

STOP TB

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Contributing to health system strengthening

Guiding principles for
national tuberculosis programmes



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Foreword

This is a dynamic and challenging time for those working in public health, in global health cooperation, and in tuberculosis control specifically. As a result of commitments to health at the highest political levels, there are unprecedented opportunities for expanding response to disease epidemics and simultaneously improving health systems. These commitments have resulted in innovations in financing streams, public-private partnerships, civil society engagement, frameworks for cooperation, and channels of rapid communication and knowledge-sharing.

The rapid scaling-up of HIV, TB, malaria and immunization programmes has reinforced awareness of the well-known weaknesses in health systems and services that require new strategies and new funds in addition to those serving the urgent needs to address priority public health conditions. There is consensus that strengthening health systems is essential if the health Millennium Development Goals (MDGs) are to be achieved and that the Paris Aid Effectiveness Principles¹ provide essential guidance for ensuring that actions are aligned with national priorities and harmonized in practice.

In TB control, we have a rich and well-documented history of evolving policies in line with primary health care aims since Alma Ata, across all levels of health systems, and within and outside the public sector.² In the early 1990s, TB control practitioners and partners were actively engaged in the dialogue on documenting the cost-effectiveness of interventions and crafting relevant packages of services. Later in the decade, we contributed to documentation of the effects of rapid health sector reforms and helped to identify the need for an expanded resource base for global health in order to optimize benefits for poverty reduction and for economic and human security. We recognized early the need for well-functioning general health systems,³ and we pursued initiatives to contribute to integrated service delivery innovations, such as the practical approach to lung health (PAL),⁴ community engagement,⁵ public-private mix approaches⁶ and TB/HIV collaborative activities.⁷ Most recently, we have been actively involved in wide-ranging discussion on how best to reach the MDGs, and in the development of a WHO-wide health system strengthening strategy and framework.⁸

This document draws on lessons learnt at country, regional and global levels over the past 30 years. It also builds on the current momentum to act with urgency to reverse the spread of epidemics, strengthen systems and address inequities. The WHO Stop TB Strategy⁹ and the Stop TB Partnership's Global Plan to Stop TB, 2006-2015¹⁰ demonstrate the commitment of the TB control community to contribute to stronger health systems and thereby greater health impact. It is impossible to offer detailed global guidelines on how best to contribute: given the diversity of health systems and the range of determinants of disease and vulnerability, we feel that the most useful approach is to offer a broad framework on how national TB programmes can contribute to this challenging agenda. We hope we can help countries and partners further document their progress and problems in the coming years.

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¹ www.oecd.org/document/18/0,3343,en_2649_201185_35401554_1_1_1_1,00.html, accessed 4 March 2008.

² Raviglione M, Pio A. Evolution of WHO policies for TB control, 1948-2001. *Lancet*, 2002, 359:775-778.

³ *Report on the meeting of the Second Ad Hoc Committee on the TB epidemic: recommendations to Stop TB Partners. Montreux, Switzerland, 18-19 September 2003.* Geneva, World Health Organization, 2004 (WHO/STB/2004.28).

⁴ Ottmani SE et al., eds. *Practical Approach to Lung Health (PAL): a primary health care strategy for the integrated management of respiratory conditions of people of five years of age and over.* Geneva, World Health Organization, 2005 (WHO/HTM/TB/2005.351).

⁵ *Community contribution to TB care: practice and policy.* Geneva, World Health Organization, 2003 (WHO/CDS/TB/2003.312).

⁶ *Engaging all health care providers in TB control: guidance on implementing public-private mix approaches.* Geneva, World Health Organization, 2006 (WHO/HTM/TB/2006.360).

⁷ *Guidelines for implementing collaborative TB and HIV programme activities.* Geneva, World Health Organization, 2003 (WHO/CDS/TB/2003.319).

⁸ *Everybody's business. Strengthening health systems to improve health outcomes: WHO's Framework for Action.* Geneva, World Health Organization, 2007.

⁹ *The Stop TB Strategy: building on and enhancing DOTS to meet the TB-related Millennium Development Goals.* Geneva, World Health Organization, 2006 (WHO/HTM/STB/2006.368).

¹⁰ *The Global Plan to Stop TB 2006-2015.* Geneva, World Health Organization, 2006 (WHO/HTM/STB/2006.35).

Preparation of this document

In the preparation of this policy paper, key WHO documents that summarized the available literature on TB control, health system structures, processes and reforms were reviewed. Of special note are a 2003 publication on expanding TB control services in the context of a changing health system¹ and a series of editorials and articles on health systems, sector reforms and TB control to which WHO staff contributed in a theme issue of the *International Journal of Tuberculosis and Lung Disease* in 2000.² Subsequent literature in this area was identified through a PubMed search and through continuous review of the e-mail list *TB-Related News and Journal Items Weekly Update*, prepared by CDC (Centers for Disease Control and Prevention, Atlanta, USA), between January 2006 and December 2007. In addition, selected national TB control programmes and academic institutions were contacted directly.³

Expert guidance was provided by members of the WHO TB Control and Health System Strengthening Task Force, which was created in 2005 and includes representatives of selected national TB programmes, WHO Regional TB Advisers, health planning officers, and health policy and TB control experts from technical agencies and academia.

The policy paper was drafted by Knut Lönnroth and Diana Weil on the basis of recommendations made by the WHO TB Control and Health System Strengthening Task Force. Draft versions were presented to the WHO Strategic and Technical Advisory Group on Tuberculosis (STAG-TB), to the Stop TB Partnership Coordinating Board, and at a scientific symposium at the World Lung Health Conference in Cape Town, South Africa, in 2007. Staff of the WHO Stop TB Department and Health Systems and Services Cluster provided feedback on several iterations of the draft. The document has also been circulated to all WHO Regional TB Advisers and to selected health systems experts and other individuals interested in disease control and health systems. Significant contributions to the completion of the document were made by: Karin Bergström, Léopold Blanc, Pierpaolo de Colombani, Peter Gondrie, Nani Nair, James Newell, Vikram Pathania, Claudio Politi, Kathrin Thomas, Mukund Uplekar and Fraser Wares. No relevant conflict of interest was reported by the contributors.

It is intended that this policy paper be reviewed for possible revision in 2011.

This is the first in a new series of WHO Stop TB policy papers.

¹ *Expanding DOTS in the context of a changing health system*. Geneva, World Health Organization, 2003 (WHO/CDS/2003.318).

² • Weil D. Advancing tuberculosis control within reforming health systems. *International Journal of Tuberculosis and Lung Disease*, 2000, 4:597-605.
• Bosman MCJ. Health sector reform and tuberculosis control: the case of Zambia. *International Journal of Tuberculosis and Lung Disease*, 2000, 4:606-614.
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• Kritski AL, Ruffino-Netto A. Health sector reform in Brazil: impact on tuberculosis control. *International Journal of Tuberculosis and Lung Disease*, 2000, 4:622-626.

³ See, for example:

- Travis P et al. Overcoming health systems constraints to achieve the Millennium Development Goals. *Lancet*, 2004, 364:900-906.
- Mosneaga A, Yurasova Y. *Enabling the health systems for effective tuberculosis control: challenges and opportunities in the former Soviet Union countries. Discussion Paper*. Copenhagen, World Health Organization Regional Office for Europe, Tuberculosis Programme, 2005.
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- Hill PS, Tan Eang M. Resistance and renewal: health sector reform and Cambodia's national tuberculosis programme. *Bulletin of the World Health Organization*, 2007, 85:631-636.
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THE STOP TB STRATEGY

VISION

A WORLD FREE OF TB

GOAL

To dramatically reduce the global burden of TB by 2015 in line with the Millennium Development Goals and the Stop TB Partnership targets

OBJECTIVES

- Achieve universal access to high-quality diagnosis and patient-centred treatment
- Reduce the human suffering and socioeconomic burden associated with TB
- Protect poor and vulnerable populations from TB, TB/HIV and multidrug-resistant TB
- Support development of new tools and enable their timely and effective use

TARGETS

- MDG 6, Target 8: ...halted by 2015 and begun to reverse the incidence...
- Targets linked to the MDGs and endorsed by Stop TB Partnership:
 - By 2005: detect at least 70% of new sputum smear-positive TB cases and cure at least 85% of these cases
 - By 2015: reduce prevalence of and deaths due to TB by 50% relative to 1990
 - By 2050: eliminate TB as a public health problem (<1 case per million population)

COMPONENTS OF THE STOP TB STRATEGY

1 PURSUE HIGH-QUALITY DOTS EXPANSION AND ENHANCEMENT

- Political commitment with increased and sustained financing
- Case detection through quality-assured bacteriology
- Standardized treatment with supervision and patient support
- An effective drug supply and management system
- Monitoring and evaluation system, and impact measurement

2 ADDRESS TB/HIV, MDR-TB AND OTHER CHALLENGES

- Implement collaborative TB/HIV activities
- Prevent and control multidrug-resistant TB
- Address prisoners, refugees and other high-risk groups and special situations

3 CONTRIBUTE TO HEALTH SYSTEM STRENGTHENING

- Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems
- Share innovations that strengthen systems, including the Practical Approach to Lung Health (PAL)
- Adapt innovations from other fields

4 ENGAGE ALL CARE PROVIDERS

- Public-Public, and Public-Private Mix (PPM) approaches
- International Standards for TB Care (ISTC)

5 EMPOWER PEOPLE WITH TB, AND COMMUNITIES

- Advocacy, communication and social mobilization
- Community participation in TB care
- Patients' Charter for Tuberculosis Care

6 ENABLE AND PROMOTE RESEARCH

- Programme-based operational research
- Research to develop new diagnostics, drugs and vaccines

1. Why is a health system strengthening component included in the Stop TB Strategy?

The inclusion of "Contribute to health system strengthening" (HSS) among the six components of the new WHO Stop TB Strategy¹ explicitly acknowledges that effective and sustainable TB control relies on the general health system, especially on well-functioning primary health care (PHC). Weak health systems pose many barriers to effective TB control.

The HSS component aims to sensitize national TB programme (NTP) managers to ongoing developments in the health sector and assist them in becoming active participants in the development process. The NTP and its TB control partners should be aware of national health sector strategy and plans and other related HSS initiatives in their country. Where possible, NTP managers should engage proactively in these initiatives. In a changing health system, awareness and participation may be crucial in preserving priority and funding for TB control, and in advances in TB control and health objectives.

TB programmes are an important part of, and are normally well integrated into, general health systems, especially at the point of service delivery. They can therefore contribute substantially to HSS through investments in laboratory infrastructure, capacity-building of health staff and increased routine use of health data, as well as by developing innovative service delivery strategies in response to specific health systems barriers; such strategies include the practical approach to lung health (PAL), public-private mix (PPM) approaches and community-based care.^{1,2} The extent to which such interventions contribute to a strengthening of the general health system - beyond its capacity to effectively deliver TB control services - depends on how they are planned and implemented.

The contribution of NTPs to the strengthening of the general health system can be optimized by applying an "HSS mindset" to all aspects of TB programme planning and implementation. Application of an HSS mindset, which should give rise to positive system effects beyond TB control, includes the consideration of a set of guiding "dos and don'ts for HSS", which promote:

- harmonization of the TB control planning and budgeting process with sector-wide planning frameworks;
- optimized use of shared resources such as frontline health staff; and
- reduction of duplicative structures.

While striving for further harmonization and integration, however, NTP managers must safeguard the provision of effective TB services by ensuring that core TB control functions are not compromised and this requires that certain "non-negotiable TB-specific functions" are preserved. The appropriate balance between integration and the retention of some separate and fully TB-dedicated health systems structures will vary from country to country, depending in particular on the robustness of the national general health system.

¹ *The Stop TB Strategy: building on and enhancing DOTS to meet the TB-related Millennium Development Goals.* Geneva, World Health Organization, 2006 (WHO/HTM/STB/2006.368).

² DOTS is the core technical approach of the Stop TB Strategy.

2. What does contributing to health system strengthening mean in practice for NTPs?

For NTPs, contributing to HSS involves:

- helping to analyse general health system weaknesses;
- identifying opportunities offered and the challenges posed by ongoing and planned health sector development processes;
- joining health system partners in addressing barriers, challenges and opportunities while safeguarding core TB functions.

2.1 Help analyse health system weaknesses

There are six health systems "building blocks" defined in WHO's HSS framework;¹ (see Figure 1). NTP managers can help assess the potential health system barriers that may have a negative impact on TB control. Some of these barriers are listed in Box 1; the list is indicative only. The relevant focus of analysis depends on country context, including structure of the general health system, the structure and operation of the NTP within the health system, and the structure and operation of other public health programmes, such as national AIDS programmes.

Identification of health system barriers is a part of routine TB programme planning² and review processes;³ guidance on the methodology for assessing barriers is not included in this document. Routine TB programme monitoring and evaluation often reveal programme limitations that stem from weaknesses of the general health system. In fact, the well-established routine monitoring and evaluation system for TB control means that NTPs are often relatively well placed to contribute to the understanding of specific health system areas that require strengthening. By closely monitoring performance indicators, such as number of outpatient visits, number of persons tested for TB, sputum smear positivity, case notification rates and treatment outcomes, NTPs can help to identify the associated system weaknesses, both those that are TB-specific and those that relate to broader structures.

In addition, the monitoring of certain aspects of TB programme management, including the health workforce, drug management, laboratory quality, and the role of the private sector and the community, also generates data that may help health policy-makers to identify areas of the general health system that need to be improved. Further specific guidance on assessment of health system barriers may be found in the document *Expanding DOTS in the context of a changing health system*.⁴

It is essential that assessments are undertaken jointly with health system planners and other public health programmes, so that information is shared and there is common learning from experiences and identification of cross-cutting approaches to solving problems. Needless to say, any existing health system assessment should be used as a starting point.

¹ *Everybody's business. Strengthening health systems to improve health outcomes: WHO's Framework for Action*. Geneva, World Health Organization, 2007.

² *Implementing the Stop TB Strategy – a handbook for national tuberculosis programmes*. Geneva, World Health Organization, 2008 (WHO/HTM/TB/2008.401).

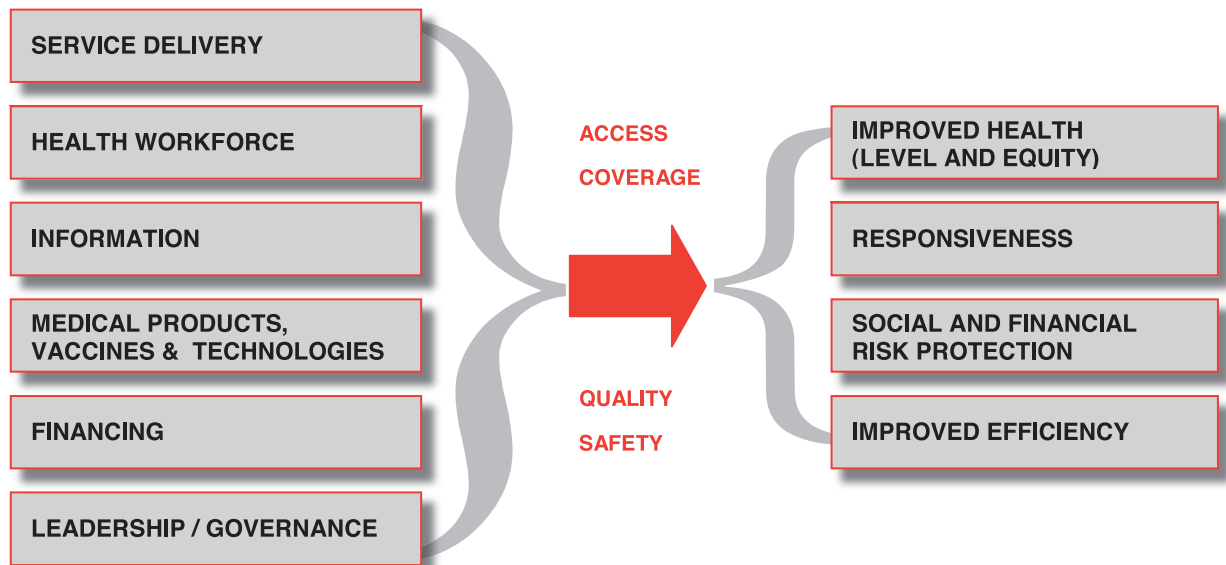
³ Kumaresan J, Luelmo F, Smith I. *Guidelines for conducting a review of a national tuberculosis programme*. Geneva, World Health Organization, 1998 (WHO/TB/98.240).

⁴ *Expanding DOTS in the context of a changing health system*. Geneva, World Health Organization, 2003 (WHO/CDS/2003.318).

Figure 1.

Six building blocks for health systems

Overall goals / Outcomes



Source: WHO. *Everybody's Business*, 2007

Box 1. Potential health systems weaknesses with implications for TB control

Leadership and governance (stewardship)

- Weak capacity for health policy analysis, priority setting, sector policy development and central health sector management. This may involve limitations in the quantity of human resources for health, and their capacity, as well as limitations related to planning, decision-making and management structures.
- Poor coordination between different parts of ministries of health, for example between different public health programmes (e.g. AIDS and TB), and/or between departments responsible for public health, curative and diagnostic services, drug supply and other logistics, information systems, etc.
- Poor coordination between different public sector entities involved in health care planning and implementation, including limited coordination between different ministries and between national, provincial, and local governments.
- Decentralization with increased sub-national/local autonomy, without sufficient legislation and central coordination to secure adequate disease control measures.
- Weak health sector regulation and limited mechanisms and resources for enforcing existing regulation.
- Non-existent or weak policy on the role of the private health care sector, including limited information on the private sector and poor regulatory framework.
- Limited engagement with civil society in the design, operation and accountability of health systems.

Financing

- Limited general health sector budgets and caps on expansion of health resources.
- Unfair financing systems, e.g. little or no coverage of health insurance functions with the ability to pool and redistribute resources in a way that minimizes financial access barriers and financial burden for patients.
- Weak mechanisms for tracking financial flows and poor capacity for national health accounting.
- Weak mechanisms for strategic resource allocation and purchasing of services.

Health workforce

- Lack of basic information about the number, composition and geographical distribution of all health providers (public and private) and the type and quality of the services they provide.
- Insufficient coordination of human resource development across different parts of the health system and between different public health programmes, e.g. TB and AIDS programmes.
- Inadequate size and competence of the health workforce.
- Weak structure and poor quality of educational systems for health professionals, including continuing medical education and in-service training.
- Absent, unclear or non-performance-based career opportunities.
- Poor supervision and quality control mechanisms.
- Perverse incentives linked to employment policies, salary structure and payment mechanisms.

Medical products (including drugs and diagnostic facilities)

- Weak regulation of medical products and/or weak enforcement mechanisms
- Weak systems for procurement, distribution and management of drugs and equipment.
- Weak mechanism for promoting rational use of drugs.

Information (including monitoring and evaluation)

- Poor quality of vital statistics and demographic information.
- Weak general systems for disease surveillance and poor disease notification system.
- Lack of data on patterns of health care utilization.
- Limited skills for analysing existing data at service and supervisory levels.
- Limited capacity for health systems research and operational research.

Service delivery (including health care provision and management/supervision of services)

- Lack of information and/or resources for improving and expanding health service infrastructure.
- Lack of integration of service delivery between different levels of the system and between different public health programmes.
- Lack of comprehensive policy and plan for optimal utilization of existing health providers.
- Limited capacity to plan and manage health care provision, including contracting, certification and accreditation of public and private providers.
- Limited use of quality standards and evidence-based guidelines.
- Poor systems for referral and information exchange between providers.

2.2 Identify opportunities and threats of health sector development processes

Many of the potential health system weaknesses listed in Box 1 are beyond the direct influence of NTPs; they are determined by broader public health policy and by political and economic trends at local, national and international levels. Nevertheless, NTPs need to plan and implement realistic strategies within the limits set by such policies and practice. In most settings, they could seek to become more proactively involved in processes aimed at improving the general health system.

Health sector policy changes and reforms can bring major opportunities for improved TB control, through strengthened health care financing, infrastructure, health workforce capacity, etc. However, NTP managers are not normally directly engaged in the design of policy changes and these processes may not always be fully transparent or coherent. Among possible changes are decentralization and devolution of health care financing, management and decision-making; integration of public health oversight structures and programmes; privatization and/or provider/purchaser split with more independent health institutions; and changing financing mechanisms, e.g. introduction of health insurance schemes.

If NTPs are not fully informed about the objectives and mechanisms of policy changes, public health programmes are at risk of being neglected and/or dramatically changed without proper preparation. There may also be missed opportunities for programmes to contribute lessons, experience and know-how to general health system strengthening. It is therefore crucial that NTPs proactively seek out information on health sector policy and strategy developments and offer to contribute early in these processes.

Similarly, it is important that NTPs are aware of the health care planning and financing frameworks, processes and approaches used by ministries of health, partners and international donors, including, for example:

- processes for aligning donor funding streams with a comprehensive health sector plan and budget, such as sector-wide approaches (SWAp);
- budgeting mechanism that aims to bring a multiyear perspective to the annual budgeting cycle, such as medium-term expenditure frameworks (MTEFs); and
- strategies for broad-based growth and poverty reduction, such as Poverty Reduction Strategy Papers (PRSPs) and associated credits.

NTPs need also to be alert to opportunities that arise for HSS support through various initiatives, such as under the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization, and the International Health Partnership+.

As discussed above, a comprehensive document has already been developed to guide TB programmes in responding to and planning TB services in the light of changing health systems. Annex 1 of this policy paper provides brief descriptions of SWAp, MTEFs and PRSPs.

2.3 Address weaknesses and challenges, and seize opportunities

Having identified health systems weaknesses and mapped out ongoing and planned health sector development processes, NTPs should devise HSS actions that balance three objectives:

- helping to improve the capacity of the general health system to effectively deliver TB control services;
- optimizing the positive impact on the general health system of specific TB programme activities through adequate coordination and harmonization of financing, planning and service delivery (the "dos and don'ts");
- ensuring core functions for effective TB control are maintained and sustained.

The mandate of an NTP is to improve the capacity of the health system to deliver high-quality TB control interventions within an integrated health system. This may require, especially in very weak health systems, the maintenance of some TB-dedicated structures that support effective services within primary care and referral levels. While certain TB-specific elements are required to ensure good quality and coverage, TB control should be planned and implemented with the goal of ensuring alignment and harmonization within the general health system in order to optimize use of limited resources to advance health outcomes.

Indicative "dos and don'ts for HSS" and "non-negotiable" functions for TB control are listed below. They should be considered as guiding principles rather than as strict rules: country context, the strength of the general health system, and TB burden will guide the appropriate balance.

The dos and don'ts for HSS

Leadership and governance (stewardship)

Do

- maximize alignment of TB programme planning with overall health sector planning frameworks;
- collaborate across public health programmes to promote joint planning and share programmatic policies and strategies;
- improve coordination of external technical assistance for TB with other technical assistance;
- when engaging NGOs and the private sector, ensure that the stewardship function remains with the ministry of health and that major financing is not diverted to private sector providers.

Don't

- develop national TB control strategies and implementation plans in isolation from overall health system planning.

Financing

Do

- align budgets and programme-specific financial flows within MTEFs or equivalent resource allocation tools;
- as far as is feasible, pool domestic and international NTP funding into a "mini-basket" fund for TB control or use larger pooled mechanisms if there is a clear budget for TB control;
- pursue policies that reduce patients' out-of-pocket spending on health care and related costs.

Don't

- create parallel administration, reporting and monitoring systems for different sources of external funding;
- create unnecessary transaction costs through unsynchronized planning.

Health workforce

Do

- use a systematic approach based on job descriptions to: (a) clearly determine human resources needs for comprehensive TB control; (b) develop long-term strategic plans, and (c) develop medium-term implementation plans to enable alignment with general human resource development strategies and plans;
- collaborate and coordinate with other public health programmes, with other departments and services in the ministry of health (especially hospital and diagnostic services administration) and with other units in the provincial/district health services to ensure synergy and consistency with overall local health sector plans and capacity-building frameworks;
- share experiences of engaging the health workforce outside the public sector (such as PPM approaches and community involvement in TB control), with other public health programmes and with health system stakeholders.

Don't

- develop TB-specific solutions to speed up the implementation of interventions - such as intervention-specific incentives, or increasing the number of emergency or longer-term staff - without considering the implications for other programmes;
- develop implementation plans for human resources development without being realistic about the time needed and the opportunity cost related to time spent on training.

Medical products and infrastructure (including for diagnostic and treatment needs)

Do

- plan actions to strengthen the capacity of laboratory services for sputum smear microscopy, culture, drug susceptibility testing and new diagnostic tools in concert with relevant planning units, public laboratory authorities, other public health programmes, and across public and private providers, in order to avoid duplication and unnecessary transaction costs;
- develop national procurement, distribution and stock management systems that are harmonized and (when relevant and possible) integrated within general supply systems;
- ensure that urgent temporary systems, if required to ensure safe and timely delivery, are planned with central authorities and that support is provided to replace them by integrated systems as quickly as possible.

Don't

- develop or maintain parallel systems for laboratory or drug management when strong general laboratory and drug management systems are in place or under development.

Information (including monitoring and evaluation)

Do

- ensure that the TB recording and reporting system is harmonized within national health information systems while sharing experiences on how it can be used as a model for analysing and making full use of routine data for local performance improvement;
- align monitoring requirements with overall poverty and health monitoring master plans in the country and work with donors to consolidate reporting demands;
- share information from TB monitoring and evaluation, including performance and programme management data, to help map health system deficiencies and opportunities;
- seek common platforms for any service- or population-based surveys.

Don't

- create new indicators without careful consideration of overlap and inconsistency with general health system performance indicators;
- demand unnecessary process indicators or special reports on performance beyond routine reporting requirements.

Service delivery (including health care provision, management and supervision of services)

Do

- harmonize management and supervision structures with general health system managerial structures, including mechanisms for working with the private sector;
- plan delivery of diagnostic and treatment services with the authorities responsible for planning service delivery on all levels, particularly primary health care, and for delivery of other public health programmes, such as national AIDS programmes;
- join efforts to build competencies that are common to all health care planners and managers;
- harmonize quality standards with general health system quality standards;
- implement PAL as a means to strengthen management of respiratory illnesses in primary health care;
- share experience of and expertise in engaging all public and private care providers and communities in TB control, and strive to coordinate such initiatives with those of other public health programmes to work with these sectors.

Don't

- plan or implement supervision and quality control in isolation from general health service supervision and quality control;
- create incentives structures that distort priority-setting and/or performance in other areas of work among managers and supervisors.

Core "non-negotiable" functions for TB control

There are a number of core "non-negotiable" functions required for effective TB control as specified in the Stop TB Strategy. These include evidenced-based clinical care and public health approaches and sound management functions to support their implementation. The nature of the supportive health system structures required to secure these functions varies across settings. Structures are therefore, in principle, variable and adaptable to local circumstances. However, experience from several countries shows that a limited set of core TB-specific structures may be required to ensure that the essential functions are carried out effectively. If such structures are in place and working well, they should not be changed unless alternative approaches (such as, for example, fully integrated drug distribution, supervision, monitoring and evaluation) have proved equally or more effective. The degree of integration is thus negotiable, but negotiation should be based on solid evidence on effectiveness and cost-effectiveness.

In particular, NTPs should ensure that:

1. Tuberculosis continues to be considered a *public health priority*. Specifically:
 - TB is explicitly addressed in sector strategy, planning and policy documents.
 - TB control is included in any essential or basic package of health services.
 - Anti-TB drugs are included in any essential drugs package.
 - TB control indicators are used in routine reports of a unified health management and information system.
2. There is a *clear and results-based operational plan* for implementation of the Stop TB Strategy. In the context of a national health sector plan, the TB control component is transparent, and supported by clear commitments of financial, human and other resources.

3. There is *TB management capacity* with competencies in policy and planning, budgeting and logistics (including drug and supplies procurement and distribution), monitoring and surveillance and laboratory supervision. Normally, this means that:
- There is one dedicated senior staff member with overall accountability for TB control within the country. This person is backed up by a central-level team with sufficient planning, management and technical capacity for guiding and supporting TB control implementation in the country.
 - There are dedicated staff to ensure uninterrupted and timely supply of anti-TB drugs. Job responsibilities include estimation of need, ensuring timely procurement, preparing distribution lists, and tracking stock and flow.
 - There are dedicated staff to manage the TB control information system, including collation of case-finding and treatment reports, and national-level quarterly treatment cohort analysis.
 - The national unit has sufficient operational budget (apart from salaries and other fixed overheads), and a line-item in the health budget, such that it is able to carry out planning and reporting functions, essential supervisory and training programmes, and rapid response during a crisis, e.g. drug stock-out in a province.
 - There is full- or part-time dedicated and well-defined TB supervision capacity at the provincial/district level. Sufficient supervision capacity is particularly important in high- and intermediate-burden countries with weak health systems. The TB coordinator is supported with adequate financial and physical resources (full access to transport, communications, etc).

3. How is health system strengthening incorporated into a programme review?

This section lists some key questions for assessing how an NTP is performing with regard to its contribution to health system strengthening; it can be used as a checklist for internal or external programme reviews. The ambition level of such an assessment depends on the objectives of the review and resources available. Experience from a number of regular external TB programme reviews has shown that it is feasible to address most of the listed questions during a mission of 1-2 weeks.

To ensure that there is a sufficiently comprehensive HSS element in a programme review, interaction with other public health programmes is recommended, as well as with ministry of health units responsible for health care planning, financing, human resource development, regulation, medical products, information systems, etc. Similarly, there should be interaction with nongovernmental entities, donors and organizations providing technical and financial support for health system strengthening.

The assessment may focus on the following six broad questions:

1. How are the NTP and its functions integrated within the general health system? (See Box 2.)
2. What specific health system weaknesses constitute barriers for TB control? (See Box 1.)
3. What health sector development processes/reforms are planned or ongoing, and what positive or negative impact might they have on TB control? (See sections 2.1 and 2.2, and Annex 1.)
4. To what extent is the NTP involved in influencing these processes/reforms, and how can the NTP become more proactive?
5. To what extent is the NTP adhering to the "dos and don'ts" while protecting the "non-negotiables"? (See section 2.3.)
6. How can the NTP further improve the positive impact of programme implementation on the health system, through applying "dos and don'ts" principles for HSS? (See section 2.3.)

Box 2. Key questions for assessing how TB control is integrated within the health system

Financing and funding streams

- What are the main domestic and international funding sources for TB control and what are the shares of different funding sources?
- Are there different reporting requirements for the different sources?
- What proportion of total expenditure on TB control (including TB control costs incurred by the general health system) is represented by the NTP budget (domestic + donor contribution)?
- What proportion of total government expenditure on health is represented by the NTP budget?
- To what extent are funds for TB control allocated in line with the national health development plan, PRSP, MTEF? Is TB control formally part of these mechanisms?
- Is there a SWAp and what share of TB control financing comes from this source? What are the trends?
- To what extent do co-payment and exemption systems affect TB patients' access to health care?

Overall planning, HR strategy, and lines of authority for supervision and quality control

- Apart from the NTP, which national partners have taken part in the planning of TB control (e.g. ministry of health planning department; hospital administration department or equivalent; other ministries such as education, interior/justice, defence; drug regulatory body; national health insurance office; HIV programme; other public health programmes; nongovernmental organizations; professional associations, etc).
- Is the strategic plan for human resources development for TB control linked to and coordinated with the national human resources for health plans for the entire health sector?
- On what levels of the health system are there staff who are dedicated full-time to TB control? Who is paying their salary - the NTP or the general health system (provincial/state, district/sub-district, health facility level)?
- What is the line of authority for personnel responsible for supervising TB control implementation at provincial/state and district/local levels? To whom are these personnel accountable (i.e. to the NTP or to other authorities)?

Supply chains, and delivery of diagnostic and treatment services

- How are TB drug procurement, distribution and stock management systems integrated within or coordinated with general drug management systems?
- How are TB laboratory supply and stock management systems integrated within overall public health laboratory or general management systems?
- How are TB laboratory services integrated into overall laboratory and service structures and is laboratory equipment shared or TB-specific in laboratories that provide routine TB diagnostic services?
- Which health staff are responsible for identification of TB suspects, diagnosis, prescribing treatment, directly-observed treatment and patient support, follow-up of patients lost from care? Are they all integrated general health staff or are some staff fully dedicated to TB control?
- Are initiatives that reach out to engage providers in the private sector and/or in communities TB-specific or linked to other public health programmes?

Annex 1

Sector-wide approach (SWAp)

The sector-wide approach is a partnership mechanism for aligning donor funding streams with a comprehensive health sector plan and budget. The recipient government takes the lead in strategy formulation and plan implementation; it evaluates the health needs of the country as a whole and establishes priorities. Funds from donors and the government are often pooled in a “basket” and then allocated to priority activities. Donor focus tends to shift from technical and funding assistance for specialized health interventions to collaboration with the ministry of health in sectoral planning and performance monitoring that should explicitly incorporate these interventions and expected outcomes.

The potential benefits of SWAp include greater national ownership of health sector planning and budgeting, reduced duplication and conflict in donor activities, and more rational evidence-based allocation of resources.

For NTPs, SWApS carry the potential risk of loss of previously dedicated donor funding for core functions, without replacement of such funds. Whether sufficient funds are made available to the NTP from overall pooled funds depends on the priority accorded to TB control and the specificity of budgets in the health sector plan. However, many countries have defined an essential package of health interventions, and TB is almost always included in this package. If implementation of this package, including all necessary support functions, is adequately elaborated in the national health plan and MTEF (see below) and supported by a SWAp, this mechanism can be a means of securing more sustained financing for the health sector, including for TB control. Annual SWAp reviews provide a key opportunity to highlight the results and impact of public health programmes within national plans.

Medium-term expenditure framework (MTEF)

The medium-term expenditure framework is a budgeting mechanism that aims to bring a multiyear perspective to the annual budgeting cycle. Social programmes such as health and education have long-term needs, and intelligent budgeting should take a longer-term view of macroeconomic realities and trends in expected government revenue and donor funding. MTEF is a rolling process with a medium-term horizon (usually up to 3 years in the future). There are three components: a top-down estimate of the total resources available for public expenditure, based on overall macroeconomic goals; a bottom-up estimate that is the sum of the expected line expenditures in different programmes; and a framework for reconciling the two estimates. The MTEF can also be implemented on a sectoral basis.

The MTEF helps to create a more predictable environment for planning activities since planners have an idea of the overall spending envelope and how it is likely to evolve. The focus shifts from short-term cash management to medium-term expenditure planning.

Where MTEFs are in use, NTP managers should aim to ensure that their planning and budgeting are synchronized and incorporated within these processes.

Poverty reduction strategy paper (PRSP)

A poverty reduction strategy paper spells out a comprehensive country strategy for broad-based growth and poverty reduction. It is prepared by the government in consultation with domestic stakeholders and external development partners, in particular the International Monetary Fund (IMF) and the World Bank. A PRSP will typically detail the macroeconomic and structural policies and social programmes planned over several years, and the associated external financing needs. PRSPs provide the operational basis for concessional lending and debt relief by the IMF and the World Bank. They are updated every 3 years with annual progress reports.

A PRSP contains a discussion of the health sector and the current health status of the population, usually with references to Millennium Development Goal targets and related health indicators. In most countries, communicable disease control is mentioned and targets may be explicit.

The PRSP is of most relevance to senior policy-makers and donors. However, NTP managers should still be aware of poverty reduction strategies and the opportunity for promoting TB control and poverty linkages and for including TB indicators among those used for tracking progress.



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