A policy analysis from Kenya and 31 other countries.
Acknowledgements

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Author: Rachael Hore.

October 2019
Introduction

If UN member states committed at the UN High-Level Meeting on Universal Health Coverage (UHC) to “strengthen efforts to address communicable and noncommunicable diseases including HIV/AIDS, tuberculosis (TB), malaria and hepatitis as part of UHC and to ensure that the fragile gains are sustained and expanded by advancing comprehensive approaches and integrated service delivery and ensuring that no one is left behind.” This follows years of commitments, at the highest political levels, targeting the world’s biggest disease epidemics, including the UN High-Level Meeting on TB in 2016. While the move towards a more holistic approach to global health is welcome, it must build on, learn from, and protect the gains made against infectious diseases, especially for those most often left behind by health systems.

The agendas of ending TB and of achieving UHC are co-dependent. The World Health Organization (WHO) lays this out clearly in the 2019 Global TB Report: “the End TB Strategy milestones for 2020 and 2025 can only be achieved if TB diagnostic treatment and prevention services are provided within the context of progress towards UHC.” In addition, the required rates of decline in incidence and mortality rates of TB have only been achieved in the context of UHC, combined with social and economic development that reduces known risk factors for TB infection and disease.

This report aims to define what provision of TB services in “the context of progress towards UHC” looks like in practice, and to what extent the recognition of the co-dependency of achieving TB and UHC at international fora like the UN and WHO translates to action at ground level. It defines an essential set of services that would build all elements of UHC, each with a specific focus.

The agendas of ending TB and of achieving UHC are co-dependent. The World Health Organization (WHO) lays this out clearly in the 2019 Global TB Report: “the End TB Strategy milestones for 2020 and 2025 can only be achieved if TB diagnostic treatment and prevention services are provided within the context of progress towards UHC.” In addition, the required rates of decline in incidence and mortality rates of TB have only been achieved in the context of UHC, combined with social and economic development that reduces known risk factors for TB infection and disease.

World leaders committed to successfully diagnose and treat 40 million people with TB worldwide by 2022, including 1.5 million people with drug-resistant TB, with the ultimate aim of achieving the Sustainable Development Goal (SDG) target of ending the TB epidemic by 2030. Investment in people-centred services is fundamental to achieving this and in turn this could foster more accessible, available, acceptable and affordable health services for all. As such, TB services must apply the principles of UHC (that services should be people-centred) and UHC programmes must learn from and maintain specific elements of disease programmes that help to reach those most commonly left behind.

Global targets are only useful if they are adapted to local levels and prompt change if it is required to meet them. The Stop TB Partnership has calculated national-level targets based on the global UN High-Level Meeting on TB targets. However, there is a question mark over whether these national-level targets are communicated beyond high-level policy fora to reach the sub-national levels where the response is to be implemented. This report will not just look at whether countries have provisions in their policy documents to help reach all people with TB services, but also how these policies trickle down to implementation at all levels.

BACKGROUND TO THE SCORECARD AND CASE STUDIES

The report identifies 18 essential services that help to make TB services more available, affordable, acceptable, integrated and with other services. The 18 services have been put in a scorecard, and 32 of the TB burden countries’ TB policies have been analysed to see whether the services are included. In recognition of the differences between policy and implementation, the report will draw on examples from Kenya.

Kenya was chosen for more in-depth research firstly because it follows many global policy recommendations for TB; it recently revised its National Strategic Plan for TB, and has completed a national prevalence survey, a national patient cost survey and a legal environment assessment. It offers examples of how having the right policies in place can make a difference to programmes, as well as offering lessons learned on the challenges to implementation.

Secondly, the President of Kenya, Uhuru Kenyatta, has identified UHC as one of the “Big Four” agenda that he wants to achieve before the end of his time in office (2022). UHC is currently being piloted in four counties, selected due to a high prevalence of communicable and non-communicable diseases, high population density, high maternal mortality, and high incidence of road traffic injuries. Prior to this, there have been other efforts to expand health insurance initiatives, including the National Health Insurance Fund which is mandatory for the formal sector.

RECOMMENDATIONS

01 Measures to increase access to TB services must address the needs of people who are at increased risk of exposure to TB owing to where they live or work, as well as people who have limited access to services. Service delivery must be adapted according to these needs. In order to do this, community health workers must be adequately empowered and remunerated to provide TB services. Any decision making on TB policy should be consultative, including with civil society and communities, to ensure that it is sufficiently adapted to the specific needs of the population. This is relevant for implementation of national level policy, targets and survey findings, such as National Patient Cost surveys, National TB Prevalence surveys and Community, Rights and Gender Assessments. Consultation processes with sub-national committees should be facilitated and funded by national governments.

02 Social protection measures must address social determinants of health and vulnerabilities to out-of-pocket costs. In recognition of a majority of out-of-pocket TB costs relating to non-medical costs, social protection measures and National Insurance or UHC packages must include non-medical components of the TB response when considering what makes TB services “affordable.” Countries can better understand the main drivers of out-of-pocket costs by conducting a National Patient Cost Survey.

03 Integration of services must include co-morbidities as well as risk factors and side effects. Integration of TB services must go beyond service delivery level to reach out to people who are prevented from accessing services due to stigma (including self-stigma or others). Health systems must respond to people’s needs, rather than just the disease. People must be supported psychologically throughout treatment and afterwards to ensure that they mentally well enough to take their treatment for the required duration.

04 UHC programmes must ensure that roll-out of financial risk protection for health is matched with availability of quality services. Implementation of UHC programmes must be two-fold – measures to increase equity and strengthening of health systems to meet increased demand. Health systems must be equipped to provide quality and timely services and this relies on strong systems from procurement of commodities to distribution.

05 If donor financing currently supports social protection measures, governments must prioritise continuity of these services as donor relationships change. Many of the services across social protection measures and integration of services are largely, if not wholly, funded by external donors in many countries. Governments must work with donors to plan for the takeover of such services in a timely way that does not jeopardise continuity or scale-up of services.
<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>ACCESS</th>
<th>SOCIAL PROTECTION</th>
<th>INTEGRATION</th>
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<td></td>
<td>FINDING &amp; TREATING EVERYONE WITH TB</td>
<td>AVAILABILITY &amp; AFFORDABILITY OF TB SERVICES</td>
<td>INTEGRATION</td>
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<td></td>
<td>TB services are available to everyone (outside of health settings).</td>
<td>A National Patient Cost</td>
<td>Provisioned care and coverage supports</td>
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<tr>
<td></td>
<td>Community health workers are supported.</td>
<td>*non state</td>
<td>Integrate TB and NCD services integrated.</td>
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<td></td>
<td>TB prevention and screening services are supported.</td>
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Chapter 1: Access

Finding and Treating Everyone with TB

Tuberculosis and Universal* Health Coverage

SUMMARY OF SCORECARD FINDINGS

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>FINDING &amp; TREATING EVERYONE WITH TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB services are available in:</td>
<td>Community health workers who are supported to provide TB services.</td>
</tr>
<tr>
<td>tuberculosis and screening services are available for people in prisons.</td>
<td>Services are available to ensure people with disabilities can access TB services.</td>
</tr>
<tr>
<td>Provisions exist to ensure people with disabilities, migrants and refugees can access TB services.</td>
<td>TB services are accessible to homeless children.</td>
</tr>
<tr>
<td>% OF COUNTRIES THAT INCLUDE IT IN THEIR NATIONAL POLICY DOCUMENTS</td>
<td>66</td>
</tr>
</tbody>
</table>

KEY FINDINGS FROM THE SCORECARD:

01 Most countries include provisions in their policies to enable community health workers or volunteers to provide TB services. These services are often reliant on NGOs or CSOs for implementation. Community Health Volunteers (CHVs) often do not receive a salary; for example, in Kenya, any payment that CHVs receive is dependent on donor or county government initiatives rather than national policy.

02 Provisions to address high exposure to TB owing to where someone lives or works, such as in the mining sector, health sector and prisons, are more common than provisions to address barriers faced by people with limited access to services such as people with disabilities, migrants and refugees, and homeless people. Services for people with limited access are often reliant on support from external partners, for example, the International Organisation for Migration (IOM) for refugees.

03 There is a glaring lack of any mention of specific provisions to ensure that people with disabilities can access services. This might be because provisions for people with disabilities are included elsewhere, such as legal texts, but reference to such documents is missing from the TB policy documents and vice versa. For example, in India “The Rights of Persons with Disabilities Act” stipulates that health services must be accessible, but there is a lack of specific reference to TB in the Act, or conversely any reference to the Act in TB policy documents. In Sierra Leone, the National Strategic Plan references the National Commission for Persons with Disabilities and the Disability Act.

08 | TUBERCULOSIS AND UNIVERSAL* HEALTH COVERAGE

SUMMARY OF SCORECARD FINDINGS

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>FINDING &amp; TREATING EVERYONE WITH TB</th>
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<tr>
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</tr>
<tr>
<td>% OF COUNTRIES THAT INCLUDE IT IN THEIR NATIONAL POLICY DOCUMENTS</td>
<td>66</td>
</tr>
</tbody>
</table>

Tuberculosis and Universal* Health Coverage

Empowered community health workers are essential to help all people access services. However, despite exposing ourselves to deadly diseases, their work often does not result in any financial reward, so they are often called Community Health Volunteers (CHVs). In Kenya, only two counties are proposing to include CHVs on the payroll. In Kisumu, CHVs will receive 2,500 KES (approximately US $25) per month, but this is still set closer to the value of a stipend to cover their costs than a salary. However, along with the rest of the government-paid health workforce in Kisumu, CHVs have faced months without this payment due to delay of payments from the national level. CHWs roles are varied, from checking there is adequate clean water and sanitation in the household to testing for malaria, and they are expected to cover about 100 households per month.

For TB-specific interventions, such as contact tracing and tracing people who are lost to follow up (those who drop out of care). CHWs, supported by the Global Fund (through Amref Health Africa). For this work, the Global Fund remunerates them with 840 KES (around US $8.40) per person (with TB or contacts of people with TB) they visit. An important part of their role is on health education on topics including the importance of taking the correct doses of treatment for the recommended length of time, the importance of all contacts being tested for TB, and for children to start on isoniazid preventive therapy (IPT). CHWs are chosen by their communities and are therefore trusted by the communities they serve. This can be especially important for spreading awareness about the signs and symptoms of TB and the importance of getting a diagnosis and treatment, rather than self-medicating at a pharmacy or referring themselves to a herbal practitioner. They also help to address stigma around the disease within the community, dispelling myths and disseminating facts.
Boars (left) is a 22-year old cobbler in Kilala, Makueni, Kenya. He is pictured here with his community’s health volunteer Stanislaus who is attached to the Makueni County Referral Hospital. Stanislaus played a crucial role in Boars’ successful TB treatment because Boars’ community initially raised funds for him to access herbalist treatment, but someone else in the community was aware of Stanislaus’ work and reached out to him. Stanislaus recommended that Boars should access treatment at the public health centre and he was successfully cured of TB.

Boars still faced certain difficulties, for example the 300 KES (around US $3) cost for a round-trip to the health facility, and the difficulty of buying the food he was recommended to eat during treatment to help his recovery. He had to close his cobbler’s shop for 6 months.

ADDRESSING TB IN PRISONS

People in prisons are often at higher risk of TB due to overcrowding, low light levels, limited access to health services, malnutrition, alcohol and drug use, and comorbidities such as HIV. For example, in Brazil (with the third highest prison population in the world), 11% of people with TB are those deprived of liberty. Studies in Brazil show that targeted interventions within prisons could have a substantial effect on the broader TB epidemic. In recognition of this, the National TB Programme (Ministry of Health) and the Health Coordination of the National Penitentiary Department (Ministry of Justice) created a joint strategy for tackling the disease, including a health education campaign to raise awareness and facilitate early diagnosis and treatment in over 1,000 prisons housing over 700,000 people, as well as their visitors.

ADDRESSING TB IN WORKPLACES

Others might be vulnerable to TB owing to the nature of their work, such as those working in mines, manufacturing jobs, and health workers. Given that TB mostly affects adults in their most productive years, it is essential that TB services are available in workplaces.

In southern Africa, mining is a major driver of TB. Mines facilitate the spread of TB due to occupational hazards and social conditions such as high prevalence of silicosis (a lung disease caused by exposure to silica dust leading to scarring of the lungs), high temperatures and humidity in mine shafts, and crowded working and living conditions.

In South Africa, the TB rate among the mining workforce is 10 times the WHO threshold for a health emergency and nearly three times the incidence rate in the general population.

A multi-sectoral regional initiative, the Southern Africa TB in the Mining Sector Initiative (TIMS) aims to address this through establishing occupational health service centres, developing screening models for the specific context, conducting studies and conducting community systems strengthening. These initiatives are reflected in several National Strategic Plans analysed in this report, such as that of Lesotho, where activities include screening for all miners upon employment, periodically and at the end of the contract, as well as household contacts, and coordination with the Medical Bureau for Occupational Diseases and Compensation.

Healthcare workers, including nurses, physicians, laboratory workers and community health workers, are vulnerable to TB. Adequate prevention measures must be put in place for them, including testing, prevention and infection control. In Kenya, all healthcare workers are supposed to be screened for TB every 6 months. They are incentivised to do this because if they contract TB and have not had a test in the last 6 months, they are not eligible for compensation.

PEOPLE WITH DISABILITIES

Provisions to ensure that TB services are accessible for people with disabilities varies between countries. For example, in Kenya it is a requirement that all health facilities are made accessible to people with physical disabilities, such as wheelchair access and accessible toilet facilities. The Ugandan organisation MADIPHA has developed 21 recommendations for addressing disability in TB prevention, treatment, and care. This includes ways that attention to disability can be better integrated into TB programmes, and could provide a model for more explicitly linking TB guidelines with protections and entitlements for people with disabilities affected and infected by TB. TB services must also be accessible for people with intellectual disabilities and mental health problems which could prevent people accessing diagnosis or make it difficult for them to complete treatment.
Chapter 2: Affordability and availability

SUMMARY OF SCORECARD FINDINGS

<table>
<thead>
<tr>
<th>SOCIAL PROTECTION</th>
<th>A National Patient Cost Survey has been carried out/is underway/is scheduled to start in 2019 or 2020.</th>
<th>National Health Insurance policies exist and cover TB services.</th>
<th>Insurance provisions cover loss of income due to TB.</th>
<th>Nutritional support is available for people on TB treatment.</th>
<th>Financial support is available to cover transport costs for people with TB.</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDICATOR</td>
<td>% OF COUNTRIES THAT INCLUDE IT IN THEIR NATIONAL POLICY DOCUMENTS</td>
<td>63</td>
<td>47</td>
<td>34</td>
<td>84</td>
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</tbody>
</table>

KEY FINDINGS FROM THE SCORECARD:

01 Key social interventions, including nutrition supplements and support for transport costs are often limited in their scope, for example only for people with drug-resistant TB rather than all people with TB. Of countries providing nutrition support, this is limited to people with drug-resistant TB in a third of them. Of countries providing transport support, this is limited to people with drug-resistant TB in half of them.

02 Despite the existence in official policy of various social interventions, their implementation is dependent on health systems that can ensure their supply. For example, the delivery of nutrition supplements relies on national procurement and supply agencies to deliver them to where they are needed. In Kenya, health centres across the country have not received nutrition supplements for up to a year or have received supplements that are too close to their expiry date to be dispensed.

03 Nutrition and transport interventions are wholly funded by external donors in many of the plans analysed in the scorecard, meaning that their sustainability relies on governments taking up responsibility for them once donors withdraw funding. For example, in Namibia, both nutrition and transport support are listed in their National Strategic Plan up to 2022 as provided by the Global Fund. However, those activities are no longer being implemented due to a reduction in funding, and have not been taken up by the Ministry of Health.

Every year, almost 100 million people are pushed into extreme poverty by out-of-pocket healthcare expenses. TB is not only a consequence of poverty, but also a cause. This chapter will assess various social protection interventions, sometimes called “enablers,” that are essential to prevent such costs occurring. National Health Insurance schemes or UHC programmes help to address direct medical costs (consultation, diagnosis, medicines, etc.), but countries must also consider direct non-medical costs (e.g. transport, food) and indirect costs (such as loss of income) associated with the disease when designing such schemes. Investment in social protection interventions across direct medical, direct non-medical and indirect costs will be essential to prevent costs to individuals.

The need to go beyond addressing direct medical costs through health insurance is clear for TB. Despite diagnosis and treatment being available free of charge in many of the countries surveyed in this report, significant costs can be incurred before a correct TB diagnosis, for example, due to the need for several trips to a health centre with incorrect diagnoses or self-prescribing at the local pharmacy. Costs associated with TB treatment also contribute significantly, such as purchasing the additional nutrition supplements that are prescribed, transport costs to health centres during treatment, and loss of income. A study by Wingfield, based on 32 shantytown communities in Peru, argues that beyond catastrophic costs to families, TB-related costs cause other adverse outcomes including multi-drug resistant TB. Socio-economic interventions in such households reduce the likelihood of incurring catastrophic costs, increase the chances of contacts accessing TB preventive therapy, and lead to a greater chance of cure.
Although the literature on the impact of social protection interventions on TB responses is not exhaustive, many studies have highlighted the impact of social protection interventions on TB incidence, mortality, treatment success rates and rates of out-of-pocket costs. Below are a few examples of interventions.

**CASH TRANSFERS**

Cash transfers can be a lifeline for people with TB as the disease often renders people unable to work. If their job is in the informal sector, this means no income or social protection support. The impact of this is stretches far beyond the person with TB. For example, the child of a TB patient may be prevented from attending school because the fees cannot be paid. In Kenya, people with TB cite transport to health facilities and nutritional supplements for people with TB as the two most important factors needed to access TB care.40,41

**NUTRITION SUPPORT FOR PEOPLE WITH TB**

UHC must consider nutrition as a key component of the health response. Undernourished people are at higher risk of developing TB because of a weakened immune system.42 Globally, undernourishment was an underlying cause of TB for an estimated 2.3 million people in 2018, the biggest risk-factor for TB.43 In Kenya in 2017, 82% of people with TB were assessed for their nutritional status and 48% of them were malnourished, but only 15–28% of them accessed nutritional support.44 TB can lead to or worsen pre-existing undernutrition, and undernutrition can increase the risk of TB mortality and of getting TB again after cure. If a person with TB comes from a household affected by food insecurity, the household contacts are also at higher risk of developing TB.45

People with TB need to have eaten before taking their medication to help keep it down, and nutritional supplements for people with TB can help aid recovery and a return to active life.46 The need to tackle health and undernutrition as co-dependent issues is recognised in many countries. For example, steps towards UHC in India are following four main pillars of health care, one of which is the “National Nutrition Mission” to improve the nutritional status of mothers and children.47 India’s Ministry of Health also developed a “Guidance Document on Nutritional Care and Support for patients with active tuberculosis in India.” It recommends a food package with good quality protein for people with active TB, and an enhanced ration for the family through the public distribution system. In 2018, the Government announced an annual budgetary allocation of 6 billion Rupees (around US$ 84 million) for nutritional support of TB patients. States have been directed to provide it as either a cash transfer of 500 Rupees (around US$ 7) per month or in kind.48

In Kenya, the national policy is for nutritional supplements to be given to people with TB who have a body mass index (BMI) under 18.5.44 The nutrition supplements are funded by the Global Fund, and when this programme was implemented by Amref as one of the principle recipients, the supply was consistent. However, since implementation of this programme was transferred to the National Treasury, there have been extensive stock-outs of nutritional supplements in counties across the country, and sometimes when stock does arrive, it is close to expiry and so some of it cannot be used.49 For example, a health facility visited in Nairobi reported that it had not received the commodities for over a year (as of September 2019).50 The consequences of this are deadly; among people with TB with a BMI of under 18.5, between 2012 and 2016, the mortality rate was over 50%.51
Chapter 3: Acceptability and Integration

### SUMMARY OF SCORECARD FINDINGS

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<td>TB and NCD services are integrated.</td>
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<td>50%</td>
</tr>
<tr>
<td>TB and harm reduction services are integrated.</td>
<td>78%</td>
<td>50%</td>
</tr>
<tr>
<td>Psychosocial support services are available for people with TB.</td>
<td>78%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### KEY FINDINGS FROM THE SCORECARD:

**01** In response to gaps between the number of people with TB who present to private providers compared with the number of people with TB who are reported to National TB services, including many countries with specific TB-HIV guidelines. Most countries’ policies also include measures to promote integration of TB and non-communicable diseases, notably diabetes.

**02** Most countries’ policies include measures to promote integration of TB and HIV services, including many countries with specific TB-HIV guidelines. Most countries’ policies also include measures to promote integration of TB and non-communicable diseases, notably diabetes.

**03** There is a lack of policy on TB service provision integration with harm reduction services outside of condom distribution in TB services. There is a specific lack of integration of services for drug-users, such as needle-exchange or drug-substitution services. Where these services are included in a policy, they often rely on external donor implementing partners or NGOs, or are limited to specific geographic areas.

**04** Provision of psychosocial support is often reliant on donors for funding and NGOs for implementation.

### PUBLIC-PRIVATE MIX

One reason there is such a huge gap between the estimated number of TB cases and the number that are diagnosed or notified is that the places they seek care are not linked up to the public notification system. For example, in 2018, in the seven highest burden countries that account for 57% of the global TB incidence and 63% of the “missing” people with TB, 75% of initial care-seeking happened at private providers, but private for-profit notifications represent only 19% of total notification and 12% of estimated incidence. As such, WHO and many national governments have acknowledged the need to engage all providers through public-private mix (PPM) approaches which have been shown to increase case detection up to four-fold.

### INTEGRATION WITH HIV, NON-COMMUNICABLE DISEASES AND HARM-REDUCTION SERVICES

People living with HIV are 20-30 times more likely to develop active TB. At a service level, it is important for TB and HIV services to be integrated, for example services such as prevention, diagnosis, treatment, and counseling within the same facility and peer-to-peer or community-led health education on both diseases. At the policy level, both TB and UHC have a lot to learn from the HIV response in terms of communicating in an accessible way and translating technocratic, high-level policy to community-level implementation. Facilities must also consider integration of TB services with services for those non-communicable diseases that can

### BOX 3: IMPLEMENTATION OF PUBLIC-PRIVATE MIX IN KENYA

In Kenya, the private sector is prominent in primary healthcare provision and health financing. In response to survey findings that a significant number of people with TB in Kenya present first to the private sector compared with the number of notifications that come from the private sector, and a higher burden of people with TB are in urban rather than rural settings, Kenya is implementing PPM activities, many funded by the Global Fund.

For example, in Embakasi West division of Nairobi, a “hub and spoke” model exists to facilitate greater integration between private and public facilities. The project also developed simplified tools to aid the private facilities in the new activities, for example, for TB screening. Now, people who present to private facilities with TB symptoms can be screened and have samples taken there, which are then taken by the rider to the diagnostic centre, and the linkage assistant is able to follow up with people and their contacts if they have a positive diagnosis. Greater integration of TB services between private and public facilities will act as a pathfinder for greater integration more generally.

A challenge that comes with better integration with the private sector is that the increasing number of people at public facilities who need to access services is not being matched by increased human resources or equipment. In Embakasi West, for example, there is one modern molecular diagnostic machine at the sub-county hospital which is connected to 150 “spokes” and runs about 320 tests per month. If the machine is not working or cartridges are not available, there are serious delays to diagnosis.
also make people more at risk of developing TB, such as diabetes, alcohol use and smoking-related conditions.64

In Kenya, county-level HIV plans exist for all counties,65 & their development involves a multi-stakeholder consultative process, coordinated and funded by the National AIDS Control Council (NACC). The implementation is aided by NACC’s nine Regional Offices, 47 County Representatives, 29 Constituency AIDS Control Committees (CACCCs) and multi-sectoral County HIV Committees that meet every quarter and report to the County Governor.66 For TB, county-level strategic plans should be developed, facilitated by a framework for their development, including a similar multi-stakeholder consultation. Makueni County was the first county to establish a joint TB-HIV strategic plan.67 While most of the countries reviewed in this report have national TB-HIV guidelines, only South Africa has a National Strategic Plan that integrates HIV, TB and sexually transmitted infections (STIs).68 As well as a specific Human Rights Plan to address human-rights related barriers to HIV and TB services and gender inequality.

Harm reduction services are another programmatic area where HIV and TB services should be integrated as people who inject drugs have increased risk of both diseases. HIV infection increases the risk of developing TB,69 but TB is also a risk among HIV-negative people who inject drugs owing to environmental factors such as crowded and poorly-ventilated living conditions. WHO’s Comprehensive Package of interventions for the prevention, treatment and care of HIV among people who inject drugs includes prevention, diagnosis and treatment of people with TB as a key intervention.70

In Kenya, integration of harm-reduction services with TB services is ad hoc and reliant on NGOs for implementation. Owing to high levels of stigma71 this population is less likely to access the health services they need.72 Médecins Du Monde (MDM) is one organisation trying to address the barrier of stigmatisation through specific initiatives in two sub-counties in Nairobi, Westland and Dagoretti, where TB prevalence among people who inject drugs ranges from 5 to 10%. MDM’s outreach services for people who use drugs include screening, health education and referral for diagnosis at their nearest public health centre. The facilities also stock syringes and needles. TB coordinators and lab personnel collect samples for diagnosis after screening, and if a person is found to have TB, an outreach worker called a link-age assistant reaches out to them to link them to their health centre. They are supported through treatment, for example, if people do not have a place to keep their medication, it is stored elsewhere and treatments can be delivered by them, rather than requiring them to present to the facility.

INTEGRATION OF PSYCHO-SOCIAL SUPPORT

Another key component of a person-centred, integrated approach to TB is the provision of social support.73 For reasons ranging from high levels of stigma associated with TB to treatment durations with certain medicines that can cause mental health problems such as depression or psychosis.74 Prevalence of depression is estimated to be as high as 50% among people with TB.75 It is important to address this for the wellbeing of people with TB, for better treatment outcomes, and to prevent further transmission (because people with TB who are depressed are three times more likely to stop treatment due to side effects).76,77 While many countries surveyed include an element of psychological support, it is often limited in its reach by applying only to certain groups such as people with HIV or drug-resistant TB only, or by being dependent on where community-based or peer support groups exist to deliver it. Moreover, the services are often funded by external donors and so the continuity of the service once donors withdraw is dependent on governments taking up the funding.

In Kenya, UHC is being piloted in four counties by the National Government; Isiolo, Kisumu, Machakos and Nyeri. In addition, Makueni County Government is implementing a model of UHC on its own initiative, separate from the national pilot. In Makueni, all people can register for a UHC card that entitles them to free health care (up to the referral level) at a cost of 500 KES (around US $5) per year per household. This is prohibitive high for some families to pay up front, and it is not universally known that it is possible to register at any public facility, not just in Wote, the capital of the county. In Kisumu, UHC cards are free for everyone who registers, and all health services are included.

Previous attempts by the Kenyan government to increase insurance coverage have been limited in their uptake. For example, the 2017 National Patient Cost survey found that only 14% of people with TB were covered by the National Health Insurance Fund (NHIF) during their TB treatment. One reason that the scheme does not cover more people is a prohibitive cost of 500 KES (around US $5) per month.78

In Kisumu, the UHC pilot programme began in December 2018, so it is too early to determine how successful it has been. Its impact, however, has been severely hampered by strikes by public health staff because of months of not being paid, due to payment delays at the national level. As of September 2019 this had been ongoing for 3 months. One immediate impact of UHC has been increasing numbers of people presenting to health facilities but the number of people with TB being notified decreased in 2018-19 compared to the previous year due to facilities not being equipped to cope with the increased demand for diagnosis. This is because while UHC has encouraged more people to seek care, this has not been matched by increases in health staff or necessary equipment, such as x-ray or modern molecular diagnostic machines.

In terms of personal economic impact for people with TB, while UHC could help with covering the costs of morbidity treatments such as diabetes and referral-level procedures such as x-rays that were not previously covered in public systems, other causes of out-of-pocket costs persist, such as loss of income and increased transportation costs. Loss of income is especially prevalent for people working in the informal sector (who are not covered by labour insurance schemes). In Kenya, an estimated 80% of the workforce is in the informal sector, meaning that they are not protected by labour laws, and have no access to social protection or employment benefits such as paid sick leave.79

KENYA’S NATIONAL PATIENT COST SURVEY WAS USED TO IDENTIFY SIX PRIORITY ACTIONS

1. Addition of TB as an eligibility criterion for existing social support programmes, particularly cash-transfer programmes and systematic identification of TB patients eligible for social protection.
2. Ensuring systematic assessment of nutritional status and associated counselling for all TB patients, with provision of food support according to need, including for malnourished children of TB-affected households.
3. Inclusion of TB care in the NHIF benefit package, and increased NHIF coverage among TB patients through a fast-track, premium-free enrolment.
4. Development and implementation of policies and laws to eliminate discrimination and ensure job security for TB patients, in collaboration with national authorities in the labour sector.
5. Engagement of all care providers in the provision of timely and quality-assured TB care, to reduce delays in accessing diagnosis and treatment.
6. Establishment of a high-level multi-stakeholder coordinating mechanism and forum for the implementation of the End TB Strategy.

While these recommendations exist at the national level, the responsibility for delivering the response lies with the 47 county governments, yet there are few county-level adapted TB plans or targets.
Chapter 5: Sustainability

The role of donors in continuity and scale-up of tuberculosis services and UHC. The example of Kenya.

A key component of tackling TB and achieving UHC is ensuring “that the fragile gains are sustained and expanded.” Kenya’s response to TB, HIV and malaria remains heavily reliant on external donor funding, namely the Global Fund, USAID and PEPFAR, with 60% of the TB response and almost all of the MDR-TB programming funded by the Global Fund.58 Kenya’s National Strategic Plan for TB 2019-23 is fully costed but only 50% funded, including donor funding. This poses major risks to the sustainability of services.

Kenya became a low-middle-income country in 2014 as most oversight – the size of the economy was found to be 25% larger than previously thought during the re-basing of its National Accounts (including GDP and GNI).59 In some respects, this new economic status is reflected in health gains; for example, the under-5 mortality rate dropped from 114.6 per 1,000 live births in 2003 to 46 in 2017.60 However, many key development challenges persist, including high rates of poverty, inequality, and vulnerability to climate change. Kenya remains a high-burden country for TB, HIV and malaria.

The new economic ranking affects Kenya’s ability to access external donor funding – the proportion of total health expenditure attributed to donors declined from 35% in 2009/10 to about 23% in 2015/16.61 For example, PEPFAR funding for HIV has been decreasing for the past few years from US $517.9 million in 2011 to an average of 6-9 months from the time of ordering until delivery.62 Procurement is another potential issue. As mentioned previously, nutrition supplements offer an example of procurement-related challenges through the country’s central procurement system. While this is not currently an issue for TB in Kenya because commodities are funded and procured by the Global Fund, it is concerning given that many countries with increasing co-financing requirements from the Global Fund decide to fulfill co-financing obligations by using domestic funds for procurement through national systems. If this happens for all TB commodities in Kenya, there could be serious issues of stock-outs or delays. Kenya is already using Global Fund funding to procure ARVs for HIV and there have been issues of low stock and long lead times (an average of 6-9 months from the time of ordering until delivery).63

Managing at the Ministry of Health to replace those lost. For the USAID-funded staff that are left, their salaries were predicted to be cut almost in half to try to make available funding last longer.64

The benefits of a more equitable health response that targets the social determinants of health, as well as vulnerabilities not only to disease, but also to financial hardship as a result of the disease. TB offers an example of indirect and direct non-medical costs causing greater financial hardship than direct medical costs associated with the disease.65 Studies have found that total costs for people with TB and their families on average correspond to more than half of yearly income.66 If social protection measures, including those that address social and economic determinants of health and vulnerability to economic hardship as a result, will have benefits far beyond clinical outcomes for individuals, but also prevent crippling out-of-pocket costs, adverse treatment outcomes, spread of drug-resistance.67

TB is not the only disease for which this is the case. Other diseases, including many non-communicable diseases, also require more frequent visits to health services and result in loss of income.68 The benefits of a more equitable health response that targets the social determinants and economic vulnerabilities of people with TB will therefore have far-reaching benefits that will contribute to the achievement of UHC. Interventions must be guided by research to ensure that the they reach the poorest, most marginalised and vulnerable groups.69 Many tools to assess this exist for TB, such as the WHO’s National Patient Cost surveys and the Stop TB Partnership’s Community, Rights and Gender (CRG) Assessments.70 Currently, many of the initiatives that address social determinants of health and malaria remains heavily reliant on external donor funding.
Methodology

18 INDICATORS ASSESSED IN THE SCORECARD

The 18 indicators used in the scorecard were identified based on extensive desk-based research. This included a literature search on PubMed using the term “Tuberculosis and Universal Health Coverage” for academic literature. Academic literature reviewed included publications in The Lancet, such as the 2019 Lancet Commission Building a tuberculosis-free world: The Lancet Commission on tuberculosis. Full details of the literature search are available on request.


The Political Declaration of the UN High-Level Meeting on TB was also used to identify the 18 indicators based on who it identifies as vulnerable to and more at risk of TB, and actions it proposes to address barriers to accessing services. This report aims to show how countries can deliver on these commitments in practice, through identifying specific key interventions.

Certain elements of the TB response were identified as already monitored and reported on in other publications so were not included as indicators in the scorecard, for example:

- The WHO Global TB Report includes reporting on patient cost surveys, estimated anti-retroviral therapy coverage, SDG indicators for UHC, cash transfer schemes, smoking prevalence, diabetes prevalence, HIV prevalence, alcohol use disorders prevalence.
- The MSP/Stop TB Partnership Out of Step report covers models of care including assessing whether drug-sensitive TB (DS-TB) treatment is started at the primary health care level, whether drug-resistant TB (DR-TB) treatment is started at the district level, whether hospitalisation is required for DS- or DR-TB or not, and if anti-retroviral treatment is offered to all people living with HIV.
- The O’Neill Institute and Stop TB Partnership review of TB-related laws.

The timing of publication of the report was chosen because it is a year on from the 2018 UN High-Level Meeting on TB and just after the 2019 UN High-Level Meeting on UHC. It also just follows the Global Fund’s Sixth Replenishment Conference. The report will be launched at the 2019 Union Conference.

18 CRITERIA WERE SORTED INTO THREE MAIN CATEGORIES

The 18 criteria were sorted into three main categories:

- **Access**
  - Finding and Treating Everyone with TB
  - TB services are available in the workplace (outside of health settings); Community health workers or volunteers are supported to provide TB services; TB prevention and screening services are available for people in prisons; Services are available to prevent TB in health care workers; Provisions exist to ensure people with disabilities can access TB services; Provisions exist to ensure migrants and refugees can access national TB services; TB services are accessible for homeless people; TB services are adapted to the needs of children.

- **Social Protection**
  - Availability & Affordability of TB services
  - A National Patient Cost Survey has been carried out and is underway scheduled to start in 2019 or 2020 (as of July 2019); National Health Insurance policies exist and cover TB services; Insurance provisions cover loss of income due to TB; Nutritional support is available for people on TB treatment; Financial support is available to cover transport costs for people with TB.

- **Integration**
  - Provisions are in place to increase notification and referral rates between the private and public health sectors; TB and HIV services are integrated; TB and NCD services are integrated; Psychosocial support services are available for people with TB.

COUNTRIES INCLUDED IN ANALYSIS

RESULTS UK and the ACTION Global Health Advocacy Partnership (ACTION) began by looking at all 48 countries with high TB, TB/HIV and MDR-TB burden according to WHO. Due to language, time and document availability constraints, the following countries were not included in the analysis:

- Angola, Azerbaijan, Botswana, Brazil, Cambodia, Cameroon, DPR Korea, Eswatini, Ethiopia, Ghana, India, Indonesia, Kazakhstan, Kenya, Lesotho, Liberia, Malawi, Myanmar, Namibia, Nigeria, Papua New Guinea, Pakistan, Russian Federation, Sierra Leone, South Africa, Tajikistan, UR Tanzania, Thailand, Uganda, Zambia and Zimbabwe.

The analysis began with analysing just National Strategic Plans but was expanded to include other supporting documents such as guidelines and manuals for TB, DR-TB, TB-HIV, and TB in children. These documents were found online, or provided by the Stop TB Partnership or National TB Programmes.

SEARCH TERMS USED

Search terms (full list of terms are available on request) were used to help determine whether or not National Strategic Plans and supporting documents in the 32 countries included a policy for each of the 18 indicators. A binary coding system was used with “1” indicating the presence of a specific policy and a “0” indicating the absence of that policy. Once a reference was found in one of the documents, the country was awarded a “1” and the other documents were not searched for this indicator.

RESEARCH VISIT TO KENYA

To support the report, RESULTS UK conducted a research visit to Kenya (3 counties – Nairobi, Makueni and Kisumu) to look at policy implementation. Kenya was chosen as the detailed case study for the report given that it has recently revised its National Strategic Plan for TB and has completed a National Patient Cost Survey and a Legal and Gender Environment Assessment. Further, Kenya is moving towards implementation of UHC through county-specific programmes. During the visit, interviews were conducted with a range of stakeholders in charge of policy and implementation of the TB response including national and county government officials, external donors and NGO implementers. As well as interviews with advocacy groups, people with TB and TB survivors, and a consultation with a range of Nairobi-based NGOs working on TB, HIV or UHC.
The following documents were reviewed by RESULTS UK in collaboration with ACTION from May to October 2019.

Angola
- Guidelines for the Management of Drug Resistant Tuberculosis (DR-TB) in Angola, 2017
- Tuberculosis Prevention and Control Program: TB-HIV / HIV-TB in Angola, 2018

Azerbaijan
- National Tuberculosis Program of the Republic of Azerbaijan, 2015-2020

Bangladesh
- National Strategic Plan Public-Private Mix in Tuberculosis, 2016-2020

Bottswana
- Botswana TB/HIV Policy Guidelines, 2011
- National Tuberculosis Programme Manual, sixth edition, 2017
- National Tuberculosis Control Program Strategic Plan, 2018-2023
- Draft review of Botswana National TB Program, 2014

Brazil
- Brasil-Plan de Controle da Tuberculose: Plano Nacional pelo Plano de Tuberculose como Problema de Saúde Pública, 2017
- Planos De Recomendações Para O Controle Da Tuberculose No Brasil, 2016, 2019
- Recomendações para o manejo da infecção por TB-HIV em serviços de atenção especializada a pessoas vivendo com HIV/AIDS, 2019
- Direitos Humanos, Gênero e Tuberculose: Na Perspectiva da Diversidade Sexual, 2º edição, 2015

Cameroon
- Plan Stratégique De Lutte Contre La Tuberculose Au Cameroun, 2015-2020

Congo, Republic
- National Tuberculosis Strategic Plan of the Republic of Congo, 2015-2020

Côte d'Ivoire
- National Strategic Plan Public-Private Mix in Tuberculosis, 2015

Democratic People’s Republic of Korea
- National Strategic Plan for Tuberculosis Control, 2018-2021

Eswatini
- National Tuberculosis Strategic Plan, 2015-2019
- Drug Resistant Tuberculosis Management Guidelines and Manual, 2018
- National Policy Guidelines for TB/HIV Collaborative Activities, 2017

Ethiopia
- National Strategic Plan Tuberculosis and Leprosy Control, 2006-2013

Ghana
- The National Tuberculosis Health Sector Strategic Plan for Ghana, 2015-2020
- Guidelines for the Clinical Management of TB and HIV Co-infection in Ghana, 2007
- Guidelines for Diagnosis and Management of TB in Children, 2015
- Plan to Initiate and Expand Drug-Resistant TB Management in Ghana, 2013

India
- National Strategic Plan for Tuberculosis Control 2017-25 Elimination by 2025, 2017
- Guidelines on TB-HIV Linkages for Targeted Intervention (TB) and Link Worker Scheme (LWS), 2018
- Technical and Operational Guidelines for TB Control in India, 2016

Indonesia
- National Strategy for Tuberculosis Control, 2015-2019

Kenya
- KOMISSIONI NASILODO SHURUUTIGI WAKIINGA WAKIINGI NA MUWASHA NA KUJILA NAJAMA KWA JINAME 2018-2030 dimensioni yake, 2015

Cambodia
- National Strategic Plan for Control of Tuberculosis, 2014-2020
- National Guidelines for Diagnosis and Treatment of TB in children, 2008
- Standard Operating Procedures (SOP) for Implementing the Three Ds in Continuum of Care (GoC Settings, 2020

Cameroun
- Plan Stratégique De Lutte Contre La Tuberculose Au Cameroun, 2015-2020

Côte d’Ivoire

Kazakhstan
- KOMISSIYONI KASYRGAN AS HUBIGI WAKIINGI NA MUWASHA NA KUJILA NAJAMA KWA JINAME 2018-2030 dimensioni yake, 2015

Korea
- National Strategic Plan for Tuberculosis, Leprosy and Lung Health, 2016-2020
- Guidelines for Management of Tuberculosis and Leprosy in Kenya, 2013
- Programmatic Management of Drug Resistant Tuberculosis (PMdT), 2014
- Public Private Mix for TB Prevention and Care Action Plan, 2017-2020

Kyrgyzstan
- KOMISSIYONI KASYRGAN AS HUBIGI WAKIINGI NA MUWASHA NA KUJILA NAJAMA KWA JINAME 2018-2030 dimensioni yake, 2015

Lesotho
- National Tuberculosis Strategic Plan of Lesotho, 2018-2022

Lithuania
- National Tuberculosis Program National Strategic Plan, 2015-2020

Malawi
- Tuberculosis Control Programme National Strategic Plan, 2015-2020

Myanmar
- National Strategic Plan for Tuberculosis, 2016-2020
- Guidelines for the Management of Drug Resistant Tuberculosis (DR-TB) in Myanmar, 2017
- Tuberculosis Infection Control Manual, 2017

Namibia
- Third Medium Term Strategic Plan for Tuberculosis and Leprosy, 2017-2021
- National Guidelines for the Management of Tuberculosis, fourth edition, 2019
- Guidelines for the Management of Drug-resistant Tuberculosis in Namibia, second edition, 2017
- Official Direction Implementation for the Third Edition of the National Guidelines for the Management of Tuberculosis by Private Health Care Providers, 2019

Nigeria
- The National Strategic Plan for Tuberculosis Control, 2015-2020
- Standard Operating Procedures (SOPs) for Programmatic Management of Drug Resistant Tuberculosis (PMdT)

Papua New Guinea
- National Tuberculosis Strategic Plan (NSP) for Papua New Guinea, 2015-2020
- National Tuberculosis Management Protocol, 2011
- National Guidelines for Programmatic Management of Drug-Resistant Tuberculosis (PMdT), published 2009, revised 2012

Pakistan
- Revised National Strategic Plan, 2015-2019
- Operational Guidelines for PMM Implementation
- Doctors’ Desk Guide, Management of Childhood Tuberculosis, 2017
- Hand Book of DR-TB Practice, 2017
- National Guidelines for the Management of Tuberculosis in Pakistan, 2015
- National Guidelines for the Programmatic Management of Drug-resistant Tuberculosis (PMdT), published 2009, revised 2012

Russian Federation
- ТЕХПРОК-2014: руководство по стандартизации Российской Федерации

Sierra Leone
- National Leprosy and Tuberculosis Strategic Plan, Core Plan, 2016-2020

South Africa
- National Strategic Plan for HIV, TB and STIs, 2017-2022
- South Africa’s National Human Rights Plan: A Comprehensive Response to Human Rights Related Barriers to HIV and TB Services and Gender Inequality in South Africa

Tajikistan
- Third National Strategic Plan to Prevent the Population from Tuberculosis in the Republic of Tajikistan, 2015-2020

UR Tanzania
- National Strategic Plan for Tuberculosis and Leprosy Programme, 2015-2020
- National Guidelines for the Management of Tuberculosis in Children, 2016
- National Guidelines for the Management of Tuberculosis in Children, 2016
- Revised National Strategic Plan, 2015-2019
- Standard Operating Procedures (SOPs) for Programmatic Management of Drug resistant Tuberculosis (PMdT)

Thailand
- National Tuberculosis Strategic Plan, 2017-2021

Uganda
- National Tuberculosis and Leprosy Control Programme, Revised National Strategic Plan, 2015-2019

Zambia
- National Strategic Plan for Tuberculosis Prevention, Care and Control “Towards Elimination” (2017-2021)
- Guidelines for the Programmatic Management of Drug-Resistant Tuberculosis
- Managing Tuberculosis in the HIV Setting in Zambia, 2014

Zimbabwe
- National Tuberculosis Program, Strategic Plan, 2017-2020
- Clinical Guidelines for the Management of Drug Resistant Tuberculosis, 2018
- National Guidelines for the Treatment of Tuberculosis in Zimbabwe, 2010
- National Tuberculosis Control Programme, fourth edition,2010

TURBULOSIS AND UNIVERSAL* HEALTH COVERAGE

TERMS & CONDITIONS APPLY.

DOCUMENTS REVIEWED IN THE SCORECARD
TUBERCULOSIS AND UNIVERSAL* HEALTH COVERAGE

1. UN High Level Meeting on UHC, 22 September 2019
2. Political Declaration of the UN High Level Meeting on UHC, September 2019, paragraph 6.
3. UN High Level Meeting on UHC, September 2019, paragraph 8.
9. UN High Level Meeting on UHC, September 2019, paragraph 13.

*TERMS & CONDITIONS APPLY.

REFERENCES

1. UN High Level Meeting on UHC, 22 September 2019
2. Political Declaration of the UN High Level Meeting on UHC, September 2019, paragraph 6.
3. UN High Level Meeting on UHC, September 2019, paragraph 8.
9. UN High Level Meeting on UHC, September 2019, paragraph 13.

*TERMS & CONDITIONS APPLY.
RESULTS UK is a non-profit advocacy organisation that works to create the public and political will to end extreme poverty. RESULTS’ focus is on educating and empowering people – whether they are ordinary citizens or key decision-makers – to bring about policy changes that will improve the lives of the world’s poorest people. Our advocacy focuses on areas that have the most potential to make a difference.

RESULTS UK has a track record of expertise in education, global health, and economic opportunity. RESULTS UK is a partner of ACTION, a global partnership of advocacy organisations working to influence policy and mobilise resources to fight diseases of poverty and achieve equitable access to health. ACTION partners work across five continents in both donor and high-burden countries. Founded in 2004, ACTION began as a partnership of independent, locally established civil society organisations working to mobilise new resources against tuberculosis. Building on successes in fighting TB globally, ACTION expanded its efforts to include child survival – with a focus on expanding access to childhood vaccines and increasing the political will and investment needed to fight childhood undernutrition.

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