal engagement of leadership in key sectors for the TB response

DOTS: directly observed treatment course

DR-TB: drug-resistant TB

DST: drug susceptibility testing

MDR/RR-TB: multidrug-resistant or rifampicin-resistant TB

NSP: national strategic plan

NTP: national TB programme

SOP: standard operating procedure

TB: tuberculosis

TPT: TB preventive treatment

HANDOUT D: SAMPLE M&E COMPONENT OF THE NSP

Item	Indicator	Purpose	Calculation	Source of information	Periodicity	Who will collect the information	Level of information collection	Baseline (2020)	Target (2025)
Goal	TB incidence	Impact	WHO estimates	Global TB Report (baseline); Modelling (target)	Annually; once	NA	NA	100 per 100000	77 per 100000
Goal	Number of TB deaths	Impact	WHO estimates	Global TB report; modelling	Annually; once	NA	NA	1000	680
Goal	TB-affected families facing costs >20% of household income or expenditure due to TB (%)	Impact	Survey results	TB patient cost survey	At the end of the NSP period	M&E focal point	National	47%	10%
	Proportion of annual budget defined in TB strategic plan that is funded	Input	Available domestic and international funding each year divided by the estimated NSP funding needs for the same year	NTP, finance department	Annually	Finance focal point	National	75%	100%
Objective 1	TB treatment coverage	Outcomes	Number of new and relapse cases that were notified and treated, divided by the estimated number of incident TB cases in the same year, expressed as a percentage	Surveillance system	Quarterly	M&E focal point at relevant levels	Facility, district, province, national	50%	75%
	Number of people diagnosed with TB	Output	Number of new and relapse cases that were notified and treated	Surveillance system	Quarterly	M&E focal point at relevant levels	Facility, district, province, national	5000	6380
	Costed implementation plan to improve specimen transportation system	Process	NA	NTP	Once off (2023)	NA	NA	Implementation plan not available	Implementation plan developed and costed

HANDOUT E: CHECKLIST

No.	Assessment Items	Status
A	The number of trained staff and the availability of training opportunities	
B	The process for identifying and managing patients suspected to have TB	
C	The efforts made in implementing TB screening activities	
D	The procedures used to diagnose TB and the quality of diagnosis	
E	The procedures and approaches to addressing comorbidities (e.g., HIV/AIDS or diabetes) as well as risk factors such as smoking or malnutrition that may influence the effectiveness of care	
F	The appropriateness of the TB treatment provided	
G	The monitoring of and support provided to patients receiving treatment, and any related human rights concerns on access, discrimination or provision of care	
H	The recording and reporting systems, the completeness of registration, the availability of quarterly reports, and whether there is consistency between the registers and reported data	
I	How the implementation and provision of TB prevention and care services are supervised, and whether supervisory visits are recorded	
J	The supplies of anti-TB medicines, including buffer stock, and laboratory consumables and equipment	
K	Whether informational, educational and communication materials are available to promote TB prevention and care within the community	
L	Whether mechanisms are in place to overcome access barriers related to stigma, discrimination, gender norms or other factors such as migrant status	
M	Whether link person with TB to social protection mechanisms to ensure access to relevant benefits	
N	The level of involvement in identifying and managing patients with MDR-TB	
O	The links with community-based organizations and volunteers	
P	Collaboration between the national TB programme and the national HIV/AIDS programme and/or other national programmes addressing important comorbidities or risk factors	
Q	When acceptable and feasible, discussions should be arranged with small groups of patients as well as with a small group of community workers and volunteers to elicit their perspectives on access to care and treatment	
R	Interviews with individual patients should be also organized	
S	The team should schedule appointments with the respective authorities (such as the provincial or district health director, the hospital director and relevant stakeholders) to provide feedback on their findings and to make recommendations for improvements, if necessary	
T	Individual team members should be given responsibility for making specific observations as well as for specific places to visit and people to meet	
U	The designated recorder should note the key points of the discussion, and these should be included in the field report	

HANDOUT F: ACTIONS BEFORE AND AFTER TB

	RISK OF TB	WITH TB	POST TB
Empowered people and communities	Health literacy and promotion for communities to understand risk factors for TB, prevention options, and when to access care Building capacity of health systems, community systems and networks to measure TPT, and other indicators that are important Stigma reduction in important community fora, such as schools, places of worship, markets, sports halls, starting with measurement Awareness raising through community systems to train people affected by TB on prevention, screening, and early treatment Safeguarding health as a human right by facilitating access to legal aid and using commitments to the primary care concept as a mechanism for government advocacy Planning for prevention, in partnership with National TB Programme, especially around vaccine preparedness and TPT; providing treatment support for preventive treatment Support for research that advances implementation of End TB strategies Community-led monitoring for evidence-based advocacy, action, and advancement of programmatic goals.	Promoting a human-rights-based approach to end TB through use and understanding of the Declaration of the Rights of People Affected by TB Finding missing people with TB through accessible care pathways, especially for vulnerable populations and families of people with TB Providing home-based care, including boosting TB and health literacy, diagnostic access, referrals for families of affected household members, treatment adherence support, psychosocial counseling, and interventions to reduce stigma Advocacy for access to medicines and quality care as the first step for successful treatment of TB Community-led monitoring of service needs and deficits, as identified by community members, to create demand for quality care and ensuring continuous access	Awareness raising as experts of the lived experience Community-led monitoring, utilizing digital technologies where possible Complete recovery and community integration for those who faced stigma or ostracization during TB

	RISK OF TB	WITH TB	POST TB
Integrated care & health services	Screening for TB that respects autonomy and privacy, especially for stigmatized communities Utilizing digital technologies for information sharing, community mobilization and diagnosis Providing access to diagnostic tools and protocols for linking people to care without economic consequences to affected people and their families Capacity building and training for peer groups, champions, and advocates to reduce stigmatization and discrimination; use of the TB stigma index TB Preventive Treatment for all people who are eligible and who agree to treatment; support for completing a full course of preventive treatment Vaccination preparedness, utilizing learnings from COVID-19 to prepare messaging and systems for vaccine deployment Assessment and evaluation of systems for sensitizing populations and preparing them to enter care Infection control practices at the health center and community	Task sharing between NTPs and communities for referral mechanisms, sputum transport and collection, and engagement with traditional healers and private providers Screening and care for comorbidities, including HIV, diabetes, COVID-19, etc., and risk factors such as smoking and heavy alcohol use Utilizing digital technology to facilitate adherence to treatment and referral pathways for receiving integrated care Household contact triaging and prevention, including testing for TB infection and TB preventive treatment Protection from economic consequences for services and treatment needed to recover from TB; free care and access for everyone	Management of TB-related disability, including persistent pulmonary dysfunction Quality follow up to prevent relapse and re-infection

	RISK OF TB	WITH TB	POST TB
Multi-sectoral policy and action	Infection prevention in the workplace and public gathering points; promotion of ventilation, cough hygiene, and other lessons learned from COVID-19 Resource mobilization for fair financing for community and civil society engagement to end TB Transport services for connecting people with TB symptoms and community health workers to facilities with diagnostic tools Social determinants of TB interventions to prevent TB, including nutrition support, housing, education, and poverty reduction Strengthen community legal empowerment	Social protection and support through holistic health service that addresses employment status, housing, nutrition support, prevention for affected families Legal services for people affected by TB who need support accessing treatment, employment protection, housing protection, etc.	Income generation and vocational training, and recovery from catastrophic costs


World Health Organization
REGIONAL OFFICE FOR South-East Asia
Global Coalition of TB Advocates