

People-Centred Planning Framework in Action: The Kenyan NSP Experience

In 2014, when the country developed the National Strategic Plan (NSP) for Tuberculosis (TB), Leprosy and Lung Health (2015–2018), the National Programme (NLTP) applied a classic planning process. Over several months of intensive planning period, all relevant stakeholders were engaged. A comprehensive range of interventions were identified that aimed at addressing critical epidemiological and programmatic gaps while sustaining gains that had been achieved. The NSP that emerged was aspirational, and as with many other NSPs, was far from being fully funded. And so, when planning for program implementation less than a year later, the programme had to repeat a major planning process to prioritize its domestic funding and its request to the Global Fund.

The NLTP is now embarking on the development of its NSP for the period of 2019-2023. In the context of recent prevalence survey findings, which demonstrated that more than half of people with TB disease in Kenya are not diagnosed or not notified, there was enthusiasm and clear commitment to identify new and effective ways to address the epidemic. The planning Secretariat decided to try a new approach for the upcoming NSP. They have embarked upon a historic effort to consolidate all available national and sub-national data, map it to the care continuum, and prioritize interventions within a patient-centred plan. In a participatory three-day workshop, over fifty international, national and local stakeholders pioneered a *People-Centred Planning Framework* described in the accompanying white paper, to kick off the process of the NSP development.

The process used the patient care continuum as a framework to review in-country evidence, prioritise the issues, analyse their root causes and programmatic gaps to inform a set of priority interventions. It followed the three steps described below.

(1) Problem Prioritization (Day 1)

The magnitude of problems was assessed across the care continuum by mapping evidence on burden of disease, patient behaviour and health and social systems. Participatory discussions resulted in problem prioritization supported by evidence.

(2) Root Cause Analysis (Day 2)

For priority issues identified in the step 1, their determinants, root causes and priority domains for action were identified.

(3) Strategic Intervention Optimization (Day 3)

Programmatic objectives were defined and key interventions were identified for each of the priority domains identified in the step 2.

Day 1: Problem Prioritization

Prior to the workshop, an M&E team had consolidated data points from recent studies including the prevalence survey, WHO Global TB Report, patient pathway analysis, epidemiological review, TB inventory study, and other national surveys such as Demographic Health Surveys and health expenditure and utilization survey. Data points were mapped to the care continuum. The resulting evidence summary sheets were distributed to all participants. Figure 1 shows the landscape of collated metrics, and Figure 2 shows the aggregated data points in a specific category.

After plenary presentations on key findings from major surveys and studies, the workshop was divided into groups to identify systems and epidemiological gaps across the patient care continuum, assess progress in these areas, and assign a priority level to the issues. The groups scored, on a scale of 1-5 (1=low, 5=high) the 1) magnitude of the problem within the country; 2) extent to which progress is being / has been made against the problem; and 3) priority to be given to mounting a greater response to the problem. The intent of this step was to have stakeholders think about the epidemic holistically and to set priorities based on a desire to optimize the impact of resource allocations, human and financial.

As groups reviewed the collated data, they identified missing data points, as well as categories that had not been adequately represented. For example, instead of looking exclusively at the epidemiology of TB in terms of people affected, several groups noted the importance of including data on the burden of disease, including mortality and health systems costs, which made an important difference in priority setting for topics such as MDR-TB.

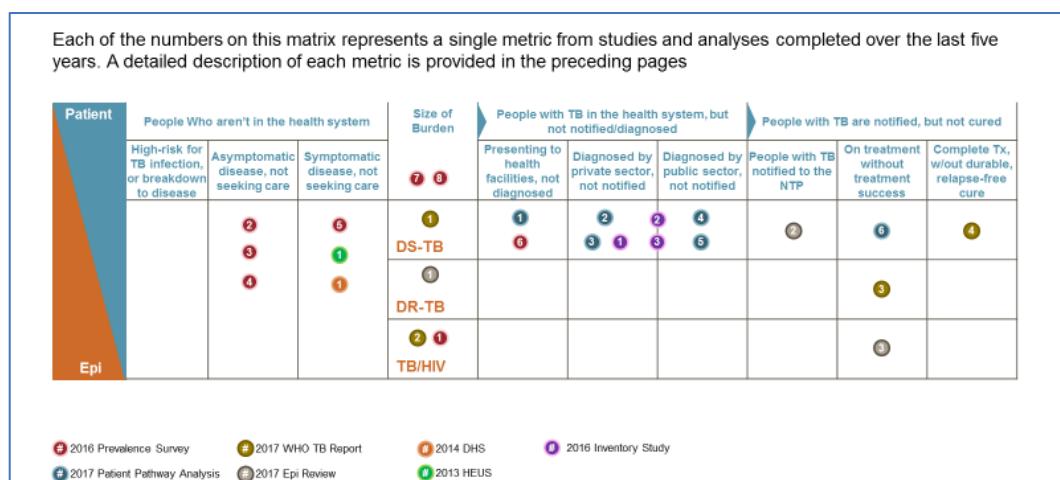


Figure 1: Collated Metrics from Evidence Resources

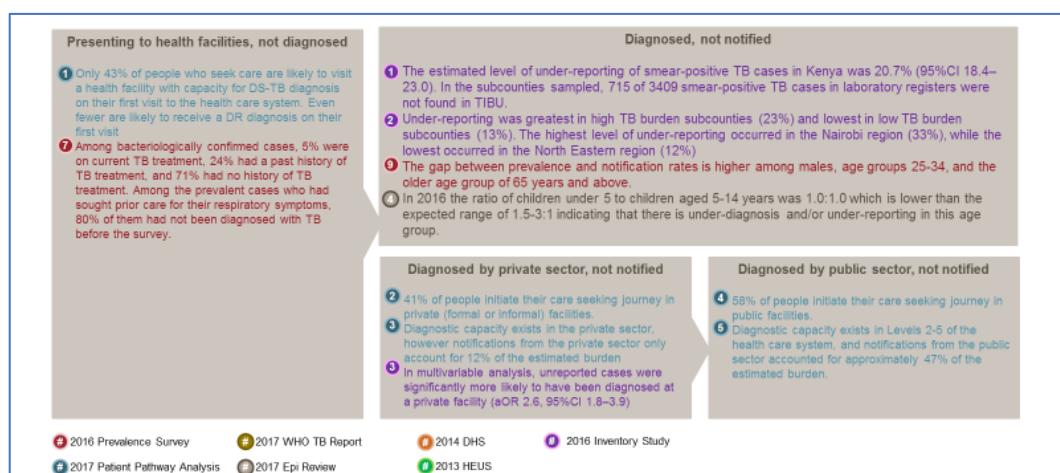


Figure 2: An example of data summary for “People with TB in the System, Not Notified or Diagnosed”

There were areas where the paucity of data became an over-riding consideration: in paediatric TB, despite lower incidence levels, there was a clear emphasis on the need to prioritize children with TB, as

well as the need to be able to better characterize the issue with improved data. For special populations, for example, there was not adequate data to assign a high priority based on magnitude, but groups felt it would be an unacceptable outcome to exclude them based on this. Instead, better understanding the extent of TB within special populations was noted as a priority research agenda, while inclusion of special populations as a priority area for intervention was explicit.



Figure 3: Summarized Priority Rankings

Each group consolidated and heat-mapped the prioritization rankings at the end of Day 1. There was a high level of convergence among teams, and many areas emerged as high priority, with full consensus of high priority areas (e.g. paediatric TB and people in diagnosed by the public sector and not notified).

There was also notable divergence in a few areas. For the team of county (sub-national) representatives, drug resistant TB was not a priority, while at a national level, it was a high priority; it was hypothesized that this was due to the small numbers at the county level, versus the aggregated view at the national level. Figure 3 shows the summarized findings from the Prioritization Session, and Figure 4 shows examples of noted data gaps categorized by area.

Before the findings are considered as the basis for the NSP, a similar prioritization exercise will be conducted with the 47 counties of Kenya as well as with focus groups of patients and health workers. A triangulation of these inputs will be required.

Session	Category	Sub-Category	
Session 1 - Epidemiology	Drug Sensitive	EPTB	6
Session 1 - Epidemiology	Drug Sensitive	Pediatric	5
Session 2 - People who are not in the health system	Asymptomatic disease, not seeking care	-	4
Session 3 - People with TB in the health system, but not notified/diagnosed	Presenting to health facilities; not diagnosed	-	4
Session 1 - Epidemiology	Drug Sensitive	Special Populations	4
Session 2 - People who are not in the health system	High-risk for TB infection or breakdown to disease	-	3
Session 1 - Epidemiology	Drug Sensitive	School Going Children	3
Session 1 - Epidemiology	Drug Sensitive	TB and Diabetes	3
Session 1 - Epidemiology	Drug Sensitive	TB in Prisons	3
Session 2 - People who are not in the health system	Symptomatic disease, not seeking care	-	2
Session 3 - People with TB in the health system, but not notified/diagnosed	Diagnosed by private sector, not notified	-	2
Session 4 - People with TB are notified, but not cured	Complete Rx, w/out durable, relapse-free cure	-	2
Session 4 - People with TB are notified, but not cured	People diagnosed with TB but not started on treatment	-	2

Figure 4: Categories with Most Comments on Data Gaps

Day 2: Root Cause Analysis

The second part of the workshop focused on exploring root causes of the identified priority issues. The content-specific working groups reviewed and consider data and evidence from the sources identified above as well as other additional studies and surveys. These groups built analyses to categorize determinants of issues (see Figures 5 and 6 for examples).

Notable overlaps began to emerge, signalling the potential for cross-cutting interventions that can focus on addressing patient needs holistically, and may require collaboration with other sectors. Common themes included ensuring access to care, improve patient-centredness in services, the quality of care, financial constraints associated with care seeking, and overall lack of resources for facilities.

Groups also identified data gaps limiting their ability to adequately assess root causes. For example, the group examining paediatric TB noted the urgent need to collect additional data on the magnitude and impact of the issue.

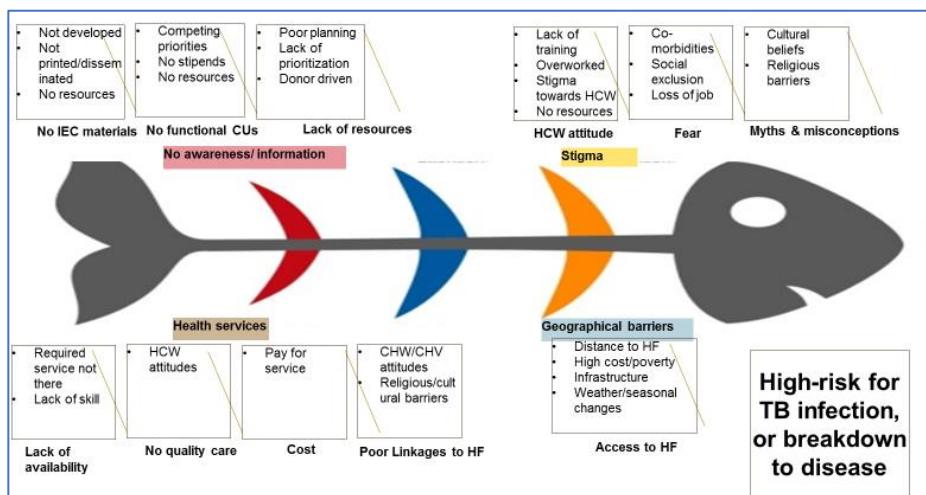


Figure 5: "Fishbone" Analysis for High-risk for TB infection or Breakdown to disease

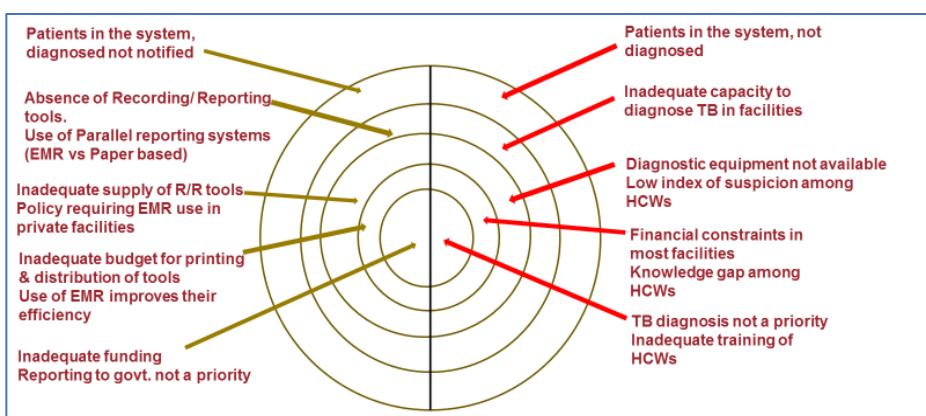


Figure 6: Root Cause Analysis for Patients in the System Not Diagnosed Notified

Day 3: Strategic Intervention Optimization

Finally, the groups discussed potential strategic interventions to address the identified root causes, or action domains. For each of the identified action domains (3 to 4 domains per group), a primary objective was determined; i.e. the groups expressed needs to be achieved in the specific domain. Then discussions focused around which strategic interventions would bring the desired changes to achieve the objective. The emphasis was on high-level interventions, rather than activities. After identifying strategic interventions, the groups mapped the feasibility and potential impact of different interventions to prioritize the interventions, including consideration of the roles of other sectors and partners for enabling the interventions to succeed. As with the root cause analysis, potential cross-cutting and multi-sectoral interventions emerged. Central themes included ensuring universal access to diagnosis and treatment, addressing the financial burden of TB patients, providing patient-centred care including decentralized services, service integration and coordination, and health care workers' capacity to provide holistic care.

Notably, different groups had different assessments of the feasibility of interventions. For example, one group identified universal access to chest X-ray as highly feasible, and another ranked it as low feasibility. This signalled the need for further exploration of implementation approaches, including mapping and optimization options, cost-effectiveness analyses and diagnostic algorithms.

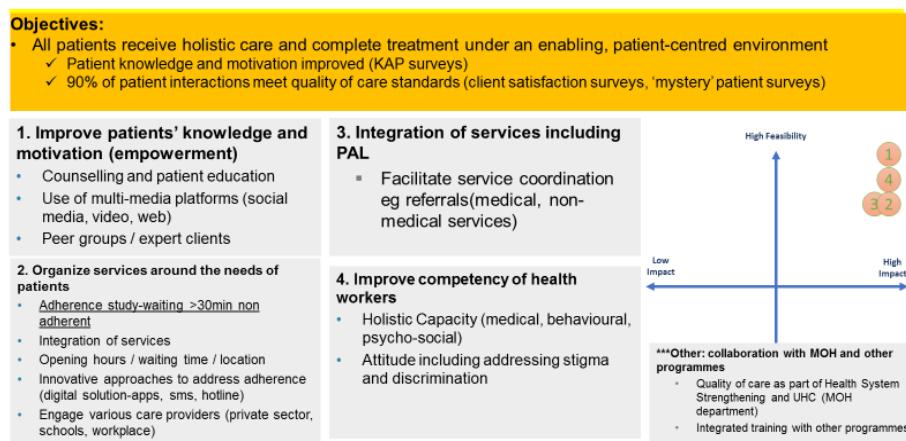


Figure 7: Interventions to Address Gaps in Patient-Centered Care



Figure 8: Interventions to address Low Index of Suspicion for Childhood TB

Conclusion

While the process was a pilot and in need of iteration and refinement, stakeholders indicated that they found the process to be a highly productive starting point for the process of the NSP development.

Many appreciated the participatory, people-centred and evidence-driven nature of the approach, and NTP leadership committed to using the findings as the foundation of the new NSP. The pivotal shift towards planning and data analysis aligned to the care continuum represents an important move to truly patient-centred TB response.

The NSP process is far from over, and in addition to refinements to the larger process, the Kenyan NTP plans on implementing a shorter, simpler version at the county-level, to ensure that county perspectives are appropriately represented and prioritized in the national plan.

Even in its first iteration, this process stood in stark contrast to previous planning approaches. It takes significant effort and discipline to apply data in programmatic settings, while maintaining objectivity and adhering to guiding principles and values, and the Kenyan NLTP has demonstrated the promise and practicality of this approach.