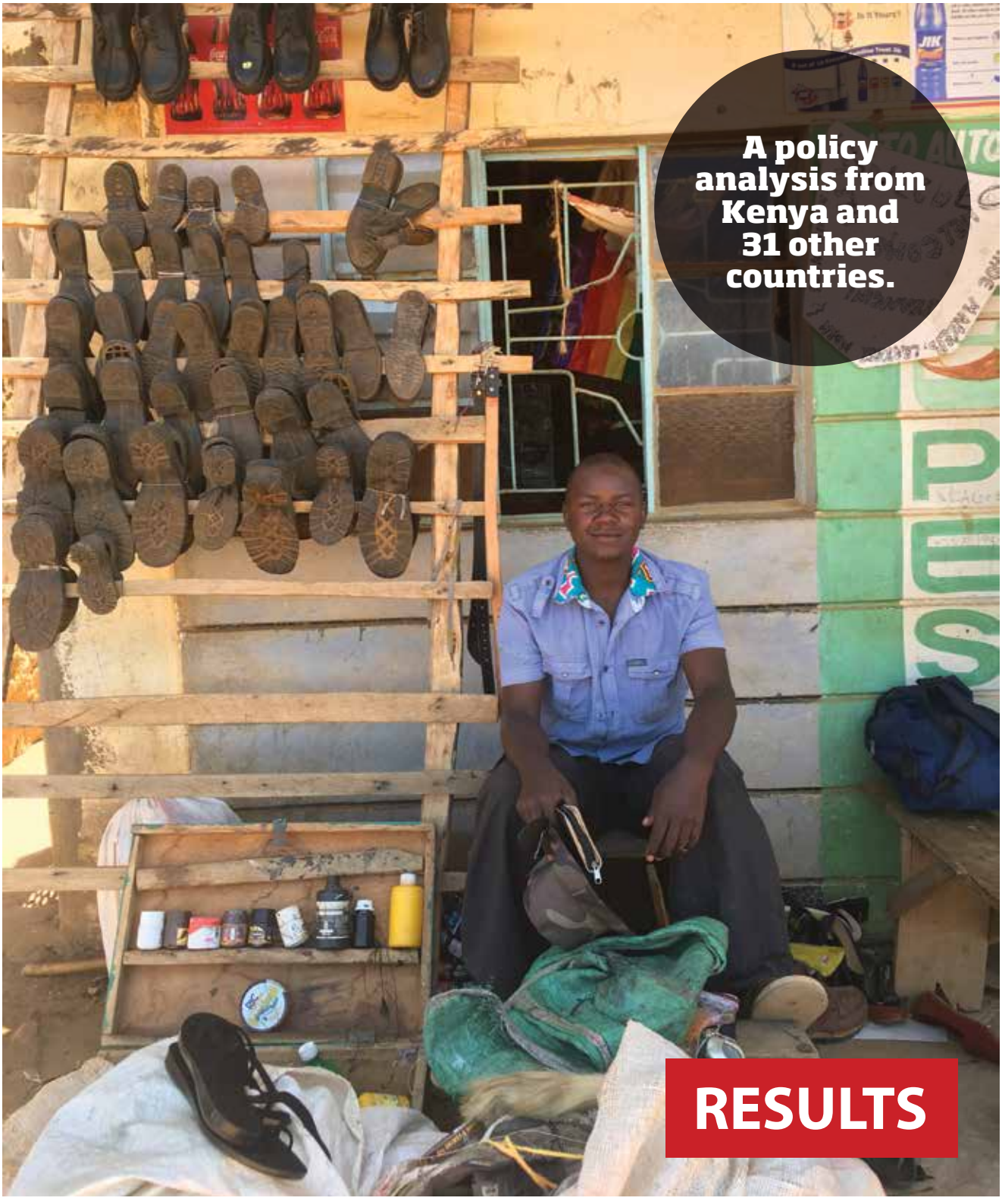
TUBERCULOSIS & UNIVERSAL* HEALTH COVERAGE

*TERMS & CONDITIONS APPLY.



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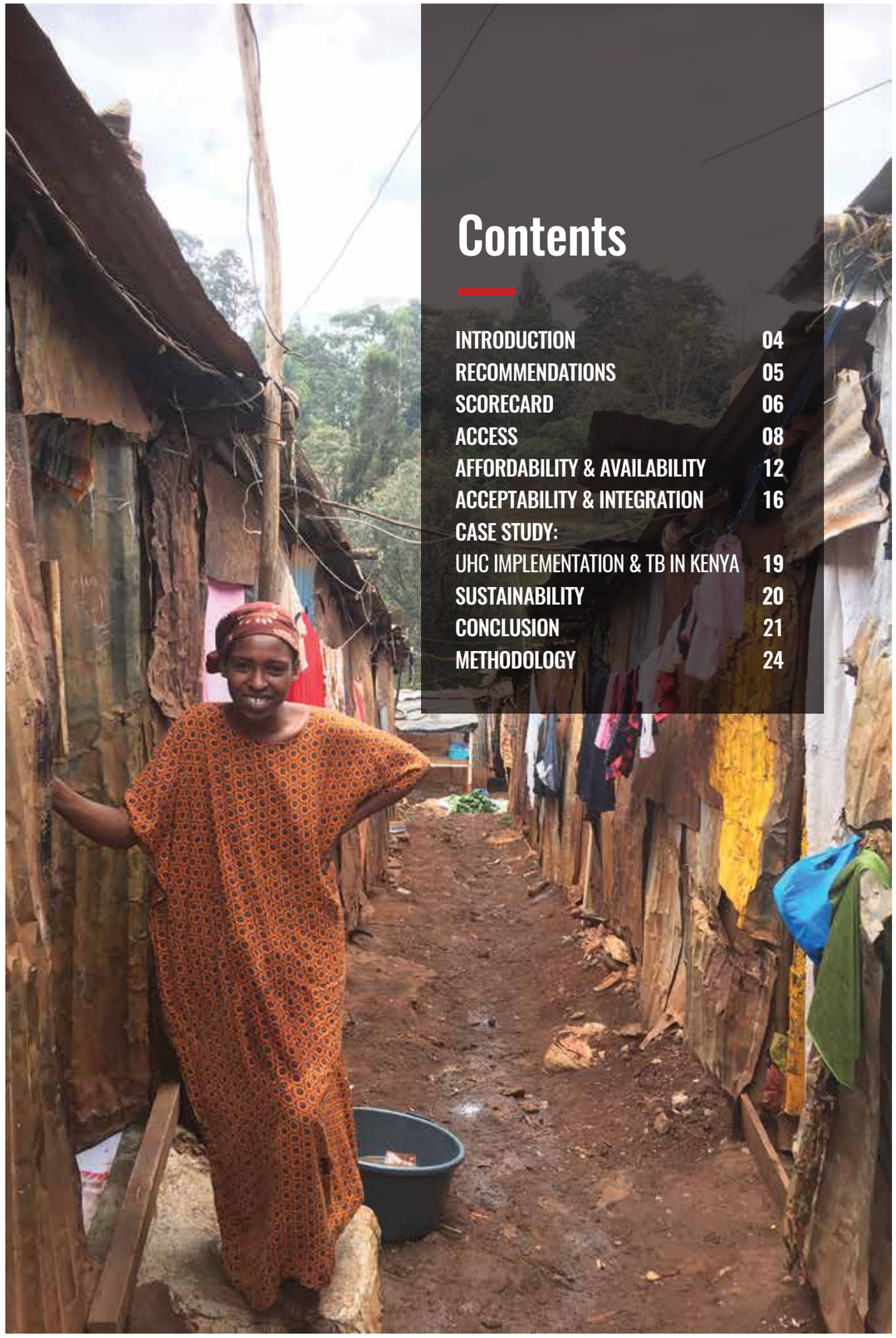
Photos: Rachael Hore/RESULTS UK



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Introduction

All UN member states committed at the UN High-Level Meeting on Universal Health Coverage (UHC)[1] to "strengthen efforts to address communicable 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."[2] 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 2018. 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 diagnosis, treatment and prevention services are provided within the context of progress towards UHC."[3] 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.[4]

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 both help to make the TB response "universal" and help to make the TB response contribute to the achievement of UHC more broadly.

WHO describes UHC as a social contract: "an ambitious agenda contributing to peaceful and inclusive societies that provide equal access to health services based on respect for human rights, the effective rule of law, good governance, and effective and accountable institutions. UHC is the outcome of investments in people-centred services with participation and dialogue as underlying principles."[5] This report argues that, when done deliberately and well, investing in people-centred TB services builds every element of UHC.

Investing in people-centred TB services builds every element of UHC.

Currently, a major obstacle to successfully tackling the TB epidemic is that nearly 30%[6] of all people with TB are not officially diagnosed, notified or treated each year – often referred to as "missing" people with TB. This means that people do not access appropriate treatment, are more likely to develop drug-resistance, more likely to transmit the disease to others, and significantly more likely to die as a result of TB infection. One reason for this is that not all TB services are sufficiently people-centred.

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,[7] 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, accessible, acceptable and integrated with other services. The 18 services have been put in a scorecard, and 32 of the TB high burden countries'[8] TB policies[9] 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"[10] 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.[11] 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 or indirect costs, social protection measures and National Insurance or UHC packages, must look beyond 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 other reasons. 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.

Scorecard

KEY
- Has been carried out
- Is underway
- Is scheduled to start in 2019 or 2020 (as of July 2019)
- MDR-TB only

ACCESS
FINDING & TREATING EVERYONE WITH TB

SOCIAL PROTECTION
AVAILABILITY & AFFORDABILITY OF TB SERVICES

INTEGRATION

COUNTRY	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.	A National Patient Cost Survey ***see key**	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.	Provisions are in place to increase notification & referral rates between private and public health sectors.	TB and HIV services are integrated.	TB and NCD services are integrated.	TB and harm reduction services are integrated.	Psychosocial support services are available for people with TB.	Count (18 indicators in total)	%
ANGOLA	0	1	1	0	0	1	0	1	0	0	0	0	0	1	1	1	0	0	7	38.9
AZERBAIJAN	0	1	1	1	0	1	1	1	0	1	1	1	0	1	1	1	0	1	13	72.2
BANGLADESH	1	1	1	0	0	0	0	1	1	0	0	1	0	1	1	1	0	1	10	55.6
BOTSWANA	1	1	1	1	0	1	1	1	0	0	1	0	0	1	1	1	1	1	13	72.2
BRAZIL	0	1	1	1	0	0	1	1	1	1	1	1	0	1	1	1	0	1	13	72.2
CAMBODIA	1	1	1	1	0	0	0	1	0	1	1	0	1	1	1	0	1	0	11	61.1
CAMEROON	1	1	1	1	0	1	0	1	1	0	0	1	1	1	1	0	0	1	12	66.7
DPR KOREA	0	1	0	1	0	0	0	1	0	0	0	1	0	1	1	1	0	0	7	38.9
ESWATINI	1	1	1	1	1	1	1	1	0	0	0	1	1	1	1	1	1	1	15	83.3
ETHIOPIA	1	1	1	1	0	1	1	1	1	1	0	1	0	1	1	1	1	1	15	83.3
GHANA	1	1	1	1	0	1	0	1	1	1	1	1	1	1	1	1	0	1	15	83.3
INDIA	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	17	94.4
INDONESIA	1	0	1	1	0	0	0	1	1	1	0	1	0	1	1	1	1	0	11	61.1
KAZAKHSTAN	0	1	1	1	0	1	0	1	0	0	0	1	1	0	1	1	0	1	10	55.6
KENYA	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	0	1	15	83.3
LESOTHO	1	1	1	1	0	1	0	1	1	0	0	1	1	1	1	1	1	1	14	77.8
LIBERIA	0	1	1	1	0	1	0	1	0	1	0	1	1	0	1	1	1	1	12	66.7
MALAWI	1	1	1	1	0	0	0	1	1	0	0	1	1	1	1	1	1	1	13	72.2
MYANMAR	1	1	1	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	16	88.9
NAMIBIA	1	1	1	1	1	0	0	1	1	0	1	1	1	1	1	0	0	0	12	66.7
NIGERIA	0	1	1	1	0	1	0	1	1	1	0	0	1	1	1	1	1	1	13	72.2
PAPUA NEW GUINEA	1	1	1	0	0	0	0	1	1	0	0	1	1	0	1	0	1	0	9	50.0
PAKISTAN	0	1	1	1	0	1	1	1	0	0	0	1	1	1	1	1	0	1	12	66.7
RUSSIAN FEDERATION	0	0	1	0	0	0	1	1	0	0	1	0	0	0	0	0	0	1	5	27.8
SIERRA LEONA	1	1	1	0	1	0	0	1	0	1	0	1	1	1	1	1	0	1	12	66.7
SOUTH AFRICA	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	17	94.4
TAJIKISTAN	0	1	1	1	0	1	0	1	0	0	0	1	1	0	1	0	0	1	9	50.0
UR TANZANIA	1	1	1	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	16	88.9
THAILAND	1	1	1	1	0	1	0	1	1	1	1	1	0	1	1	0	0	1	13	72.2
UGANDA	0	1	1	1	0	1	0	1	1	0	0	1	1	1	1	1	1	0	12	66.7
ZAMBIA	1	1	1	1	0	0	1	1	1	0	0	1	1	1	1	1	0	1	13	72.2
ZIMBABWE	1	1	1	1	0	1	1	1	1	0	0	1	1	1	1	1	1	1	15	83.3
COUNT (32 COUNTRIES IN TOTAL)	21	30	31	27	4	19	14	32	20	15	11	27	22	27	31	25	16	25		
%	65.63	93.75	96.88	84.38	12.50	59.38	43.75	100.00	62.50	46.88	34.38	84.38	68.75	84.38	96.88	78.13	50.00	78.13		

Chapter 1: Access

Finding and Treating Everyone with TB

SUMMARY OF SCORECARD FINDINGS

INDICATOR	ACCESS *FINDING & 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.
% OF COUNTRIES THAT INCLUDE IT IN THEIR NATIONAL POLICY DOCUMENTS	66	94	97	84	13	59	44	100

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 are 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.

To find all people with TB, services must actively look for them, understand why people are unable to access services, and implement appropriate measures to assist them. The Political Declaration of the UN High-Level Meeting on TB listed the people who are vulnerable to TB (paragraph 17).[12] It is essential that rather than just listing these groups of people, TB responses take appropriate action to address their needs. The 2019 Global TB Report shows that political will, policy change, strategic initiatives and increased funding can result in finding and treating more people with TB. The percentage of people with TB "missed" fell from 40% in 2017 to 30% in 2018 and this was helped a strategic initiative by the Global Fund to Fight AIDS, Tuberculosis and Malaria, Stop TB Partnership and WHO that aims to accelerate progress on finding more people with TB in the 13 countries with the highest disease burden[13] through initiatives such as increased community engagement and active case finding.[14]

This chapter and chapter 3 will outline various measures that must be included in TB responses if countries want to deliver on their commitment to reach all people with TB, especially those they recognise as especially vulnerable. These vulnerable groups are often in the same risk groups for other diseases and more likely to lack adequate access to services[15] – currently over half the world's population lacks access to essential health services.[16] As such, if health services adapt to the needs of all people with TB, this should offer a window in to the health system more broadly for those currently missing out, and therefore TB can be a pathfinder for UHC.

Some people have increased exposure to TB owing to where they live or work, for example, people who live in urban slums, refugee camps or poorly ventilated or dusty environments, people who are contacts of individuals with TB (including children), people who work in environments that are overcrowded or are health professionals.

Others have limited access to quality TB services, for example migrant workers, women, refugees or internally displaced people, people from tribal populations or indigenous groups, people who are homeless, people who live in hard-to-reach areas, people who have mental or physical disabilities, people who face legal barriers to access care, or people who are LGBTQI+. Stigma attached to the disease also prevents some people from seeking care. Investment in UHC in the form of infrastructure alone will be not be effective unless coupled with measures to help people access services. Below are a few examples of interventions.

COMMUNITY HEALTH WORKERS

Empowered community health workers are essential to help all people access services. However, despite exposing themselves 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.[17] CHVs 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), CHVs are 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). CHVs 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 cobblers 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),[18] 11% of people with TB are those deprived of liberty.[19] Studies in Brazil show that targeted interventions within prisons could have a substantial effect on the broader TB epidemic.[20] 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.[21]

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,[22] 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.[23] 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.[24]

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.[25] 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.[26] 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.[27]

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.

In Kathonzweni, Makueni County Kenya, Makou is in need of psychiatric medicines for suspected schizophrenia but lacks access. He also has TB, and is thought to have contracted it while being remanded in police custody for four months. He wanted to get well quicker so he could get back to work digging wells, so decided to take sixteen pills per day rather than the prescribed four. Rather than the intended effect of speeding up his cure, it instead caused side-effects such as dizziness.

Chapter 2: Affordability and availability

SUMMARY OF SCORECARD FINDINGS

INDICATOR	SOCIAL PROTECTION — AVAILABILITY & AFFORDABILITY OF TB SERVICES				
	A National Patient Cost Survey has been carried out/ is underway/is scheduled to start in 2019 or 2020.	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.
% OF COUNTRIES THAT INCLUDE IT IN THEIR NATIONAL POLICY DOCUMENTS	63	47	34	84	69

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.[28]

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.[29]

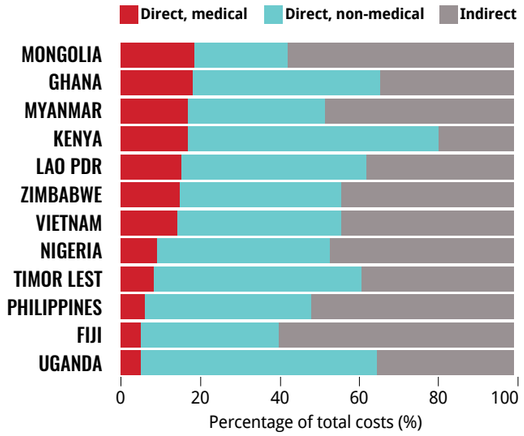

FIGURE 2: DISTRIBUTION OF COSTS FACE BY PEOPLE WITH TB AND THEIR HOUSEHOLDS IN 12 NATIONAL SURVEYS.
Source: WHO Global TB Programme, Global TB Report 2019.

Every year, almost 100 million people are pushed into extreme poverty by out-of-pocket healthcare expenses.[30] TB is not only a consequence of poverty, but also a cause. This chapter will assess various social protection interventions, sometimes called "enablers,"[31] that are essential to prevent such costs occurring. National Health Insurance schemes or UHC programmes help to address direct medical costs (consultations, 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.[32] 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[33] 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,[34] 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.[35]

BOX 1: WHO NATIONAL PATIENT COST SURVEYS

WHO's National Patient Cost surveys[36] for TB aim to find out the causes of out-of-pocket payments and who incurs them. These findings must be discussed in a multi-sectoral fora and acted on to address the drivers of costs for people with TB and their families. The surveys should inform policies to help mitigate costs by improving approaches to TB service delivery and financing, and any remaining costs should be mitigated by social protection measures in collaboration with stakeholders across the social sector.

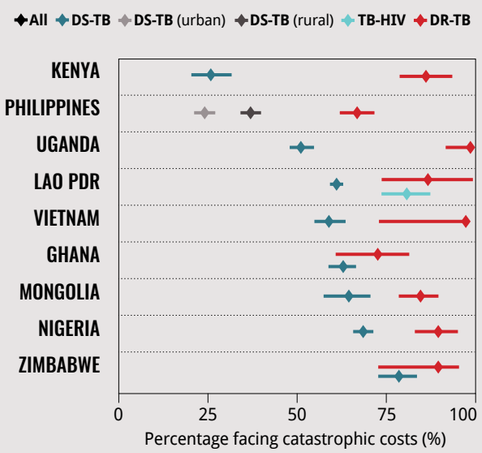

FIGURE 3: ESTIMATES OF THE PERCENTAGE OF PEOPLE WITH TB AND THEIR HOUSEHOLDS FACING CATASTROPHIC COSTS DUE TO TB DISEASE IN 12 NATIONAL SURVEYS (BEST ESTIMATES AND UNCERTAINTY INTERVALS SHOWN).
Source: WHO Global TB Programme, Global TB Report 2019.

Catherine is a community health volunteer in Kathonzweni, Makueni County, Kenya. Many of the people she visits with TB cite transport costs as a major driver of out-of-pocket payments associated with TB, especially during the first phase of treatment (2 months) when weekly trips to the health centre can be required. People have to spend up to 500 KES (around US $5) per visit.

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.[38] 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 drug-resistant TB are given a monthly stipend of 6,000 Kenyan Shillings (KES) per month (approximately US $60) which helps to cover loss of income, extra transportation costs to health facilities and nutritional supplement costs. This is only available for people with drug-resistant TB, not all people with TB. Transport costs are often cited as a major financial burden before diagnosis and during TB treatment. The implications for this can be far-reaching, for example, transport costs can prevent money being spent on food.[39]

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.[40] Globally, undernourishment was an underlying cause of TB for an estimated 2.3 million people in 2018, the biggest risk-factor for TB.[41] 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.[42] 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.[43]

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.[44] 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,[45] one of which is the "National Nutrition Mission" to improve the nutritional status of mothers and children.[46] 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.[47]

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.[48] 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 morality rate was over 50%.[51]

BOX 2: IMPACT OF UHC ON TB IN THAILAND

In Thailand, UHC has been implemented since 2002 using funds raised through general taxation.[52] The UHC programme focuses on primary healthcare infrastructure, health workforce training and distribution, and the extension of financial risk protection to different target populations.

It has had great epidemiological success, as well as success in reducing levels of out-of-pocket payments and incidence of catastrophic health spending, resulting in a reduction of impoverishment[53] caused by health expenses.[54] Life expectancy rose from 70.6 years in 2000 to 74.6 years in 2015, and deaths from communicable or maternal, prenatal and nutrition conditions as a percentage of total mortality fell from 26.1% in 2000 to 18.3% in 2015. Thailand has also prevented mother-to-child transmission of HIV and the high coverage of universal anti-retroviral therapy indicates the likelihood of ending the AIDS epidemic as a public health threat by 2030.[55]

However, Thailand remains one of the 30 countries with the highest burden of TB, TB-HIV co-infection and multi-drug resistant TB. This is in part due to the complexity of case finding, contact tracing and successful treatment in highly mobile populations such as migrants.[56]

Therefore, while building people-centred TB services, when done deliberately and well, makes an essential contribution to UHC, building UHC does not automatically result in improved TB outcomes. UHC programmes must look beyond financial risk protection through insurance schemes that make medical aspects of the disease free, to specific social measures tailored to the population and the diseases that affect them.

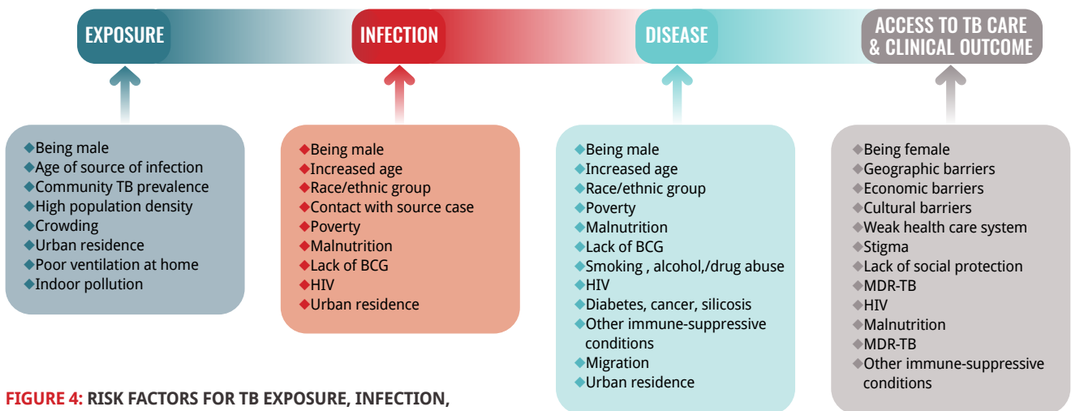

FIGURE 4: RISK FACTORS FOR TB EXPOSURE, INFECTION, DISEASE, ACCESS TO CARE AND CLINICAL OUTCOME.
Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052350/

Chapter 3: Acceptability and Integration

SUMMARY OF SCORECARD FINDINGS

	INTEGRATION				
INDICATOR	Provisions are in place to increase notification & referral rates between private and public health sectors.	TB and HIV services are integrated.	TB and NCD services are integrated.	TB and harm reduction services are integrated.	Psychosocial support services are available for people with TB.
% OF COUNTRIES THAT INCLUDE IT IN THEIR NATIONAL POLICY DOCUMENTS	84	97	78	50	78

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 Programmes by private providers, most countries include provisions to increase notification and referral rates from the private to public sector, including through specific guidelines.

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[57] 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.[58] 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.[59]

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

People living with HIV are 20-30 times more likely to develop active TB.[63] At a service level, it is important for TB and HIV services to be integrated, for example services such as prevention, diagnosis, treatment, and counselling 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.[60] 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,[61] 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 better integration between private[62] and public facilities. The project began by mapping all of the private facilities, about 100 in total, including small clinical providers and chemists/pharmacies (spokes), and a public health facility where the modern molecular diagnostic machine is based (hub). The hub is connected to the spokes with help from outreach workers called "linkage assistants" and riders (motorbike riders who transport samples from private to public facilities). All the private facilities received training tailored to the services they would provide, ranging from a 5-day training for clinical providers to a 1-day sensitisation on infection prevention for the riders. 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 Embaksi 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, 290 Constituency AIDS Control Committees (CACCs) 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 join 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.

In Kenya, integration of harm-reduction services with TB services is ad hoc and reliant on NGOs for implementation. Owing to high levels of stigma,[71] 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 linkage 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 to 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 psycho-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.

POSTER FOR THE NATIONAL HEALTH INSURANCE FUND (NHIF) IN MAKUENI SUB-COUNTY HOSPITAL, KENYA.

Chapter 4: Case study

UHC implementation and TB in Kenya

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 prohibitively 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 co-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:[80]

1. Addition of TB as an eligibility criterion for existing social protection 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 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.

As identified in the UN High-Level Meeting on UHC, 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.[81] 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 almost overnight – 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).[82] 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.[83] 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, TB/HIV co-infection and MDR-TB.

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.[84] For example, PEPFAR funding for HIV has been decreasing for the past few years from US $517.9 million in 2011 to an allocation of US $375 million in 2019.[85] As of 1 October 2019, there were substantial changes in allocations from USAID to Kenya. For example, in Kisumu, with the third-highest adult prevalence of HIV of all counties in Kenya (16.3% compared to national average of 4.9%),[86] the effects of this are already being felt. We were told that the sub-county hospital was expecting to lose 100 HIV and TB staff in October 2019, leaving only 55 mainly management level staff, with no commitment from 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.[87]

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 such 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 fulfil 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 the delivery).[88]

Kenya's response to TB, HIV and malaria remains heavily reliant on external donor funding,

Conclusion

There is correlation between the coverage of health services and the number of people with TB. The majority of people with TB come from the poorest 40% of the population globally and nationally – the population that UHC programmes pay particular attention to.[89] Poor performance of TB programmes usually correlates with ineffective health coverage more broadly for the poorest 40% of people, while good performance of TB programmes indicates that the poorest 40% of people are reached with at least one key health intervention. This 40% of people needs to be disaggregated further to ensure that the poorest 10% or 20% of people is not left behind, but it shows that TB is a good place to start to expand fit-for-purpose social protection for the poorest and most marginalised people.[90]

Social protection interventions for TB must address 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.[91] Studies have found that total costs for people with TB and their families on average correspond to more than half of yearly income.[92] 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.[93]

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.[94] 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.[95] 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.[96]

Currently, many of the initiatives that address social determinants of TB or the non-medical and indirect causes of out-of-pocket costs are funded by external donors, mainly the Global Fund. If countries are serious about delivering on the countless promises they have made at the highest political levels to achieving UHC and leaving no one behind, they must prioritise such interventions and ensure their continuation after donor relationships change or if donors leave.

The social, economic and environmental determinants of health are set out in the Sustainable Development Goals (SDGs), and the interconnections and impact of the goals on one another must be considered in designing multi-sectoral approaches to tackling diseases to achieve UHC. For example, achievement of SDG3, including targets to achieve UHC and to end TB by 2030, is dependent on the achievement of many of the other goals, including SDG2 (to end hunger, achieve food security and improve nutrition). This will help to foster an appropriately multi-sectoral response across government departments. For example, the different elements included in this scorecard would fall under the remit various ministries, including Nutrition, Science and Technology, Agriculture, the Environment, Trade, Development, Justice, Labour, Social Protection, Finance and Education – as outlined in commitment 39 of the political declaration of the UN High-Level Meeting on TB.[97]

Social protection interventions to address TB must include measures to prevent and mitigate not just direct medical costs, but also non-medical and indirect costs associated with the disease.[98] A focus on equity will be essential not only to end the TB epidemic, but also to achieve UHC.

With TB a disease that disproportionately affects the poorest and most marginalised of society, lessons learned and services built to support an effective TB response feed directly into ensuring a country is building robust UHC. Ending TB and building UHC are not competing goals: they are deeply and inherently complementary, and we encourage all countries to scale up their response to ensure no one is left behind.

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*.[99] Full details of the literature search are available on request.

The research also drew heavily on WHO publications, including the 2018 *Global TB Report*[100] (in particular chapter 7), *Implementing the End TB Strategy: The Essentials*,[101] and *A Healthier Humanity: The WHO Investment Case for 2019-2023*.[102]

The Political Declaration of the UN High-Level Meeting on TB was also used to identify the 18 indictors 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.[103]

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.[104]
- The MSF/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.[105]
- The O'Neill Institute and Stop TB Partnership review of TB-related laws.[106]

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.

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/is underway/is 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, TB and harm reduction 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.[107]

Due to language, time and document availability constraints, the following countries were not included in the analysis; Belarus, Chad, China, Central African Republic, Congo, DR Congo, Guinea-Bissau, Kyrgyzstan, Moldova, Mozambique, Peru, Philippines, Somalia, Ukraine, Uzbekistan, Vietnam.

Countries included in the analysis; Angola, Azerbaijan, Bangladesh, 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.

DOCUMENTS INCLUDED IN ANALYSIS

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.

Methodology (cont) DOCUMENTS REVIEWED IN THE SCORECARD

The following documents were reviewed by RESULTS UK in collaboration with ACTION from May to October 2019.

Angola
- Relatório 2015 Programa Nacional de Controlo da Tuberculose – Angola, 2016

Azerbaijan
- National Strategic Plan for Tuberculosis Control in Republic of Azerbaijan, 2016-2020

Bangladesh
- National Strategic Plan Public-Private Mix in Tuberculosis, 2016-2020
- National Guidelines on TB/HIV Management Program Collaboration & Implementation Manual, Second Edition, 2016
- National Guidelines for the Management of Tuberculosis in Children, first edition, 2012
- National Guidelines and Operational Manual for Programmatic Management of Drug Resistant TB (PMDT), second edition, 2013

Botswana
- Botswana TB/HIV Policy Guidelines, 2011
- National Tuberculosis Programme Manual, sixth edition, 2007
- National Tuberculosis Control Program Strategic Plan, 2018-2023
- Desk review of Botswana National TB Program, 2014
- Draft Report of a joint TB, ART, STI, CHBC and Hepatitis Programmes Review, 2017

Brazil
- Brasil Livre da Tuberculose Plano Nacional pelo Fim da Tuberculose como Problema de Saúde Pública, 2017
- Manual De Recomendações Para O Controle Da Tuberculose No Brasil, 2 edicao, 2019
- Recomendações para o manejo da coinfecção TB-HIV em serviços de atenção especializada a pessoas vivendo com HIV/AIDS, 2013
- Direitos Humanos, Cidadania E Tuberculose Na Perspectiva Da Legislação Brasileira, 1ª edição, 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 I's in Continuum of Care (CoC) Settings, 2010

Cameroon
- Plan Strategique De Lutte Contre La Tuberculose Au Cameroun, 2015-2019

DPR Korea
- National Strategic Plan for Tuberculosis Control, 2018-2021

Eswatini
- National Tuberculosis Strategic Plan, 2015-2019
- Drug Resistant Tuberculosis Management Guidelines and Manual, 2008
- National Policy Guidelines for TB/HIV Collaborative Activities, 2007

Ethiopia
- National Strategic Plan Tuberculosis and Leprosy Control, 2006-2013
- Guidelines for Clinical and Programmatic Management of TB, Leprosy and TB/HIV in Ethiopia, fifth edition, 2012
- Guidelines on Programmatic Management of Drug Resistant Tuberculosis in Ethiopia, second edition, 2013
- National Implementation Guidelines for TB Prevention and Control Through Public-Private Mix Approach in Ethiopia, 2017
- National Guidelines for TB, DR-TB and Leprosy in Ethiopia, sixth edition, 2018

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, 2012
- Plan to Initiate and Expand Drug Resistant TB Management in Ghana, 2011

India
- National Strategic Plan for Tuberculosis: 2017-25 Elimination by 2025, 2017
- Guidance Document on TB-HIV Linkages for Targeted Intervention (TI) and Link Worker Scheme (LWS), 2018
- National Framework for Joint HIV/TB Collaborative Activities, 2013
- Technical and Operational Guidelines for TB Control in India, 2016

Indonesia
- National Strategy for Tuberculosis Control, 2015-2019

Kazakstan
- КОМПЛЕКСНЫЙ ПЛАН ПО БОРЬБЕ С ТУБЕРКУЛЕЗОМ В РЕСПУБЛИКЕ КАЗАХСТАН НА 2014-2020 ГОДЫ

Kenya
- National Strategic Plan for Tuberculosis, Leprosy and Lung Health, 2019-2023
- National Guidelines on Management of Tuberculosis in Children, third edition, 2017
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RESULTS

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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