REPUBLIC OF KENYA

MINISTRY OF HEALTH

Kenya TB Financing Roadmap FY2023/24-FY2027/28

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USAID
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NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

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About HS4TB

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ACRONYMS AND ABBREVIATIONS

BATT	Budget Advocacy Task Team
CDOH	County Department of Health
CHMT	County Health Management Team
CHSWG	County Health Sector Working Group
CSO	Civil society organization
CSOF	County Strategic Operational Framework
DANIDA	Danish International Development Agency
ECCIF	Emergency, Chronic, & Critical Illness Fund
FY	Financial year
GOK	Government of Kenya
HSTR	Health Sector Transition Roadmap
IFMIS	Integrated Financial Management System
KES	Kenyan shilling
KHFS	Kenya Health Financing Strategy
KHPPCS	Kenya Health Public Private Collaboration Strategy
M&E	Monitoring and evaluation
MAFTWG	National TB Multisectoral Accountability Framework for TB Technical Working Group
MDR-TB	Multidrug-resistant tuberculosis
MOH	Ministry of Health
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NHSWG	National Health Sector Working Group
NSP	National Strategic Plan
NTLD-P	National Tuberculosis, Leprosy and Lung Disease Program
OOP	Out-of-pocket

PBB	Program-based budgets or program-based budgeting
PBCBP	Planning & Budgeting Capacity Building Plan
PHF	Primary Healthcare Fund
PPM	Public-private mix
RMP	Resource Mobilization Plan
SHA	Social Health Authority
SHIF	Social Health Insurance Fund
SI	Strategic Initiative
SPA	Special Purpose Account
TB	Tuberculosis
UHC	Universal health coverage
UHCTWG	Universal Health Coverage Technical Working Group
WHO	World Health Organization

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EXECUTIVE SUMMARY

TB Financing Roadmap Development Process. The situational analysis, strategic initiatives (SIs), investment plan, and implementation arrangements for this roadmap were developed by the National Tuberculosis, Leprosy and Lung Disease Program (NTLD-P) through a consultative process involving the Ministry of Health (MOH), the Universal Health Coverage Technical Working Group (UHCTWG), county government representatives, technical partners, and financial partners. This process involved a combination of desk review, one-on-one interviews with key informants, and focus group discussions.

Situational Analysis. The NTLD-P's National Strategic Plan (NSP) 2023/24-2027/28 sets forth a blueprint for overcoming persistent challenges and sustaining progress towards achieving the END TB targets by 2030. To operationalize the NSP, an estimated KES 93.2 billion ($660 million) is required in total over 5 years but, in the NSP's first year, only 17 percent of the total resource requirement has identified financial commitments. Of the $38 million of funding for TB in 2022, one third was from domestic sources. While the true funding gap for the NSP is unknown, there are promising opportunities to mobilize resources towards its strategic interventions from discretionary government budgets, newly introduced social health authority (SHA) funds, earmarks and co-financing arrangements, and the private sector.

Strategic Initiatives. The objective of the TB Financing Roadmap is (i) to summarize the approaches to be employed to mobilize additional domestic funds towards the NSP 2023/24-2027/28 cost requirement, as well as (ii) capture interventions designed to spend these funds in a more efficient manner with a view to reducing the amount of financial resources needed to implement the NSP. To achieve these objectives, the roadmap sets out the following SIs and corresponding actions.

Strategic Initiatives	Actions
SI 1. Mobilize Resources from Discretionary Government Budgets	*National-level Actions*
	Complete NSP resource mapping exercise for all five years, covering all meaningful potential sources of funding, and set and monitor resource mobilization targets by funding source and TB cost category
	Establish a Budget Advocacy Task Team within the NTLD-P
	Formulate a medium-term advocacy plan with a view to shifting GOK budgetary decision-makers' perception of TB as a donor-funded program
	County-level Actions
	Cost county strategic operational frameworks and develop resource mobilization plans
	Implement a county-level TB Planning & Budgeting Capacity Building Plan and increase annual county government disbursements for TB

	Formulate and implement medium-term advocacy plans with a view to shifting county-level budgetary decision-makers' perception of TB as a donor-funded program
SI 2. Integrate TB Services into Social Protection Schemes	Ensure the inclusion of human resource costs for TB diagnosis and clinical care, and activity costs for TB screening and TB public health activities, in the list of services and activities reimbursed by SHA
	Monitor actual and projected revenues for the SHA funds to inform whether the funds should become the domestic financing source for TB drug and diagnostics procurement when donor transition approaches
SI 3. Ring-fence Domestic Financing for Disease Programs Including TB via Earmarks and Co-financing Mechanisms	Establish special purpose accounts at the county government level to support transitioning disease programs and realize the KHFS' and HSTR's vision to ring-fence county-level funds for health
	Introduce and scale a co-financing arrangement for the county-level special purpose account for transitioning disease programs
SI 4. Supplement Government Funding for TB with Private Sector Contributions	Develop and implement a suitable financing arrangement for the PPM Workplace model
SI 5. Increase Efficiency of Government TB Expenditures through Contracting of Selected TB Services to Private Organizations	Establish government-run TB service contracting with private organizations (both for-profit and not-for-profit)

Investment Plan. The investment plan illustrates the distribution of TB programmatic categories at baseline, by the end of the current NSP (FY2027/28), and by the end of the subsequent NSP (FY2032/33). NTLD-P will seek to mobilize resources from new funding sources for commodities by the end of the subsequent NSP, while efforts during the current NSP will focus on generating resources from these sources for other TB programmatic categories.

Implementation Arrangements. As the NSP 2023/24-2027/28 Implementation Taskforce is responsible for securing funding for the NSP, it will also steer implementation of this TB Financing Roadmap. To fulfill this mandate, among the taskforce's members shall be NTLD-P finance and advocacy officers, its monitoring and evaluation (M&E) unit, MOH health financing experts, civil society organizations (CSOs), and technical partners focused on health and TB financing.

TB FINANCING ROADMAP DEVELOPMENT PROCESS

The situational analysis, strategic initiatives (SIs), investment plan, and implementation arrangements for this TB Financing Roadmap were developed by the National Tuberculosis, Leprosy and Lung Disease Program (NTLD-P) through a consultative process involving the Ministry of Health (MOH), the Universal Health Coverage Technical Working Group (UHCTWG), county government representatives, technical partners, and financial partners. This process involved a combination of desk review, one-on-one interviews with key informants, and the following focus group discussions:

- In August 2023, NTLD-P convened a one-week TB financing workshop where participants (a) designed a county-level TB resource tracking tool and (b) provided inputs via focus group discussions on SI 1. Mobilize Resources from Discretionary Government Budgets, SI 3. Ring-fence Domestic Financing for Disease Programs Including TB via Earmarks & Co-financing, and the Investment Plan component of the roadmap. MOH, county government representatives from five counties including TB coordinators, and technical partners participated in this workshop.
- In November 2023, NTLD-P held a TB Financing Roadmap brainstorming session in which MOH and technical partners provided input on the roadmap's draft SIs, investment plan, and implementation arrangements.

SITUATIONAL ANALYSIS

KENYA'S TB RESPONSE

Kenya has made notable progress in driving down the burden of TB over recent decades. TB incidence and mortality declined by 44 percent and 60 percent respectively between 2000 and 2021. Recent progress stems primarily from the Government of Kenya's (GOK) implementation of a robust TB control strategy with high-impact interventions, including the use of GeneXpert technology and expansion of community-based TB services (NTLD-P 2023a, WHO 2022).

Kenya has a bold vision for a TB-free future. To realize this vision, the country has adopted the World Health Organization (WHO) END TB targets, setting the goal of reducing TB incidence by 80 percent (compared to 2015), TB mortality by 90 percent (compared to 2015), and eliminating catastrophic costs for TB-affected households by 2035. Kenya has already made impressive strides towards these targets. In 2021, Kenya surpassed interim milestones, achieving a 32 percent reduction in TB incidence compared to 2015, against a target of 20 percent, and a 44 percent reduction in TB deaths compared to 2015, against a target of 35 percent (WHO 2022).

Figure 1. Progress towards END TB targets (incidence and mortality of TB per 100,000 population) in Kenya from 2015 to 2021

Source: WHO 2022

Despite commendable progress, TB continues to pose a major public health threat throughout the country. Kenya remains one of the 30 high-burden TB countries globally, and TB is the sixth overall leading cause of death nationally (IHME 2023, WHO 2022). Declines in TB case notification and treatment success rates are concerning, with over 48 percent of TB cases missed and only 43 percent of health facilities where people initially seek care able to diagnose TB in 2021. The fact that 27 percent of TB-affected households face catastrophic costs—which, for multidrug resistant tuberculosis (MDR-TB) patients, increases to 86 percent of households—constitute additional key challenges in the national TB response (*Ibid*).

The NTLD-P's National Strategic Plan (NSP) 2023/24-2027/28 sets forth a blueprint for overcoming persistent challenges and sustaining progress towards achieving the END TB targets by 2030. Five of the six core strategies of the NSP relate to realizing these goals, including actions to increase TB treatment coverage, increase TB treatment success, strengthen provision of integrated TB/HIV services, and strengthen program management, coordination, and accountability of TB services (*Ibid*).

HEALTH FINANCING LANDSCAPE

Kenya has shown a promising economic recovery following the COVID-19 pandemic. Real gross domestic product growth was 5.5 percent in 2022 and is expected to increase to 5.6 percent and 6 percent in 2023 and 2024, respectively (AFDB 2023). Gross national income(GNI) per capita is on the rise as well (increasing from $1,730 to $2,170 over 2018-2022), yet with its GNI/capita still just above the $1,560 threshold for lower-middle income countries, it is too early to predict when the country will attain upper-middle income status (World Bank 2023). Given its GNI/capita and consistent fulfillment of its co-financing obligations, Kenya is in the Gavi accelerated transition phase, the last phase before the country must fully self-finance vaccine procurement costs (Gavi 2023). This is a signal that transition for

other disease programs, such as TB, may not be too far in the future. It is therefore important for the government to increase its health spending to prepare for these transitions.

Kenya's National Health Accounts (NHA) 2016/17 reveal encouraging progress in increasing government spending on healthcare. Government health spending per capita increased from $31.8 to $39.5 over 2016-2020, driven by the progressive expansion of county government health allocations since devolution, which saw counties increasing health budgets from KES 42 billion to KES 124 billion over financial year (FY) 2013/14-FY2019/20 (NTLD-P 2023b, World Bank 2023). However, during the 2016-2020 period, government health spending as a share of total government spending hovered around just half (6.8 percent-8.2 percent) of the Abuja Declaration target of 15 percent, as shown in Figure 2 (World Bank 2023).

Making consistent progress towards the Abuja Declaration target will require continued increases in county government health spending, by overcoming considerable bottlenecks including weak human resource capacity in planning and budgeting, and the slow adoption of program-based budgeting (PBB) reforms within county departments of health (CDOH). Disease programs are significantly underfunded due to the lack of necessary program and sub-program codes within CDOHs' program-based budgets, and due to misalignment between the Integrated Financial Management Information System (IFMIS) codes which county treasuries use to approve budget requisition requests from line departments and those found in CDOH program-based budgets (PBBs). CDOH representatives in 26 of Kenya's 47 counties have been trained on PBB and accompanying planning and budgeting skills. These trainings have focused on equipping county health management teams (CHMTs), CDOH finance and planning officers, and participants from finance and planning departments, with the knowledge and skills necessary to ensure the right assortment of programs and sub-programs within the CDOHs' PBB frameworks, conduct activity-based costing, and mobilize resources from county government to the health sector (HP+ 2016). However, disease program heads at the county level, who are responsible for drafting the proposed budget for their disease program, have not yet received training on planning and budgeting from the MOH, and lack sufficient knowledge of PBB and key steps in annual planning and budgeting processes.

National and county governments will have to increase health allocations and spending not only to fulfill the country's commitment to reach the Abuja Declaration target, but also to prepare for the approaching transition of donor funding specifically for commodities, health activity budgets, and health service contracts. Donors remain an important source of funding for these aspects of the health sector and have contributed 16 percent-22 percent of total health spending in recent years, as seen in Figure 2 (WHO 2023). The MOH has drafted a Kenya Health Sector Transition Roadmap (HSTR) 2022-2030 which is currently undergoing validation. The roadmap sets out a number of interventions to increase the health sector's readiness to replace donor support for key line items, including an intervention whereby a 10 percent earmark of county governments' budgets, additional to existing county government discretionary budgets, would be established and allocated to key strategic programs (MOH 2022a).

The high share of out-of-pocket (OOP) health spending - roughly a quarter (23 percent-25 percent) of total health spending over the 2016-2020 period - is another concerning feature of Kenya's health financing landscape (WHO 2023). Government subsidies for health insurance mechanisms is an effective

pathway to increase government health spending while driving down OOP health expenditures, since health insurance prepayments (in the form of both salary deductions and premiums) replace OOP payments. Until 2023, the National Health Insurance Fund (NHIF) was the country's primary mechanism for pooling risks across formal sector and informal sector households and driving down the high burden of OOP expenditures. However, in recent years, NHIF has experienced serious implementation challenges, including (a) struggling with a large number of schemes, with some households simultaneously belonging to multiple schemes; and (b) conflicts of interest, where NHIF was simultaneously responsible for both [i] purchasing services and [ii] dispute resolution, among other functions[1].

As a result, the GOK adopted the Social Health Insurance (SHI) Act in 2023, which repeals the NHIF and replaces it with three funds - the Primary Healthcare Fund (PHF), the Social Health Insurance Fund (SHIF), and the Emergency, Chronic, & Critical Illness Fund (ECCIF) - all managed under a new body called the Social Health Authority (SHA). The SHA will be responsible for enrolling formal and informal sector households. All SHA members will be able to access services reimbursed by the PHF, SHIF, and ECCIF. SHA will address the challenges faced by NHIF by (a) establishing a single benefits package covering all SHA members, and (b) delegating the functions mentioned in [ii] above to third-party providers.

SHA aims to cover 85 percent of the Kenyan population, and to enroll 17,650,000 indigents (extreme poor). SHA will conduct an ability-to-pay assessment to determine paying from indigent (non-paying) SHA households. The results from this assessment will be used to recategorize households that were paying vs. indigent under NHIF as paying vs. indigent under SHA. NHIF members will continue receiving benefits under NHIF until the second quarter of FY2024/25 (i.e., October-December 2024) when the SHA is expected to be launched, at which point they must enroll in SHA to continue receiving benefits. The list of services and activities reimbursed under SHA is expected to be finalized by this point also.

Below are descriptions of each of the three funds (GOK 2023a, GOK 2023b, Thinkwell 2023):

- **Primary Healthcare Fund (PHF)**. PHF will reimburse contracted facilities for covered services at healthcare levels 1-3: community facilities, dispensaries, and health centers. PHF will draw its revenues from a national treasury earmark (called an "exchequer allocation") estimated at KES 58 billion annually. The PHF will be introduced as a fund separate from the SHIF because (a) it is a reasonable destination for GOK resources, as improving primary healthcare is a top priority for the GOK; and (b) the PHF as a stand-alone fund is likely to attract contributions from external and private domestic sources, given that the MOH has identified a number of such contributors with a vested interest in primary healthcare.

[1] When a purchaser is responsible for settling disputes raised against themselves by enrollees, they can be incentivized against adequately addressing such complaints (such as if a premium collector employed by the purchaser allegedly mistreats an enrollee) as they reflect poorly on the purchaser.

- **Social Health Insurance Fund (SHIF)**. In contrast to PHF, SHIF will reimburse hospitals (healthcare levels 4-6) for covered services. SHIF is projected to raise KES 134 billion annually from premium contributions from paying SHA members and a government subsidy for indigent members.

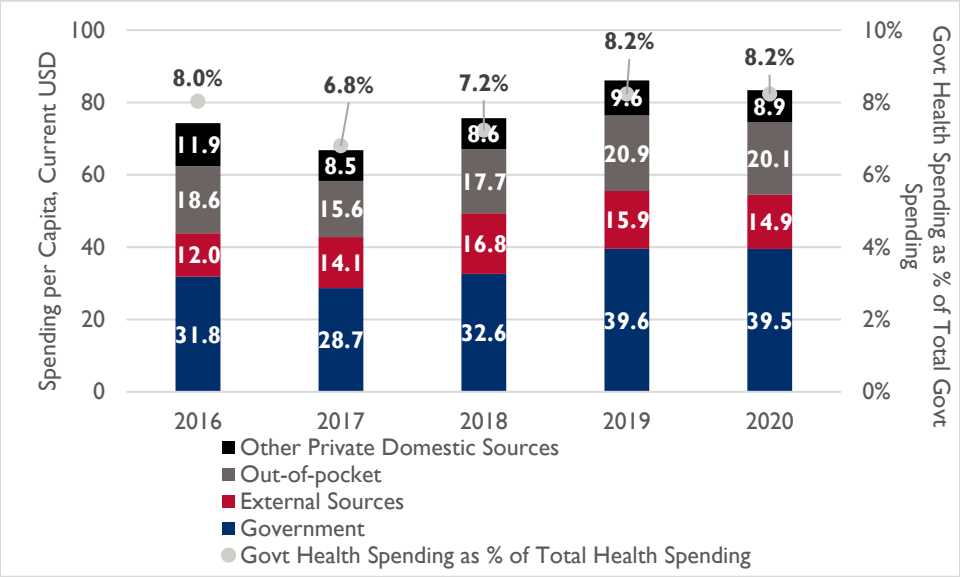
- **Emergency, Chronic, & Critical Illness Fund (ECCIF)**. SHIF will reimburse contracted facilities for covered curative services up to a certain threshold. ECCIF will reimburse services past this threshold up to another, higher threshold – both of these thresholds are yet to be determined. The ECCIF is expected mobilize KES 40.6 billion from an exchequer allocation, earmarked revenues from forthcoming tobacco and sports funds, donors, private domestic sources, and taxes on soft drinks and processed foods.

Although these represent new schemes and much is still to be determined, some characteristics of insurance-based financing in Kenya are likely to transition over, at least partly, from NHIF. For example, under NHIF, the coverage of indigent and low-income populations has not been effective. Most recent estimates indicate that NHIF achieved just 16 percent of its indigent enrolment target. Covering indigent households is critical to impact those at greatest risk of TB, and the enrollment of these individuals will partly transition over to SHA. Up until now, NHIF represented a relatively large proportion of domestic government general health expenditure (33 percent). Early estimates are SHA would spend KES 232 billion per year ($1.6 billion), which is 106 percent of general government health expenditure for 2020, making SHA a major health financing force. In addition, it is expected that SHA will include private healthcare providers, and thus it is an option for subsidizing or guiding the quality of TB care supplied by private providers (World Bank 2023).

Finally, private domestic sources, such as corporations and private domestic foundations, contribute significant financial resources to the Kenyan health sector. Accounting for 11 percent-16 percent of total health expenditures over 2016-2020, domestic private sector entities are identified as a key source of health financing in the Kenya Health Public Private Collaboration Strategy (KHPPCS) (WHO 2023, MOH 2020). The aim of the third of the strategy's six strategic objectives is to establish and operationalize a framework to mobilize financial resources from the private sector as a complement to public financing channels (*Ibid)*.

The Kenya Health Financing Strategy 2020-2030 (KHFS) is designed to address each of the challenges and opportunities covered in this section. Under its Strategic Focus for Revenue Raising, the KHFS calls for a blend of enhanced advocacy for increasing discretionary health budgets at both the national and county level. One of the key interventions of the Strategic Focus for Pooling and Management of Revenues is to establish ring-fenced health funds within county government budgets, echoing HSTR's call for such earmarks. Also under this strategic focus is a key intervention to introduce the SHIF, which was described earlier in this section. KHFS views the expansion of private health insurance as the primary pathway to mobilize resources from the private sector (MOH n.d.).

Figure 2. Health Spending Trends in Kenya



Source: WHO 2023

TB FINANCING LANDSCAPE

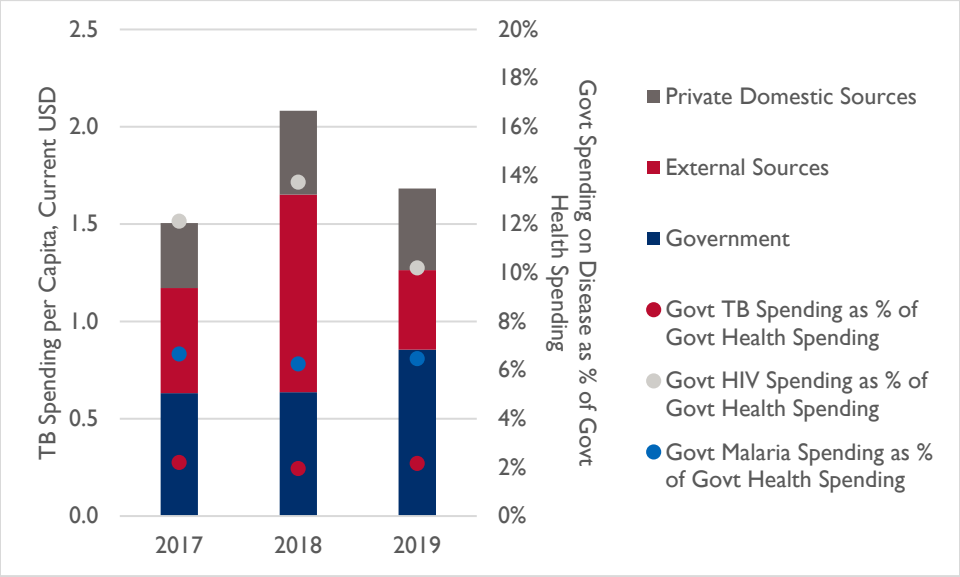
In Kenya, TB programming is financed primarily by GOK, county governments, households, and donors. The two major TB donors operating in Kenya are USAID and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

USAID's main TB project in Kenya is TB Accelerated Response and Care II, implemented by Center for Health Solutions Kenya, which had a budget of roughly $35 million over 2018-2023 to improve case finding, increase patients' access to services, expand TB prevention, and provide other support (USAID 2022). During the current Global Fund contracting period (2021-2024), the national treasury and Amref Health Africa are budgeted to receive $165 million and $182 million respectively, where the latter is contracted to support NTLD-P to expand TB screening, testing, and other services (Global Fund 2023).

Recent TB Financing Trends

Figure 3 summarizes TB spending by funding source over 2017-19 according to the most recent NHA. On average over this period, government, external sources, and private domestic sources (including OOP), represented 41 percent, 36 percent, and 23 percent of total TB spending respectively (WHO 2023). The fact that external sources accounted for 36 percent of total TB spending and 16 percent-22 percent of total health spending demonstrates that TB has been one of the more donor-reliant areas of the health sector (*Ibid*). Finally, Figure 3 shows that the GOK spent roughly six- and three-times more on HIV and malaria respectively, than on TB over 2017-2019 (WHO 2023).

Figure 3. TB Spending Trends in Kenya

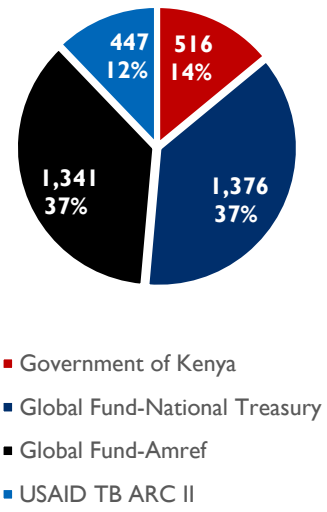


Source: WHO 2023

Future TB Resource Needs and Projected Funding

The current NSP reports a cost requirement of KES 93.2 billion (NTLD-P 2023a). The resource mapping exercise conducted to estimate the NSP funding gap generated estimated contributions for only FY2023/24, and not the remainder of the NSP period (NTLD-P 2022). Further, the mapped financial resources are not exhaustive as they ignore county government discretionary budgets, insurance reimbursements from the three new SHA funds, domestic private sector contributions, and other sources (*Ibid*). Figure 4 displays the breakdown of mapped FY2023/24 financial commitments, which amount to KES 3.6 billion or only 17 percent of that year's KES 21.1 billion resource requirement that was outlined in the NSP (*Ibid*).

Figure 4. Mapped Commitments to NSP for FY2023/24, Millions KES



Sources: NTLD-P 2022

STRATEGIC INITIATIVES

The objectives of the TB Financing Roadmap are (i) to summarize the approaches to be employed to mobilize additional domestic funds towards the NSP 2023/24-2027/28 cost requirement, as well as (ii) capture interventions designed to spend these funds in a more efficient manner with a view to reducing the amount of financial resources needed to implement the NSP.

NTLD-P sets out five SIs to achieve these objectives, all of which contribute towards the three strategic foci in the Kenya Health Financing Strategy (KHFS): revenue raising, pooling and management of revenues, and purchasing of services. The SIs and the KHFS strategic foci they support are depicted in Table 1. Further, the SIs and their constituent actions aid implementation of the following key health sector reforms and strategies:

1. **Social Health Insurance (SHI) Act**: integrating TB services and activities into the list of those reimbursed under SHA will assist the SHI Act to achieve its objective of "enhance(ing) the pooling of resources and risks based on the principles of solidarity, equity, and efficiency so as to guarantee access to health care services to all" (SI 2) (GoK 2023).
2. **Health Sector Transition Roadmap (HSTR)**: NTLD-P will initiate a partnership with other vertical programs to establish the KHFS' and HSTR's county-level earmark envisaged for transitioning disease programs, as well as create a co-financing arrangement to ensure that county treasuries and county assemblies are sufficiently incentivized to mobilize funds to the earmark during budget implementation (SI 3) (MOH 2022a).

3. **Kenya Health Public Private Collaboration Strategy (KHPPCS)**: consistent with KHPPCS Strategic Objective 3, *Harness private sector resources towards equitable financing of public healthcare*, NTLD-P will pilot and scale models to finance TB services from companies employing workers at high risk of TB. Separately, NTLD-P will scale contracting of TB service provision to private and non-governmental organizations, pursuant to Strategic Objective 4, *Guide contracting authorities on identifying and prioritizing projects that can deliver better value through collaboration with the private sector* (SIs 4-5) (MOH 2020).

Table 1. Kenya Health Financing Strategy Strategic Foci and Supporting TB Financing Roadmap Strategic Initiatives

KHFS Strategic Focus for Revenue Raising	KHFS Strategic Focus for Pooling and Management of Revenues	KHFS Strategic Focus for Purchasing of Services
SI 1. Mobilize Resources from Discretionary Government Budgets	SI 3. Ring-fence Domestic Financing for Disease Programs Including TB via Earmarks and Co-financing Mechanisms	SI 2. Integrate TB Services into Social Protection Schemes
SI 4. Supplement Government Funding for TB with Private Sector Contributions		SI 5. Increase Efficiency of Government TB Expenditures through Contracting of Selected TB Services to Private Organizations

SI 1. MOBILIZE RESOURCES FROM DISCRETIONARY GOVERNMENT BUDGETS

National-level Resource Mobilization

Based on the findings from the desk review, key informant interviews, and focus group discussions mentioned in the TB Financing Roadmap Development Process section, the key barriers to effective resource mobilization from the GOK discretionary budget are as follows:

- As mentioned in the situational analysis, the resource mapping for the NSP 2023/24-2027/28 omits financial contributions, including those from GOK and donors, over the final four years of the NSP implementation period, which the document reports as a funding gap. However, the omission of these values suggests the absence of data rather than the absence of funding. Budget advocacy messages targeting budgetary decision-makers in GOK which frame these notable data gaps as funding gaps will not be seen as credible.
- TB programming in Kenya is predominately donor-funded and while external funding for TB is expected to eventually decrease, there is no clear financial transition timeline. As a result, GOK budgetary decision-makers prioritize limited financial resources to areas of the health system where there is greater clarity around the availability or absense of external funding.

- NTLD-P lacks formal training on resource mobilization. While there are two finance officers in charge of monitoring NTLD-P's budgets and expenditures, there is no health financing or resource robilization unit or staff within NTLD-P. As a result, NTLD-P is likely unprepared to secure future increases to the national government's TB budget at a level sufficient to replace external TB funding that is slated to decline.
- With a relatively low domestic contribution to TB financing, there is also not a clear assignment of future responsibilities for the domestic financing of various parts of the TB response, i.e., which part of the domestic health financing landscape (e.g., GOK discretionary budgets, county government discretionary budgets, SHA funds, etc.) will be primarily responsible for financing which TB cost categories (e.g., commodities, TB-dedicated human resources, TB-specific public health activities, and TB clinical activities). A preliminary outline of such a plan is presented in the Investment Plan section of this document, starting on page 24.

Action #1: Complete NSP resource mapping exercise for all five years, covering all meaningful potential sources of funding, and set and monitor resource mobilization targets by funding source and TB cost category. Using the investment plan component of this roadmap as a starting point (see Investment Plan section, page 24), NTLD-P should set resource mobilization targets by year, funder, and TB cost category over the course of the NSP implementation period. The NSP 2023/24-2027/28 Implementation Taskforce will then monitor and, if necessary, revisit funding responsibilities and targets periodically (this taskforce is described in further detail in the implementation arrangements section of this document). NTLD-P and other TB advocates will also use the GOK funding targets by TB cost category in their advocacy efforts to ensure that the program is adequately funded.

Action #2: Establish a Budget Advocacy Task Team within the NTLD-P. Acknowledging the absence of a resource mobilization unit or staff within NTLD-P, the formation of the Budget Advocacy Task Team (BATT) will enable meaningful collaboration between the NTLD-P's advocacy officer, two finance officers, other relevant NTLD-P staff, and civil society to set and operationalize a strong resource mobilization agenda targeting national-level budgetary decision-makers with influence over the GOK discretionary budget. The advocacy officer will be responsible for conducting a political economy mapping to understand which budgetary decision-makers require urgent advocacy during the annual budgeting process, the messages that would resonate best with those decision-makers, and the financial evidence needed to fashion these advocacy messages. The finance officers, in turn, would be responsible for generating the financial evidence required to formulate these messages. BATT members will receive training and mentorship from technical partners to understand the national budget process, enhance political navigation skills, and convert financial analytical output into simple advocacy messaging. These training and mentorship efforts should draw from the training modules to be developed for the county-level TB Planning & Budgeting Capacity Building Plan (see Action #5).

Action #3: Formulate a medium-term advocacy plan with a view to shifting GOK budgetary decision-makers' perception of TB as a donor-funded program. Annual budget advocacy efforts led by the BATT in Action #2 will be hampered by the pervasive view that TB should remain a predominately donor-funded program due to the absence of a clear TB financial transition timeline and the urgent need to fund areas of the health system that lack external financial support. As part of its resource mobilization agenda described above, the BATT will consult with TB financial partners to ascertain when financial transition for certain elements or certain proportions of the TB

response may start. Next, the BATT will use these inputs to chart the GOK's annual TB financing trajectory that will be required to prepare the country for transition by this point in the future. The BATT will sensitize budgetary decision-makers on the GOK's annual resource requirements along this trajectory, so that the latter are more amenable when presented later on with proposed increases in the TB budget during the annual budget process.

County-level Resource Mobilization

The NSP 2023/24-2027/28 provides for the development of five-year county strategic operational frameworks (CSOFs) for TB, Leprosy, and Lung Disease (NTLD-P 2023a). CSOFs are intended to ensure smooth implementation of the NSP at the county level and elevate the status of TB in each county integrated development plan, which stipulate the five-year development priorities of each county (*Ibid*).

An NTLD-P-led county-level TB planning and budgeting assessment revealed that county-level budgetary decision-makers generally believe that TB should remain a predominately donor-funded program for the same reasons described in the section above (NTLD-P 2023b). While TB coordinators are responsible for resource mobilization for TB activities, none of the five TB coordinators interviewed as part of this assessment received training on the county budget and planning process, nor in evidence-based planning and advocacy, resource mobilization, or resource tracking (*Ibid*). To address these gaps, in 2023, NTLD-P convened a workshop supported by USAID's Health Systems for Tuberculosis (HS4TB) project to draft a TB resource tracking tool, and reach consensus on key aspects of a county-level TB planning and budgeting capacity building plan (PBCBP).

Action #4: Cost county strategic operational frameworks and develop resource mobilization plans. TB coordinators will estimate resource requirements by TB cost category (see the Investment Plan section of this document for the list of TB cost categories) for the five-year CSOF. Guided by the BATT, TB coordinators will lead development of five-year resource mobilization plans (RMPs) designed to generate financial resources from county governments' discretionary budgets, county-level special purpose accounts, GOK, national-county co-financing arrangements, private sector entities, donors, and other sources as relevant (see other SIs for more information on these funding sources) so that CSOFs are adequately funded. Through the TB resource tracking tool mentioned earlier, TB coordinators will monitor performance against RMP financing targets.

Action #5: Implement a county-level TB Planning & Budgeting Capacity Building Plan and increase annual county government disbursements for TB. The implementation of the PBCBP (the plan developed in 2023, as noted in the introductory text above) will take place in three phases, with the first two phases including 5-10 counties and 15-25 counties respectively, and phase three a nationwide, ongoing scale-up. Target participants will be TB coordinators, with other CDOH officials invited to participate in trainings, progress meetings, and technical support sessions in order to support TB coordinators in their planning and budgeting efforts. NTLD-P will oversee smooth implementation of each PBCBP phase via a blend of in-person and virtual supportive supervision. Through the PBCBP, participants will be trained on the following modules: Planning and Budgeting Processes; Priority Setting; Resource Tracking; and Budget Advocacy & Resource Mobilization. Trained participants will use these skills to ensure timely and adequate disbursements to TB from county governments' discretionary budgets.

Action #6: Formulate and implement medium-term advocacy plans with a view to shifting county-level budgetary decision-makers' perception of TB as a donor-funded program. These plans will be developed for the same reasons mentioned in Action #3 in the previous section. Similar to Action #3, TB coordinators will consult donor focal points assigned to their respective counties to learn when partial financial transitions may start in their county, and use these inputs to chart the required county government TB financing trajectory leading up to the possible transition events. Medium-term advocacy plans will be captured in each county RMP. These plans will include activities to sensitize budgetary decision-makers in broader advocacy events on this required county government TB financing trajectory so that they are primed to respond favorably to proposed increases in TB allocations from county government during annual budget negotiations. TB coordinators and county-level TB stakeholder forum members will be responsible for implementing the advocacy activities in this plan. TB coordinators and forum members will benefit from being oriented on the PBCBP Budget Advocacy & Resource Mobilization training module.

SI 2. INTEGRATE TB SERVICES INTO SOCIAL PROTECTION SCHEMES

The GOK established a UHC Technical Working Group (UHCTWG) to initiate work on the design of the list of services and activities reimbursed under SHA, a process which the SHA will continue once it is is formed. The draft list covers 16 health interventions, within which are a number of broad service categories (GOK 2023b).

Action #1: Ensure the inclusion of human resource costs for TB diagnosis and clinical care, and activity costs for TB screening and TB public health activities, in the list of services and activities reimbursed by SHA. With sufficient advocacy, NTLD-P can ensure that (a) the cost of human resources for TB diagnosis and clinical care, (b) the facility-based costs for TB screening (e.g. chest X-ray), and (c) TB public health activities (e.g. active case finding and contact investigation) are reimbursed by the SHA funds. Table 2 below illustrates the draft service categories where NTLD-P should advocate for these inclusions. Some of these categories use qualifiers such as "basic" and "basic essential" which could disqualify certain TB services and activities for inclusion if they are not explicitly associated with these qualifiers. See further discussion on the nuances of this in the Investment Plan section of this document.

According to a key informant in the UHCTWG, services will be included in the SHA list based on their fulfilment of 12 criteria, including disease prevalence and incidence, population at risk, cost of care, access to interventions, and alignment with the government's health sector priorities. NTLD-P will consolidate and present information on these indicators to the SHA to convince the latter to integrate the aforementioned TB services and activities into the SHA list, before the list is finalized during FY2023/24.

Table 2. Draft SHA Service Categories for TB Service Integration[2]

Legend

The NSP Implementation Taskforce will advocate for the inclusion of certain TB services and activities in the SHA list. To do this, the taskforce should first identify which service categories would be suitable for including which TB services and activities. The purpose of this table is to equip the taskforce with the drafted (not final) service categories under which given TB services or activities could be included, with sufficient advocacy. Clauses are colored as follows to signal which TB services or activities could be included under which service categories and health interventions:

TB clinical care || *TB diagnostics* || *TB public health activities*

Health Intervention[3]	Relevant Draft Service Categories
Community-based Preventive and Promotive Services	• **Public health services** such as water, sanitation, and hygiene (WASH), food safety, pollution management, etc. • Basic **screening services** and **outreach services** • **Reimbursements for community health volunteers**
Facility-based Promotive, Preventive, Treatment, Rehabilitative, and Palliative Services	• Medical outpatient services including, acute infections, basic **laboratory investigations**, immunization, outpatient procedures, reproductive health, ante and postnatal services; acute medical admissions • Cervical cancer screening and basic **screening tests** • Specialized **screening services** including prostate, breast, and bowel cancers
Outpatient Services	• **Consultation** (general and specialized) • Basic essential **laboratory investigations** • Basic **imaging (X-rays**, U/S, ECG)
Inpatient Services	• **Consultations** • Basic essential **diagnostic/investigative laboratory tests** • Basic **imaging (x-rays**, U/S)

[2] The text in this table was copied nearly verbatim from GOK 2023b given the importance of capturing the precise language used. The word "Services" was added to "Outpatient" in the Health Intervention column. Besides that, minor grammatical changes were made.

[3] For some Health Interventions the draft service categories had limited or no direct relevance to TB; these Health Interventions were not captured in this table. These are: Critical Care Services, Radiological/Medical Imaging Services [those more complex than chest Xray, such as MRIs] Oncology Services, Renal Dialysis Services, Surgical Package, Emergency Evacuation Services, Mental & Behavioural Health Services, Rehabilitative Services, Assistive Devices, Oral Health Services, Eye Health Services, and Overseas Treatment.

Source: GOK 2023b

Action #2: Monitor actual and projected revenues for the SHA funds to inform whether the funds should become the domestic financing source for TB drug and diagnostics procurement as donor transition approaches. Commodity costs accounted for nearly one-third (32 percent) of the NSP 2019-2023 resource requirement[4] (NTLD-P 2019). Donors and the national treasury have been the primary funding sources for both TB commodity procurement (including the procurement of TB drugs), TB rapid diagnostic machines like GeneXpert and Truenat, and the associated diagnostic cartridges and reagents for these rapid tests. These are high-cost budget items which the SHA will most likely exclude from the list of services and activities reimbursed under SHA in the near to medium term.

However, these items will require a reliable domestic funding source as donor transition approaches. The preparation and process for transition will likely be gradual and take considerable time based on the amount of funding involved and the complexities around procurement and supply chain issues. Discretionary budgets at national and county levels are not considered reliable domestic funding sources for TB drug and diagnostics procurement, given overlapping donor transition timeframes and the many competing demands from health and non-health sectors on limited funds. In contrast, the SHA funds are projected to mobilize KES 232 billion annually, 58 times the expected annual funding for the NSP (KES 4 billion) and 1.06 times recent annual government health expenditure (GoK 2023b, World Bank 2023).

For the longer-term funding sources for TB drugs and diagnostic procurement, the NSP Implementation Taskforce will therefore consider the SHA funds or the special purpose accounts (SPAs; these also have high resource mobilization potential and are described in further detail below in SI 3). These decisions will need to be reached in coordination with other transitioning disease programs. Additional rationale regarding the suitability of these financing mechanisms to fund these costs in the long term is provided in the Investment Plan section of this document. The taskforce will track actual and projected revenues for the SHA funds vs. the SPAs and their co-financing arrangement to inform a decision on which of the two will fund these procurement items. This decision will be made by FY2027/28, the end of the implementation period for this TB Financing Roadmap.

SI 3. RING-FENCE DOMESTIC FINANCING FOR DISEASE PROGRAMS INCLUDING TB VIA EARMARKS AND CO-FINANCING MECHANISMS

As mentioned in the previous section, there are generally competing demands on limited government financial resources at both national and county levels. As a result, discretionary budgets approved by treasuries and legislatures at both levels often fall below budgets proposed by line ministries and departments, and the process of sub-dividing this reduced budget to multiple competing demands can result in some areas being particularly badly neglected and under-funded. To partially overcome this challenge, the treasury-approved funds can be earmarked for certain spending purposes to ensure at least a minimum level of spending on those purposes. During budget implementation, national and county treasuries prioritize disbursements for earmarked spending purposes over discretionary ones.

[4] The same estimate for the NSP 2023/24-2027/28 does not yet exist.

In 2015 and 2019, MOH and the national treasury discussed the establishment of an HIV Fund resourced by a GOK earmark. By the time the national treasury was approached with these proposals, they had already received requests from stakeholders to establish similar funds for neglected tropical diseases, malaria, and the agricultural sector. Representatives from the national treasury are very resistant to establishing such funds because they require approval from both parliament and the cabinet, making them politically challenging to create. Instead, Treasury prefers earmarking GOK resources for such purposes as strategic interventions, which only include approval from the cabinet. GoK recently established a strategic intervention for blood transfusions, which has been successful.

The proliferation of health earmarks proposed for the SHA funds makes it unlikely that the MOH, treasury, and the rest of the cabinet would endorse yet another earmark specifically for a disease program, even if the earmark was being proposed as a strategic intervention rather than as another fund. It will be more politically acceptable for NTLD-P to advocate for the inclusion of TB services and activities in the list of those covered under SHA, to align NTLD-P with the broader UHC agenda around service integration.

Health earmarks at the county level have also been identified as a key potential source of domestic financial resources. The HSTR calls for a 10 percent earmark of county governments' general budgets, additional to existing discretionary health budgets, allocated to "key strategic programs" including TB[5] (MOH 2022a). Similarly, as mentioned in the Health Financing Landscape section of this Roadmap, the KHFS includes the establishment of health earmarks at the county level as one of its key interventions. Precedents do exist: some county governments have facility improvement funds, which are earmarked revenues for health facility upgrades. Also in Tana River county there is a Disaster & Risk Management Fund, which is resourced by a 2 percent earmark of the annual general county budget to cover urgent natural disaster costs.

Budgeted or executed funding to earmarked line items sometimes falls below earmarked funding in practice. Co-financing, an arrangement by which two payers both contribute earmarked funds to the same spending purpose, can incentivize a given payer who is at risk of failing to mobilize the agreed funds to do so. Co-financing arrangements can be designed in such a way that a government payer can only access the counterpart funding once it meets its financial commitment, thereby incentivizing full payment of the earmarked obligation. Matching funds are a common type of co-financing arrangement where the matching payer contributes an incremental amount per amount contributed by the target payer (such as a KES 2 match for every KES 1 invested).

Given the proliferation of national government health earmarks proposed under for the SHA funds, it is not advisable to pursue an additional national-level earmark for TB (unless it is intended to catalyze county government contributions via a co-financing arrangement). In contrast, as the HSTR lays out explicit plans to establish an earmark for TB and other priority services at the county government level, there is an opportunity to pilot and scale earmarks for TB and other priority disease programs in county government budgets. A co-financing arrangement in which a counterpart funder, such as the national government, catalyzes county allocations to this earmark is worth exploring.

[5] In the HSTR, several examples of "key strategic programs" are identified when discussing the county government earmark. While this particular list of examples does not include TB, TB is identified as one of such programs elsewhere in the document.

While NTLD-P's assessment of co-financing arrangements in Kenya's health sector did not yield clear examples in which national and county governments were two of the payers, the Danish International Development Agency (DANIDA) introduced a co-financing arrangement in Busia, Nairobi, and Turkana county governments to support general operational costs in level 1, 2, and 3 facilities in those counties. Under this arrangement, DANIDA and the recipient county government covered 80 percent and 20 percent respectively, during the first year of implementing the arrangement. On an annual basis, the county government share increased by five percent. A key informant from Nairobi reported that the county government was unable to meet its co-financing obligation the year in which the county share increased to 25 percent, when the county government only allocated 19 percent due to a decreased overall health budget. Busia county government failed to meet its commitment the year its share rose to 50 percent; the co-financed sum for Busia was KES 17.1 million that year.

Action #1. Establish special purpose accounts at the county government level to support transitioning disease programs and realize the KHFS and HSTR vision to ring-fence county-level funds for health. According to key informants within both national and county government, an earmark supporting multiple health programs is likely to be more successful than a TB-specific earmark. An earmark dedicated a specific disease program is likely to cause fragmentation and limit county treasuries' autonomy to allocate revenues, and would therefore be likely to meet significant resistance in county treasuries and county assemblies. In contrast, a county-level earmark aligned with the HSTR vision to urgently mobilize domestic resources to transitioning disease programs, including TB, is likely to be more politically acceptable. NTLD-P will coordinate with the National Malaria Control Programme (NASCOP), and other transitioning disease programs to establish a subcommittee within the National Inter-agency Coordinating Committee on Healthcare Financing (ICC-HCF) to steer the agenda for earmarked SPAs. The subcommittee will formulate a template county-level regulatory framework for CDOHs to tailor as needed to specific county contexts to ensure smooth approval of the framework in each county government. Further, the subcommittee will identify county governments likely to be more favorable to the SPA, such as wealthier counties with high disease burdens and prospects for expanding fiscal space for health, to pilot the earmark in a few such counties. Finally, the subcommittee and county governments adopting the SPA will jointly draft a memorandum of understanding to clearly articulate which cost categories the SPA vs. discretionary county government budgets will support to avoid the displacement of discretionary funds already allocated to TB and other transitioning programs at the county level.

Action #2. Introduce and scale a co-financing arrangement for the county-level special purpose account for transitioning disease programs. To increase the chances that prescribed funds are allocated and disbursed to the transitioning disease programs financed through the SPAs during budget implementation, the ICC-HCF SPA subcommittee will establish a co-financing arrangement between one or more national government funding sources and participating county governments. The subcommittee will formulate a menu of different co-financing options, including the progressive co-financing example introduced by DANIDA as well as a matching fund arrangement, and include the advantages and disadvantages of each option. The subcommittee will then vet these co-financing options with potential national government payers to gauge interest, willingness and ability to pay for different co-financing rates per year. For instance, the subcommittee will approach the SHA to gauge their willingness to earmark a standard proportion of annual income from each of the SHA funds

to subsidize the co-financing arrangement's counterpart fund. This would contribute to each of the three funds' objectives to support primary healthcare, reduce the burden of chronic disease, and provide financial risk protection against health expenditures across the Kenyan population. The national treasury would be similarly approached to ascertain acceptable co-financing rates that could be supported by a strategic intervention line item in the national budget specific for the transitioning disease programs. Additionally, the subcommittee will convene national treasury and members of Parliament to agree on a suitable legal and regulatory framework to establish, monitor, and audit the national-county co-financing arrangement, catalyzing county government funding through the SPA.

SI 4. SUPPLEMENT GOVERNMENT FUNDING FOR TB WITH PRIVATE SECTOR CONTRIBUTIONS

The MOH and NTLD-P developed a TB Public-Private Mix (PPM) Action Plan 2021-2023, which introduces service delivery models intended to promote enhanced involvement of the private sector in providing TB services (MOH & NTLD-P 2022). The PPM Action Plan focuses primarily on ways to involve private clinical providers. In addition, the plan introduces the workplace model which constitutes a possible pathway towards mobilizing additional domestic financial resources to NSP strategic objectives. TB circulates rapidly in crowded working conditions, causing productivity losses due to illness. Companies facing such challenges can invest in TB prevention and care to both improve employee well-being and generate a return on investment. Under the workplace model, companies invest directly in improving employees' access to TB services at their place of work.

Action: Develop and implement a suitable financing arrangement for the PPM workplace model. NTLD-P will coordinate with CDOH, workplace associates, and implementing partners to identify three to five Kenya-registered companies with employees at high risk of TB infection for a workplace model financing pilot. Once these companies are identified, NTLD-P will engage them to co-develop mutually suitable financing arrangements that would articulate which services would be provided. NTLD-P will then pilot the workplace financing arrangements at these companies. Based on the results of the pilot, NTLD-P will draft workplace model financing guidelines stipulating the specific services that will be financed as a function of different situations. Following the dissemination of these guidelines, NTLD-P will scale the workplace model and its accompanying financing arrangement to a larger set of companies.

SI 5. INCREASE EFFICIENCY OF GOVERNMENT TB EXPENDITURES THROUGH CONTRACTING OF SELECTED TB SERVICES TO PRIVATE ORGANIZATIONS

Mobilizing additional financial resources will allow NTLD-P to cover underfinanced aspects of the TB response, as well as those for which donor funding is slated to decline. However, generating additional funding alone will likely be insufficient to adequately finance these transitioning activities. Efficiency gains in TB program operations can stretch limited domestic resources across more activities. Under NSP Strategic Intervention 6.4.2., *Ensure optimal and sustainable financing for TB, Leprosy, and Lung Disease that is efficiently utilized*, NTLD-P recognizes that contracting TB services to the private sector can result in improved utilization of limited government financial resources. NTLD-Palso acknowledges the need to

transition from donor-run to government-run TB service contracts as external financial support for the former declines (NTLD-P 2023a). A thorough scan of government-run service contracts did not yield any examples of such contracts for TB, which represents a missed opportunity to spend domestic TB funds more efficiently.

Action: Establish government-run TB service contracting with private organizations (both for-profit and not-for-profit). NTLD-P should begin by conducting an assessment to understand the government's readiness, capacity, and willingness to contract TB services; uncover regulatory and technical issues experienced to-date on government-run health service contracts; and assess potential contractors' willingness and capacity to implement contracted TB services. Based on the findings of this assessment, NTLD-P will formulate a plan to build the capacity of MOH and county governments, as well as its own capacity, to conduct TB service contracting. Finally, NTLD-P will develop and implement a costed action plan to pilot and scale government-run TB service contracting.

INVESTMENT PLAN

The SIs describe the funding sources that will contribute towards the NSP resource requirement, but do not specify which TB cost categories each funding source will support. Broadly, these cost categories include commodities (both drugs and diagnostics), human resources (both clinical, including facility-based TB clinical activities, and public health), public health activities (prevention, active case finding, and private provider engagement), and program management (supervision, monitoring and evaluation [M&E], and training). See below for further details.

As Kenya's health financing landscape evolves and additional domestic funding sources are created to transition the sector from donor funding, it is critical to have an organized investment plan to reduce duplication and maximize allocative efficiency of the various funding streams for the various cost categories. The funding responsibilities in the investment plan will be monitored and, if necessary, revisited over the course of the TB Financing Roadmap implementation period.

The outputs from the county-level TB Resource Tracking Tool, described in SI 1, will be used to facilitate this process of monitoring allocations and disbursements during the TB Financing Roadmap implementation period. To effectively compare between the funding responsibilities in the investment plan and TB Resource Tracking Tool outputs, the investment plan's cost categories must be compatible with the TB programmatic categories of the TB Resource Tracking Tool. Table 3 below displays the TB Resource Tracking Tool cost categories which correspond to the investment plan categories. As depicted in the table, certain categories are in this investment plan but not in the county-level tool, because county governments are either not currently funding them (TB drug procurement), or are funding them through line items outside of the county TB budget (TB clinical staff salaries and facility-based TB clinical activities, and TB public health staff salaries).

Table 3. Investment Plan Cost Categories and Corresponding TB Resource Tracking Tool Categories

Investment Plan Cost Categories	Corresponding TB Resource Tracking Tool Cost Categories
TB drug procurement	*Not tracked*
TB diagnostics procurement	"TB diagnostics procurement"
TB clinical staff salaries and facility-based TB clinical activities	*Not tracked*
TB public health staff salaries	*Not tracked*
TB public health activities	"TB prevention", "Active case finding", "Public-private mix", "Other field activities"
Supportive supervision, M&E, review meetings	"Supportive supervision, M&E, review meetings"
Trainings and mentorship	"Trainings and mentorship"

The investment plan, displayed in Table 4, illustrates the current distribution of TB funding across each TB cost category and charts the target category-source distribution by the end of the current NSP (FY2027/28) as well as by the end of the subsequent NSP (FY2032/33). The baseline distribution of TB contributions is captured in the white cells of Table 4. The green cells in Table 4 denote cases in which the NSP Implementation Taskforce will seek to mobilize new funding for the given TB cost category by FY2027/28 (dark green) or by FY2032/33 (light green). The red cells in Table 4 denote cases where contributions exist at baseline but are expected to become insignificant by FY2027/28 (dark red) or by FY2032/33 (light red). The taskforce will seek to shift funding responsibility for TB drug and diagnostics procurement from government discretionary budgets to (a) the SPAs and their co-financing arrangement *or* (b) the SHA funds by FY2032/33 (more details are provided on this in the "TB drug and diagnostics procurement" bullet further down in this section). The corresponding cells are therefore colored in light yellow for this special case. The 10-year distribution is included as it is important for the taskforce to prepare for significant longer-term opportunities occurring beyond the lifetime of the current NSP, namely the financing of TB drug and diagnostics procurement.

Once the follow-on to the NSP resource mapping exercise is completed (see Action #1 in SI 1 under National-level Resource Mobilization), the qualitative investment plan will evolve to include quantified NSP investment targets by source and programmatic category. In cases where there are multiple funding sources for a given TB cost category, the taskforce will convene actors responsible for managing those funding sources to agree on a financing framework (i.e. which sub-categories are covered by source A vs. source B). This will reduce displacement of funding and ensure funding is additive, especially in cases where a new funding source begins contributing to a cost category already covered by another one.

At baseline, discretionary government budgets and donors are funding most of the TB cost categories. The SHA funds as well as the SPAs and their accompanying co-financing arrangement have not yet been established so are not yet contributing. There is no column for NHIF because it is being replaced by the three SHA funds.

Funding responsibilities across TB cost categories are expected to evolve as follows over the medium- and long-term:

- **TB drug procurement:** The procurement of TB drugs (including first- and second-line drugs) is a significant expense for a TB program. Donor contributions to this expense may decrease by FY2032/33, so domestic funding sources will need to gradually assume an increasing share of the financial responsibility for this area of the national TB response. The GOK discretionary budget has been the primary domestic funding source for TB drug procurement. With overlapping health commodity transition timeframes and the many competing demands from health and non-health sectors on limited funds, the GOK discretionary budget is not a reliable domestic funding source for TB drug procurement as donor transition approaches. The SPAs and their accompanying co-financing arrangement or the SHA funds would be more suitable funding sources. The rationale for this is described in the bullets below.

  Once these mechanisms are established, the taskforce will monitor revenue projections for (a) the SPAs and their accompanying co-financing arrangement and (b) the SHA funds to ascertain which would be a more suitable funding source for TB drug procurement. The taskforce will decide whether they will shift funding responsibility from government discretionary budgets for TB drug procurement to (a) vs. (b) by FY2027/28 and advocate for this transition to begin before FY2032/33, contingent on TB donor transition timeframes. Given this uncertainty, the corresponding cells are colored in light yellow instead of light green.

  - ***SPAs and their accompanying co-financing arrangement***. These mechanisms would draw their revenues from funding streams earmarked specifically for transitioning disease programs, and therefore would not be under the same level of budgetary pressure as the GOK discretionary budget. In addition, these funding sources have high resource mobilization potential. Finally, the HSTR views health commodities as the priority area to transition from donor to domestic funding, including via earmarked county government-level financing arrangements such as the SPAs (MOH 2022a).

  - ***SHA funds.*** Similar to the SPAs and their accompanying co-financing arrangement, the SHA funds will also draw revenues from earmarked funding sources and have the potential to mobilize a large volume of financial resources. However, as is the case for social health insurance schemes in other high TB burden countries, SHA is not expected to be willing to finance TB drug procurement costs before FY2027/28 or even by FY2032/33. This is because these costs are currently financed vertically, are a high-cost item, predominately funded by donors. The aim of the SHA is to begin with a modest list of reimbursed services and activities (excluding procurement costs of vertically-funded, donor-reliant programs like TB) and gradually add more services and activities as the SHA funds grow. This vision has been referred to elsewhere as a "progressive

realization" of Kenya's path to UHC (Chi & Regan 2021). Therefore, while integrating the costs of TB drug procurement into the SHA list will not be feasible in the near to medium term, the taskforce can advocate for their gradual inclusion in the longer term (i.e. between FY2027/28 and FY2032/33) under this "progressive realization" argument, contingent on the SHA funds' ambitious revenue projections being realized.

- **TB diagnostics procurement:** Rapid molecular diagnostics for TB (e.g., GeneXpert and Truenat machines, cartridges and reagents) are another significant expense for a TB program. Donors will cover much of the funding for this category into the long term as well. A transition similar to the one mentioned in the TB drug procurement bullet above is envisaged here, under the same rationale.

- **TB clinical staff salaries and facility-based TB screening and clinical activities:** Discretionary budgets at national and county levels will remain important funding sources for TB clinical staff salaries through regular facility payments to GOK and county government-run public facilities. In the medium term, the SHA funds will cover staff time and facility-based activities spent on TB screening, diagnosis, and clinical care. NTLD-P should advocate for SHA payment arrangements that are specific to TB, cover the costs of using pre-diagnostic screening tools such as chest X-ray, and incentivize (i) the use of rapid molecular diagnostics and (ii) the completion of treatment. Private companies should also cover these services under the workplace model discussed in SI 4.

- **TB public health staff salaries:** Discretionary budgets at both national and county government levels will continue to fund this category into the long term. Funding responsibility for this category will not transition to the SPAs and their co-financing arrangement nor to the SHA funds as these salaries are funded through human resources line items outside of health sector budgets.

- **TB public health activities:** It is crucial for a TB program to have robust and dedicated financing for TB public health functions or activities. These include three categories of activities that are based primarily in the community or outside of public facilities: (i) prevention activities such as contact investigation and TB preventive treatment (which may be implemented along with community-based treatment adherence support); (ii) active case finding including the use of chest X-ray and other screening and diagnostic tools outside of health facilities; and (iii) the engagement of private healthcare providers via public-private mix (PPM) schemes.

  When a health system is supported by line-item budgets, clinical staff may be expected to include some amount of these various public health activities in their daily work. But such expectations of a dual clinical-public health workload are often lost in the transition to insurance systems (which tend to emphasize clinical outcomes and clinical payments to the exclusion of public health work). As this change proceeds and donors transition, a country may therefore be left without clear financing and dedicated human resources for TB public health work.

  Such TB public health work may be implemented by either public sector or private sector workforces but, either way, it requires an activity budget for transport, per diems, community

events, communication materials, and commodities. In the future, budgets for these costs should be set aside by national and (via SPAs) county governments: either for direct implementation by government staff or, as mentioned in SI 5, via contracting these TB services to private organizations in the medium term. Government-funded contracting at both national and county government levels will be critical for replacing donor funding for such initiatives, which is slated to eventually decline. Additionally, the draft service categories to be reimbursed by the SHA funds, especially the PHF, provide promising entry points for including costs of TB public health activities, as described in SI 2. Funding these activities through so many sources simultaneously (discretionary budgets, SPAs and their co-financing arrangement, and the SHA funds) may be overly complex so, as with assigning the funding source for TB commodities, some monitoring of the situation and a future decision process will be needed.

- **Supportive supervision, M&E and review meetings:** NTLD-P will remain responsible for supportive supervision for county-level TB coordinators and the GOK discretionary budget will remain a key funding source for such activities. To ensure that county government contributions are adequate to meet rising cost requirements for these activities at the county level, funding responsibility will shift from discretionary funding to the earmarked SPAs.

- **Trainings and mentorship:** Similar to the nationally led TB supportive supervision activities described in the previous bullet, NTLD-P will remain responsible for trainings and mentorship activities targeting county-level TB coordinators as well. For this reason, the GOK discretionary budget will remain a key funding source for these activities also. According to a key informant, donor support to trainings and mentorship will "definitely" end by FY2032/33. Given this, and the need to meet rising cost requirements for these activities, funding responsibility for trainings and mentorship will shift from discretionary funding to the earmarked SPAs.

Table 4. NSP Investment Plan: Baseline, Targeted Medium-term, and Targeted Long-term Distribution of TB Contributions across Funding Sources and Cost Categories

	Donors	GOK Discretionary Budget	County Government Discretionary Budgets	SPAs & Co-financing	SHA Funds	Private Companies
TB drug procurement	x	x		x	x	
TB diagnostics procurement	x	x	x	x	x	
TB clinical staff salaries and facility-based TB clinical activities	x	x	x		x	x
TB public health staff salaries		x	x			
TB public health activities	x	x	x	x	x	
Supportive supervision, M&E, review meetings	x	x	x	x		
Trainings and mentorship	x	x	x	x		

The baseline distribution of TB contributions is captured in the white cells of Table 4 above. The green cells denote cases in which the NSP Implementation Taskforce will seek to mobilize new funding for the given TB cost category by FY2027/28 (dark green) or by FY2032/33 (light green). The red cells denote cases where contributions exist at baseline but are expected to become insignificant by FY2027/28 (dark red) or by FY2032/33 (light red).

IMPLEMENTATION ARRANGEMENTS

Participation from several multisectoral and sectoral working groups at both national and county levels will be required to facilitate smooth implementation of the TB Financing Roadmap. These groups are summarized below:

- **TB National Strategic Plan 2023/24-2027/28 Implementation Taskforce.** The taskforce is charged with overseeing rollout of the NSP strategic objectives and is responsible for ensuring that adequate resources are allocated to implement the NSP. The membership of the taskforce is to be determined as it is not specified in the NSP.
- **National TB Multisectoral Accountability Framework for TB Technical Working Group (MAFTWG)**. MAFTWG was formed in 2020 to coordinate a multisectoral response to ending TB in Kenya. MAFTWG meets monthly and is chaired by NTLD-P. Notable MAFTWG members include Kenya Health Federation, Council of Governors, Network of TB Champions, National Treasury of Kenya, and implementing partners. According to a key informant sitting on MAFTWG, TB financing is a major issue but does not receive the attention it deserves during MAFTWG meetings.
- **National Inter-agency Coordinating Committee on Healthcare Financing (ICC-HCF).** Established in 2007 and chaired by MOH, ICC-HCF was created to drive the health financing policy agenda in the country (HPP 2015). According to a key informant, ICC-HCF stopped meeting for years before it was revitalized in FY2018/19. However, as of January 2024, the ICC-HCF has stopped meeting and will again need to be revitalized. Among its members are MOH, other government institutions, implementing partners, private sector entities, research institutions, and nongovernmental organizations. Given the MOH Healthcare Financing Directorate's (HFD) mandate to develop, implement and review policies, frameworks, and legislation on healthcare financing, the HFD Director will be responsible for chairing the ICC-HCF once revitalized. The MOH's Acting Deputy Director General, under whom the HFD sits in the MOH, will be key for the revitalization of the ICC-HCF.
- **National Health Sector Working Group (NHSWG).** The NHSWG is composed of MOH representatives and convenes annually to draft the GOK Health Sector Working Group Report, which evaluates each disease program's past programmatic performance and sets medium-term priorities alongside a three-year financing plan for the sector. The three-year financing plan influences the amounts captured in the MOH's annual proposed budget. The NHSWG discusses TB financing challenges, such as reasons for delays in GOK disbursements for TB commodities (MOH 2022b).
- **County Health Sector Working Groups (CHSWGs).** The CHSWG is responsible for the county-level Health Sector Working Group Report, which covers the same information as that of the NHSWG report. The CHSWG is also charged with submitting budget proposals to the county treasury on behalf of the CDOH during the budget preparation stage of the budget process. Financing specifically for TB is typically not discussed during CHSWG meetings.
- **County TB Stakeholders' Forums.** TB stakeholders' forums serve as a platform for the county government and civil society to coordinate to address TB policy and programmatic issues. In some cases, stakeholders' forums discuss TB financing and advocate for increased budget allocations from county governments. Stakeholders' forums tend to meet quarterly and

are typically composed of the TB coordinator, sub-county representatives, CHMT, civil society organizations (CSOs), and other members.

As the NSP 2023/24-2027/28 Implementation Taskforce is responsible for securing funding for the NSP, it will also steer implementation of this TB Financing Roadmap (NTLD-P 2023a). To fulfill this mandate, among the taskforce's members shall be the NTLD-P's finance and advocacy officers, its M&E Unit, MOH health financing experts, CSOs, and technical partners focused on health and TB financing. The BATT will serve as an advocacy sub-team within the taskforce. The taskforce will be formed once the NSP is officially launched.

The taskforce will ensure that at least one of its members is also a member of the MAFTWG and ICC-HCF, once the latter is revitalized. Taskforce member(s) participating in MAFTWG and ICC-HCF meetings will be responsible for securing space in each meeting agenda to update these groups on the TB Financing Roadmap's implementation status and challenges, as well as motivating MAFTWG and ICC-HCF members to commit themselves to help address these identified implementation challenges. Conversely, taskforce members participating in MAFTWG and ICC-HCF will be expected to debrief the taskforce during its regular meetings regarding developments in broader agendas related to TB policy, health financing, and UHC that have bearing on given actions across the roadmap's SIs.

In advance of the preparation of the NHSWG report, the taskforce will be responsible for convening NHSWG members to sensitize them on annual funding needs to increase the likelihood that the GOK's annual TB resource requirement is captured in the 3-year NHSWG financing plan. Similarly, the taskforce will cascade national-level TB Financing Roadmap updates to TB coordinators to conduct the same annual sensitization efforts among CHSWG members.

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ANNEX: TB FINANCING ROADMAP IMPLEMENTATION TIMELINE

The table below illustrates the timeline for implementing the actions described in the Strategic Initiatives section of this document. The table also includes tentative priority levels for each action, which are subject to change as the TB financing landscape shifts over the course of the roadmap implementation period. The rationale for assigning priority levels is as follows:

- **SI 1. Mobilize Resources from Discretionary Government Budgets**. All actions are considered ***Top Priority***. The volume of resources expected from discretionary government budgets is high and will continue supporting all cost categories described in the Investment Plan section of this document (with funding responsibility for certain categories shifting to other sources in the medium and long term). Additionally, design and implementation challenges outside of the NSP Implementation Taskforce's direct control could (a) delay the establishment of the SHA funds and the SPAs and their co-financing arrangement and (b) affect the full and prompt flow of funds from these mechanisms to TB once these mechanisms are established. Therefore, it is possible that discretionary budgets will remain the main or sole domestic funding source for TB by FY2032/33. It will be important for the taskforce to not rely on the timely establishment of TB funds flow from these forthcoming mechanisms before FY2032/33. The taskforce will ensure sufficient focus on increasing the volume of discretionary government resources mobilized to TB at national and county levels.
- **SI 2. Integrate TB Services into Social Protection Schemes**. Integrating [a] the cost of human resources for TB diagnosis and clinical care, [b] the facility-based costs for TB screening (e.g., chest X-ray), and [c] TB public health activities into SHA (Action #1) is of ***Very High Priority***. SHA overall is expected to be a large source of health funding, and the NSP Implementation Taskforce is not expected to face serious resistance from the SHA in their efforts to advocate for the integration of these TB services and activities into the list of those reimbursed under SHA. However, these specific TB cost categories constitute just a fraction of the NSP cost requirement.
  Tracking SHA funds' revenues to inform a future decision around the gradual transition of TB drug and diagnostics procurement costs into SHA (Action #2) is of ***High Priority*** because, while it is critical to consider the decision early, it is not designed to mobilize resources during the roadmap implementation period itself.
- **SI 3. Ring-fence Domestic Financing for TB via Earmarks and Co-financing Mechanisms**. Both actions are considered ***High Priority***. While the SPAs and their co-financing arrangement have the potential to mobilize a large volume of domestic resources to TB, establishing and implementing these mechanisms may face significant political and regulatory obstacles. A trial of co-financing via donor funds may be considered as a possible starting point.
- **SI 4. Supplement Government Funding for TB with Private Sector Contributions**. This SI is of ***High Priority*** due to the relatively low volume of resources expected to be mobilized via the Workplace model's financing arrangement. However, this arrangement could play an important role in plugging financing gaps for certain TB interventions.

- **SI 5. Increase Efficiency of Government TB Expenditures through Contracting of Selected TB Services to Private Organizations**. This SI is considered ***Very High Priority***. It will be important for county governments and NTLD-P to begin testing different TB service contracting options before the end of the roadmap implementation period, so that these purchasers are prepared for the eventual transition of external funding for these contracts. However, the scale of TB service contracting by the end of the roadmap implementation period is expected to be relatively small.

Strategic Initiatives	Actions	Priority Level	Activities	Responsible	Financial Year				
					23/24	24/25	25/26	26/27	27/28
SI 1. Mobilize Resources from Discretionary Government Budgets	*National-level Actions*								
	Action #1: Complete NSP resource mapping exercise for all five years, covering all meaningful potential sources of funding and set and monitor resource mobilization targets by funding source and TB cost category	**Top**	Complete NSP resource mapping exercise for all five years, covering all meaningful potential sources of funding	NSP Implementation Taskforce					
			Set resource mobilization targets by funding source and TB cost category	NSP Implementation Taskforce					
			Monitor, and if necessary, revisit those funding responsibilities and targets	NSP Implementation Taskforce					
	Action #2: Establish a Budget Advocacy Task Team within the NTLD-P	**Top**	*N/A*	NSP Implementation Taskforce					
	Action #3: Formulate a medium-term advocacy plan with a view to shifting GOK budgetary decision-makers' perception of TB as a donor-funded program	**Top**	Consult with TB financial partners to ascertain when financial transition for TB may come	Budget Advocacy Task Team					
			Use these inputs to chart the GOK's annual TB financing trajectory that will be required to prepare the country for transition by this point in the future	Budget Advocacy Task Team					
			Sensitize budgetary decision-makers on the GOK's annual resource requirements along this trajectory	Budget Advocacy Task Team					

			Advocate for increases to TB financing from GOK during the budget process to keep the country on track with this trajectory	Budget Advocacy Task Team					
	County-level Actions								
	Action #4: Cost county strategic operational frameworks and develop resource mobilization plans	**Top**	Estimate resource requirements for CSOFs	TB coordinators					
			Develop Five-year Resource Mobilization Plans	TB coordinators					
			Monitor performance against RMP financing targets using the county-level TB Resource Tracking Tool	TB coordinators					
	Action #5: Implement a county-level TB Planning & Budgeting Capacity Building Plan and increase annual county government disbursements for TB	**Top**	Implement PBCBP Phase 1	NSP Implementation Taskforce					
			Implement PBCBP Phase 2	NSP Implementation Taskforce					
			Scale PBCBP training modules to remaining counties (Phase 3)	NSP Implementation Taskforce					
			Advocate for increases to TB financing from county governments during the budget process	TB coordinators					
	Action #6: Formulate medium-term advocacy plan with a view to shifting county-level budgetary decision-makers' perception of TB as a donor-funded program	**Top**	Consult with TB financial partners to ascertain when financial transition for certain aspects of the TB response may come	TB coordinators					
			Use these inputs to chart county governments' annual TB financing trajectory that will be required to prepare the country for transition by this point in the future	TB coordinators					

			Sensitize budgetary decision-makers on the county governments' annual resource requirements along this annual trajectory	TB coordinators					
SI 2. Integrate TB Services into Social Protection Schemes	**Action #1:** Ensure the inclusion of human resource costs for TB diagnosis and clinical care, and activity costs for TB screening and TB public health activities, in the list of services and activities reimbursed by SHA	**Very High**	Consolidate information on TB's performance on the SHA's 12 decision-making criteria used for including services and activities in the SHA list	NSP Implementation Taskforce					
			Present this information to the SHA and ensure the inclusion of human resource costs for TB diagnosis and clinical care, and activity costs for TB screening and TB public health activities, in the list of services and activities reimbursed by SHA	NSP Implementation Taskforce					
	Action #2: Monitor actual and projected revenues for the SHA funds to inform whether the funds should become the domestic financing source for TB drug and diagnostics procurement when donor transition approaches	**High**	*N/A*	NSP Implementation Taskforce					
SI 3. Ring-fence Domestic Financing for TB via Earmarks and Co-financing Mechanisms	**Action #1:** Establish special purpose accounts at the county government level to support transitioning disease programs, and realize the KHFS and HSTR vision to ring-fence county-level funds for health	**High**	Coordinate with NASCOP, the National Malaria Control Programme, and other transitioning disease programs to form a subcommittee within the National Inter-agency Coordinating Committee on Healthcare Financing (ICC-HCF) to steer the agenda for earmarked SPAs	NSP Implementation Taskforce					

			Formulate a template county-level legal framework for SPAs that CDOHs can tailor as needed to specific county contexts to ensure smooth approval of the framework in each county government	ICC-HCF Subcommittee on SPAs for Transitioning Disease Programs					
			Identify county governments likely to be more favorable to the SPA, such as wealthier counties with high disease burden and prospects for expanding fiscal space for health, to pilot the earmark in a few such counties	ICC-HCF Subcommittee					
			Draft a memorandum of understanding to clearly articulate which cost categories the SPA vs. discretionary county government budgets will support to avoid the displacement of discretionary funds already allocated to TB and other transitioning programs at the county level	ICC-HCF Subcommittee					
			Scale the SPA to additional counties	ICC-HCF Subcommittee					
	Action #2: Introduce and scale a co-financing arrangement for the county-level special purpose account for transitioning disease programs	**High**	Formulate a menu of different co-financing options and include the advantages and disadvantages of each option	ICC-HCF Subcommittee					

			Vet these co-financing options with potential national government payers to gauge interest and willingness & ability to pay for different co-financing rates per year	ICC-HCF Subcommittee					
			Convene national treasury and members of parliament to agree on a suitable legal and regulatory framework to establish, monitor, and audit the national-county co-financing arrangement catalyzing county government funding through the SPA	ICC-HCF Subcommittee					
			Introduce the co-financing arrangement in a few counties that already have SPAs for transitioning disease programs	ICC-HCF Subcommittee					
			Scale the co-financing arrangement to additional counties	ICC-HCF Subcommittee					
SI 4. Supplement Government Funding for TB with Private Sector Contributions	**Action:** Develop and implement a suitable financing arrangement for the PPM workplace model	**High**	Coordinate with CDOH, workplace associates, and implementing partners to identify three to five Kenya-registered companies with employees at high risk of TB infection for a workplace model financing pilot	NSP Implementation Taskforce					
			Pilot workplace financing arrangements at these companies	NSP Implementation Taskforce					
			Draft workplace model financing guidelines stipulating which services should be financed	NSP Implementation Taskforce					
			Disseminate the workplace model financing guidelines	NSP Implementation Taskforce					

			Scale the workplace model and its accompanying financing arrangement to a larger set of companies	NSP Implementation Taskforce					
SI 5. Increase Efficiency of Government TB Expenditures through Contracting of Selected TB Services to Private Organizations	**Action:** Establish government-run TB service contracting with private organizations (both for-profit and not-for-profit)	**Very High**	Conduct an assessment to understand the government's readiness, capacity, and willingness to contract TB services; uncover regulatory and technical issues experienced to-date on government-run health service contracts; and assess potential contractors' ability, willingness, and capacity to implement contracted TB services	NSP Implementation Taskforce					
			Formulate a plan to adjust the regulatory environment as needed and to build the capacity of MOH and county governments to conduct TB service contracting	NSP Implementation Taskforce					
			Develop and implement a costed action plan to pilot and scale government-run TB service contracting	NSP Implementation Taskforce					

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