TUBERCULOSIS POLICIES IN 43 COUNTRIES

STEP UP FOR TB

2024

Stop TB Partnership

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To access the report online: Stop TB Partnership:
https://www.stoptb.org/advocate-to-endtb/Step-up-for-TB-Policies-Tracker

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Stop TB Partnership

The Stop TB Partnership is leading the way to a world without TB – a disease that is curable but still kills three people every minute. Founded in 2001, the Partnership's mission is to serve every person who is vulnerable to TB and to ensure that high-quality diagnosis and treatment is available to all who need it. The Stop TB Partnership and its nearly 2,000 partners are a collective force that is transforming the fight against TB. They include international and technical organizations, government programmes, research and funding agencies, foundations, non-governmental organizations, civil society and community groups, and the private sector. The Stop TB Partnership operates through a secretariat hosted by the United Nations Office for Project Services (UNOPS) in Geneva, Switzerland, and is governed by a Board that sets strategic direction for the global fight against TB.

Step Up for TB is dedicated to people affected by TB around the world who are fighting for access to services, including access to the latest standards in diagnostics and medicines. No one should die of a curable disease for reasons of geography or economic status.

FOREWORD

Tuberculosis is the deadliest infectious disease in the world, responsible for 1.25 million deaths in 2023 and, being airborne, it affects all of us.

The **Step Up for TB (SUFT)** project stands as a testament to our collective efforts to end TB as it assesses national policies against internationally recommended policies and best practices. It is a powerful tool for accelerating the impact of our efforts on ending TB through swift policy changes and innovations. This year's report showcases the advancements, challenges, and commitments of 43 out of 49 high burden countries in terms of burden of TB, drug-resistant TB and HIV-associated TB.

The findings presented in this report underscore the progress achieved in endorsement, but also the critical gaps that demand our attention. They remind us that while we have seen remarkable strides in developing new diagnostics, treatment regimens, and prevention strategies, we cannot afford to lose momentum due to delays in enacting policies or continuing with efficient care delivery models. Bridging these gaps will require sustained and amplified political will, robust investments, and a steadfast focus on men, women and children affected by TB.

I extend my heartfelt gratitude to everyone who contributed to this report and bring us closer to our mission of ending TB.

As we embrace the findings and recommendations of SUFT 2024 Report, let us recommit to a future where ending TB is no longer an aspiration but a reality. Together, through partnership and action, we can achieve the ambitious targets set forth in the 2023 UN High Level Meeting on TB Political Declaration

Lucica Ditiu, MD

Executive Director
Stop TB Partnership

ACKNOWLEDGMENTS

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Content

List of Tables and Boxes

List of Acronyms

Am	Amikacin
ART	Antiretroviral Therapy
Bdq	Bedaquiline
BPaL	Regimen composed of Bedaquiline, Pretomanid, and Linezolid
CB	Clinical Breakpoint
CC	Critical Concentration
Cfz	Clofazimine
Cm	Capreomycin
CRG	Communities, Rights and Gender
Dlm	Delamanid
DOT	Directly-Observed Therapy
DR-TB	Drug-Resistant Tuberculosis
DS-TB	Drug-Sensitive Tuberculosis
DST	Drug Susceptibility Testing
DT	Dispersible Tablets
E	Ethambutol
Eto	Ethionamide
FDC	Fixed Dose Combination
FLQ	Fluoroquinolone
Gfx	Gatifloxacin
GX	GeneXpert (Instrument)
HIV	Human Immunodeficiency Virus
Hr-TB	Isoniazid-Resistant and Rifampicin-Susceptible Tuberculosis
IGRA	Interferon-Gamma Release Assay
INH	Isoniazid
INH(high)	Isoniazid high dose
IPD	Inpatient Department
IPT	Isoniazid Preventive Therapy
Km	Kanamycin
LF LAM	Lateral Flow Urine Lipoarabinomannan Assay
Lfx	Levofloxacin
LPA	Line Probe Assay
Lzd	Linezolid
MDR-TB	Multidrug-Resistant Tuberculosis
Mfx	Moxifloxacin
MoH	Ministry of Health
NGS	Next Generation Sequencing
OPD	Outpatient Department
PAS	P-aminosalicylic Acid
PLHIV	People Living with Human Immunodeficiency Virus
Pto	Prothionamide
RIF	Rifampicin
RR-TB	Rifampicin-Resistant Tuberculosis
SAT	Self-Administered Therapy
SDRA	Stringent Drug Regulatory Authority
SLID	Second-Line Injectable Drug
SSM	Sputum Smear Microscopy
SSM+ve	Sputum Smear Microscopy positive
SUFT	Step up for TB
STP	Stop TB Partnership
TB	Tuberculosis
TB LAMP	TB Loop-Mediated Isothermal Amplification
TPT	TB Preventive Therapy
TST	Tuberculin Skin Test
UNHLM	United Nations High-Level Meeting on TB
US-CDC	United States Center for Disease Control
WHO	World Health Organization
WHO PQ	World Health Organization Pre-Qualification
XDR-TB	Extensively Drug-Resistant Tuberculosis
Xpert	Xpert MTB/RIF, Rapid Molecular Diagnostic Tests for TB and RR-TB (Cepheid)
Z	Pyrazinamide

EXECUTIVE SUMMARY

The 2024 SUFT survey findings on key policies in diagnosis, treatment and prevention of TB, reveals that **only a few countries consistently and promptly update their national policies after new international best practice guidelines and recommendations on TB are issued.** Consequently, innovative solutions take far too long to reach those in need, reducing their impact and hindering progress toward global commitments to reduce unnecessary illness, deaths, and transmission.

The 2024 survey is the most comprehensive yet, with 43 high TB burden countries included. With each new SUFT survey, the scope of countries included has increased, enhancing the survey's coverage and representativeness at both global and regional levels.

The detection of TB using -recommended tests is critical as it allows people with TB to be correctly diagnosed and notified. Almost all countries surveyed have in their national policies rapid molecular diagnostic (RMD) tests as the initial diagnostic TB test for all people with symptoms or X-ray abnormalities suggestive of TB. Furthermore, by policy, primary health care facilities have access to RMD testing.

National policies in the vast majority of countries surveyed indicate some level of drug susceptibility testing (DST), but far from the universal DST recommended. Universal DST is necessary to ensure that the most effective treatment regimens are used and that people with active TB disease are not treated with medicines against which their bacteria are resistant. Policies indicating DST for rifampicin among all people with bacteriologically confirmed TB and for fluoroquinolones among people with rifampicin-resistant TB (RR-TB) are widespread. DST for isoniazid among people with bacteriologically confirmed TB and DST for bedaquiline or linezolid among people with pre-extensively drug-resistant TB (pre-XDR-TB) are less commonly found in policies.

Chest X-ray (CXR) is a primary tool in TB screening mentioned in national TB policies in almost all countries, however over half of countries reported that

they do not include CXR in national TB screening and diagnostic algorithms in parallel to symptom screening among individuals with or without symptom(s) of TB.

An emerging tool in the diagnostic arsenal is computer-aided detection (CAD) software used to interpret CXR for TB. Out of 43 countries, 31 reported on this policy. Among them, 26 have fully integrated the policy into their national guidelines, while an additional 5 have incorporated certain aspects of it. Of the 26 countries with established policies, 12 reported having provisions for using CAD software to screen and triage TB as a substitute for human readers or radiologists.

Significant progress has been made in the last two decades in the development of new, more effective TB treatments with fewer side effects, fewer pills, and shorter regimens. Uptake of the 4-month regimen (2HPMZ/2HPM) for the treatment of drug-susceptible TB remains low as less than a third of countries surveyed report a policy with this regimen. Over 72% of countries have policies on the 6-month (BPaLM) regimen for treatment of MDR/RR-TB and pre-XDR-TB in adults. However, the results are less favourable for children, with less than half of countries reporting policies on the 4-month treatment regimen (2HRZ(E)/2HR) for the treatment of drug-susceptible TB in children.

Less than half of National TB Program (NTP) managers have not yet endorsed policies on a TB stigma measurement that is validated/recognized. Without focusing on TB stigma and its drivers, we risk alienating affected people from TB care before they even enter the health system.

Reducing the burden of TB disease requires adequate funding, a problem faced in a majority of low or middle-income countries (LMICs). To address the full cost of TB program needs, countries must increase domestic financing, a large proportion of which can be addressed by Universal Health Coverage (UHC) related financing.

In the 2024 SUFT survey, only 11 (26%) of countries reported that TB services are covered by a Government supported health insurance scheme (6 countries partially met and 5 countries with no data). This is far from the UNHLM target of 100% coverage of a health and social benefits package for people with TB by 2027.

Regional differences exist in policy updates based on new best practice guidelines. The Eastern Europe/ Central Asia region showed far better uptake of new recommendations and integration into national policy compared to the Africa and Asia regions.

INTRODUCTION

Every 26 seconds a person dies from TB,

but this can change if governments implement the recommended policies and practices[1].

TB continues to be the world's deadliest infectious disease,

causing almost **1.25 MILLION DEATHS** in 2023 globally[2].

Following a steady annual decline in TB incidence and mortality prior to the COVID-19 pandemic from 2010 to 2020, TB incidence increased by almost 5% between 2020 and 2023[3]. Reaching the milestones and targets in SDG 3 of ending TB requires an annual decline in the TB incidence rate. Shortfalls in reaching the incremental decreases in TB incidence mean the overall goal of ending TB remains out of reach.

In 2023, TB was not only a major cause of deaths related to antimicrobial resistance, but the leading killer of people with HIV[4]. In 2023, an estimated 10.8 million people fell ill with TB globally, affecting some of the most vulnerable populations: 12% of the total were children and 6.1% were people living with HIV (PLHIV)[5]. PLHIV are not only about 14 times more likely to develop TB disease, they also have poorer TB treatment outcomes and a three-fold higher mortality during TB treatment compared to people without HIV[6]. Children face similar vulnerability in TB disease, with the added challenge of significant diagnostic gaps.

We are far off the mark to reach the End TB Strategy 2025 milestone of a 50% reduction in TB incidence rate compared to 2015 and a 75% reduction in TB deaths compared to 2015. Getting back on track to end TB will require sustained and committed effort by countries and the adoption of best practices and policies.

Bringing TB diagnosis closer to key populations to equitably screen people for TB and link them to care is vital to find the estimated 2.7 million missing cases of TB that go undiagnosed and untreated annually[7]. This global gap between incident cases and notified cases is down from 4 million in 2021, due to innovations in TB diagnosis and adoption of international best practices. Finding the missing cases by identifying and developing strategies to reduce the diagnostic gap is needed to save lives- TB is preventable with high rates of treatment success when promptly diagnosed and treated.

[1] World Health Organization, Global Tuberculosis Report 2024.

[2] World Health Organization, Global Tuberculosis Report 2024.

[3] World Health Organization, Global Tuberculosis Report 2024.

[4] World Health Organization, "Tuberculosis Resurges as Top Infectious Disease Killer."

[5] World Health Organization, Global Tuberculosis Report 2024.

[6] World Health Organization, "WHO Launches Updated Guidance on HIV-Associated TB."

[7] World Health Organization, Global Tuberculosis Report 2024.

Eight countries accounted for more than two thirds of the global number of people falling ill with TB and, apart from China, are countries included in this report: India, Indonesia, China, the Philippines, Pakistan, Nigeria, Bangladesh and the Democratic Republic of the Congo[8]. The top five countries alone account for over half of the global total[9]. Continued political commitment by these countries is needed to reach the targets of some important documents such as the Global Plan to End TB 2023-2030, WHO End TB Strategy and the 2023 UN High-Level Meeting (UNHLM) on TB Declaration.

While overall TB deaths have slightly decreased from 1.32 million in 2022 to 1.25 million in 2023, continued efforts to close the gaps in diagnosis and treatment are vital[10]. This is particularly important for the threat of MDR-TB. Globally, the estimated annual number of MDR-TB cases was flat between 2020 and 2023: around 400,000 people11. Ending the MDR-TB crisis and TB epidemic is possible through bold policies, supportive systems, integrated patient-centered care and prevention, pillars of the End TB Strategy.

The #StepUpforTB campaign by the Stop TB Partnership aims to increase awareness about how the gaps in TB policies and practices lead to unnecessary TB deaths around the world. The goal of the #StepUpforTB campaign is to encourage governments to adopt and implement up-to-date TB policies and guidelines. The Step Up for TB report offers resources to monitor progress and ensure accountability to UNHLM goals and reach targets of Sustainable Development Goal 3.3 to end TB by 2030. These resources will inform and empower campaigners to push governments towards closing the deadly TB diagnosis and treatment gaps.

Governments, advocates and TB-affected communities can use this report to measure and compare countries' progress, including towards political commitments made at the UNHLM in 2023, and to help identify priority areas for policy change and advocacy. While SUFT highlights national policies in place, monitoring of policy implementation falls outside the scope of this report.

Aligning national policies and guidelines with international best practice is critical in the fight to end TB. Internationally recognized recommendations and guidelines are based on contemporary scientific evidence to achieve the best health outcomes possible for people affected by TB. Outdated national policies and guidelines can lead to unnecessary transmission, and the suffering and death of people with TB.

[8] World Health Organization, Global Tuberculosis Report 2024.

[9] World Health Organization, Global Tuberculosis Report 2024.

[10] World Health Organization, Global Tuberculosis Report 2024.

[11] World Health Organization, Global Tuberculosis Report 2024.

01

METHODOLOGY

Scope

Step Up for TB (SUFT) 2024 reviews the findings from a survey of national TB policies in 43 of the 49 high-burden countries (HBCs) and whether they align with internationally recognized recommendations and guidelines.

The SUFT 2024 report is the sixth in a series (earlier reports, previously called the 'Out of Step' reports, were published in 2014, 2015 and 2017; the 2020 and 2023 reports were called 'Step Up for TB'). Previous reports examined up to 37 countries and indicators related to diagnosis, treatment, prevention, and medicines procurement. With each survey, the scope of countries included has increased, enhancing the survey's coverage and representativeness at both global and regional levels.

The 2024 survey is the most comprehensive yet, with 88% HBCs representation. The survey assessed whether national TB policies and guidelines align with international best practices across six key areas: prevention, diagnostics, treatment, models of care, TB stigma, and TB financing.

Identifying national and global trends and gaps in TB policies can help to determine where future resources, support and advocacy efforts should be directed. Countries covered in the survey are listed in Annex 3.

SURVEY OF NATIONAL TB POLICIES

in 43 of the 49 high-burden countries (HBCs)

six key areas: prevention, diagnostics, treatment, models of care, community rights and gender, and TB financing.

Reports in the series

- **2014**
  Out of Step
- **2015**
  Out of Step
- **2017**
  Out of Step
- **2020**
  Step Up for TB
- **2023**
  Step Up for TB
- **2024**
  Step Up for TB
  the most comprehensive yet, with ***88% HBCs representation***

Questionnaire

SUFT is a cross-sectional survey conducted using purposive sampling through interviews in person or by phone with the National TB Program (NTP) manager or someone officially delegated by the NTP manager. The survey's initial targeting encompassed 49 countries, all of which are designated by WHO as high TB, TB/HIV and/or MDR-TB burden countries. Cambodia was added to the list of countries under WHO's special watch after being removed from the HBC list. Collectively, these 50 countries comprise 90% of the global TB burden. Seven countries were excluded from the analysis due to non-responsiveness and unavailability to participate in the survey.

The questionnaire covered 99 indicators in total that were developed through consultation with Stop TB Partnership advisers and partners and were selected as the most critical policies for TB advocacy. The questionnaire was tested for usability and interpretation with SUFT technical consultants at a meeting held in February 2024 to ensure clear and concise language. The questionnaire was developed in English and translated as needed for each participating country (Spanish, French, Russian and Portuguese).

Data Collection

Data were collected using a semi-structured questionnaire through an in-person interview or phone call with the NTP Manager in the 43 countries by SUFT technical consultants. Interviews were conducted in the language preferred by the NTP Manager, and the study team provided simultaneous interpretations, translated versions of the questionnaire in countries where this was needed. Before the NTP interviews, the study team attempted to collect all relevant national Ministry of Health-approved TB and HIV policy documents and guidelines. At the same time, SUFT consultants also collected documents by searching online sources and documents used in the previous survey. Several rounds of clarification were implemented by the SUFT consultants with NTP managers to clarify respondent's answers and to obtain missing policies as supporting references for the data recorded. Completed questionnaires were reviewed by SUFT Stop TB Partnership technical consultants to check for consistency, clarity, translation and whether supporting documents were available for each answer. A final round of validation from the country NTPs was then obtained. Given the possibility for later policy updates, NTPs were also provided access to the SUFT online portal for further updates and uploading of the policies if needed.

Indicators

Based on the confirmed questions in the questionnaire, SUFT consultants developed data indicators that informed the survey data analysis. These indicators were subsequently grouped into three categories: "key indicators," "prioritized indicators," and "TB indicators." The "key indicators" served as the main foundation for the results and discussions presented in the report.

The full questionnaire is included as Annex 1.

The full list of indicators is included as Annex 2.

All collected data for the indicators is available in spreadsheets, automatically generated upon request on https://suft.stoptb.org/

Analysis

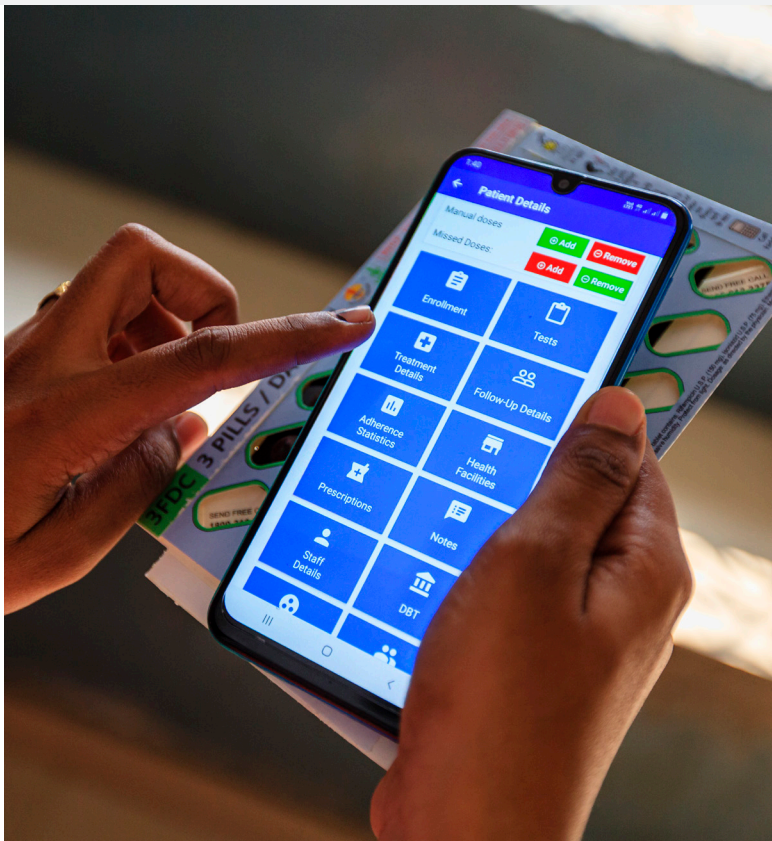
Benchmarks for the survey included internationally recognized recommendations and guidelines that were available up until November 2024. National policies and guidelines established before the end of December 2021 were not included for analysis. For survey inclusion to be deemed 'adopted by the government' at the national level, documents were either: published and in the public domain (e.g. available in hard copy or online) with the government's title or logo on it, signed by a Minister or other national government official, introduced (e.g. foreword, speech, announcement, social media post) by a Minister or other national government official, recognized in the legislation of the country, or formally circulated by the national government (e.g. Ministry of Health) to a range of internal and/or external stakeholders with an accompanying statement of guidance or action required (possibly not published and in the public domain). A sample list of national documents used is included in Annex 4. Data were entered into the SUFT e-portal hosted by the Stop TB Partnership, and key findings were provided for each area as percentages and numbers. As a result of changes made in the indicators and methodology for 2024, and newly published international recommendations, comparisons with prior surveys were not made.

Data were scored as "fully met", "partially met", "unmet" or "no data". A partially met ranking indicated that the policies were met only under operational research conditions, with specific criteria, populations or regions.

Table. 1 Data key

	Fully met	Yes
	Partially met	Only under operational research conditions/ with specific criteria/for specific group of population/only in selected conditions/for specific cases/in specific regions
	Unmet	No
	No data	Do not know / Difficult to answer/ N/A

The SUFT survey of TB prevention, testing, and treatment policies and practices results is available through the SUFT e-portal at https://suft.stoptb.org/. The e-portal enables countries to monitor their progress in establishing TB policies and guidelines against international recommendations. It features factsheets, trend lines, maps, and pivotal spreadsheets to visualize the data collected from the survey. Countries can update their data at any time directly through the portal or request the Stop TB Partnership Secretariat staff to assist. As a valuable advocacy tool, the SUFT e-portal is used by partners and countries to track TB policy adoption at national, regional, and global levels. This dynamic platform allows country NTP focal points to make timely edits and ensure that country profiles remain up to date.



Scoring

To provide a quantitative assessment of the data collection results, the SUFT team applied the following scoring system:

This quantification enabled the team to calculate final scores and determine the percentage of policy coverage.

	Fully met	Yes **– 1.0**
	Partially met	Only under operational research conditions, with specific criteria, for specific population groups, in selected conditions, for specific cases, or in specific regions **– 0.5**
	Unmet	No **– 0.0**
	No data	Do not know / Difficult to answer/ N/A **– 0.0**

Results

A. DIAGNOSING TB

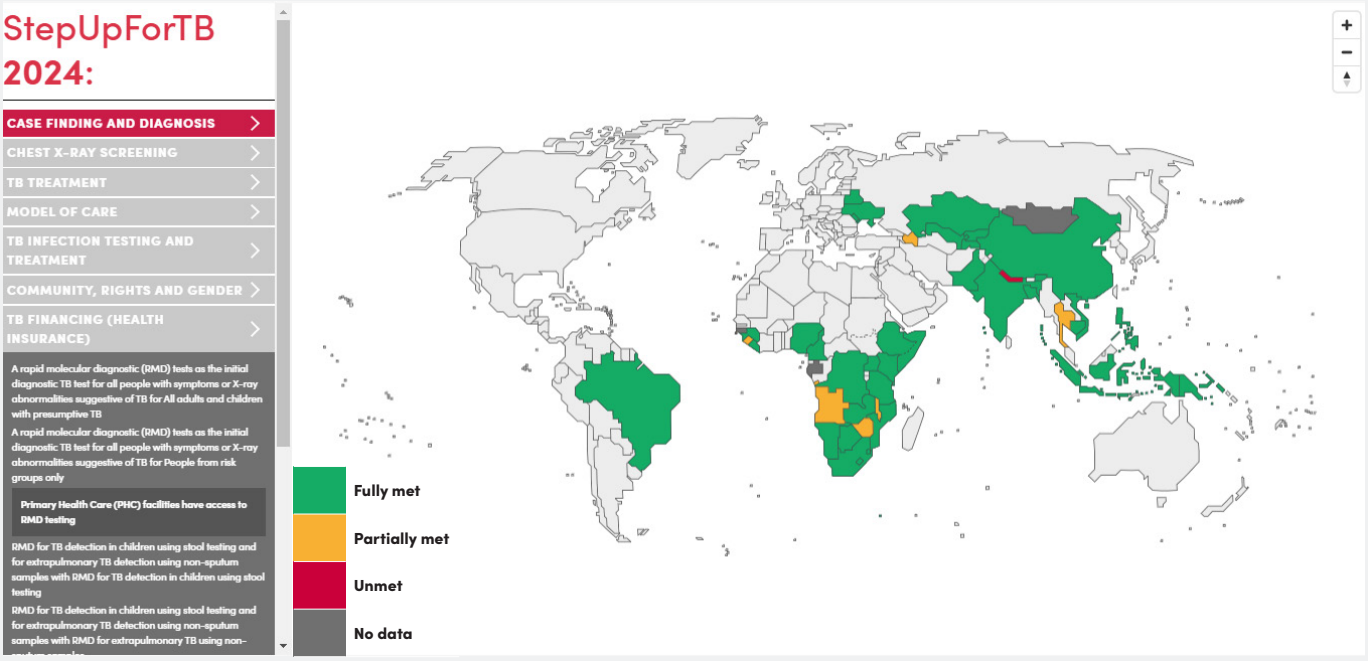
i. Case finding and diagnosis indicators

The detection of TB using recommended tests is critical as it allows people with TB to be correctly and rapidly diagnosed and notified. Previous editions of this report described the slow roll-out of rapid molecular diagnostics (RMDs) that could help transform the TB response. This report finds that 40 countries (1 partially met, 2 no data) policies now indicate RMDs as the initial diagnostic TB test for all people (adults, children and at-risk groups) with symptoms or X-ray abnormalities suggestive of TB.

Furthermore, all but one country in the survey (33 met, 6 partially met and 3 no data) indicated that primary health care (PHC) facilities have access to RMD testing, underscoring countries' commitment from the 2023 UN High-Level Meeting on TB to integrate systematic screening, prevention, treatment and care of TB, and related health conditions, within PHC, including community-based health services[12].

[12] World Health Organization, "UN Declaration on TB." 2023

Picture. 1 Step Up for TB. Indicator: Primary health care (PHC) facilities have access to RMD testing



The designations employed and the presentation of the material on this map do not imply the expression of any opinion whatsoever on the part of the Stop TB Secretariat concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

72% **OF COUNTRIES SURVEYED**

had **RMD for TB detection in children** using stool testing and

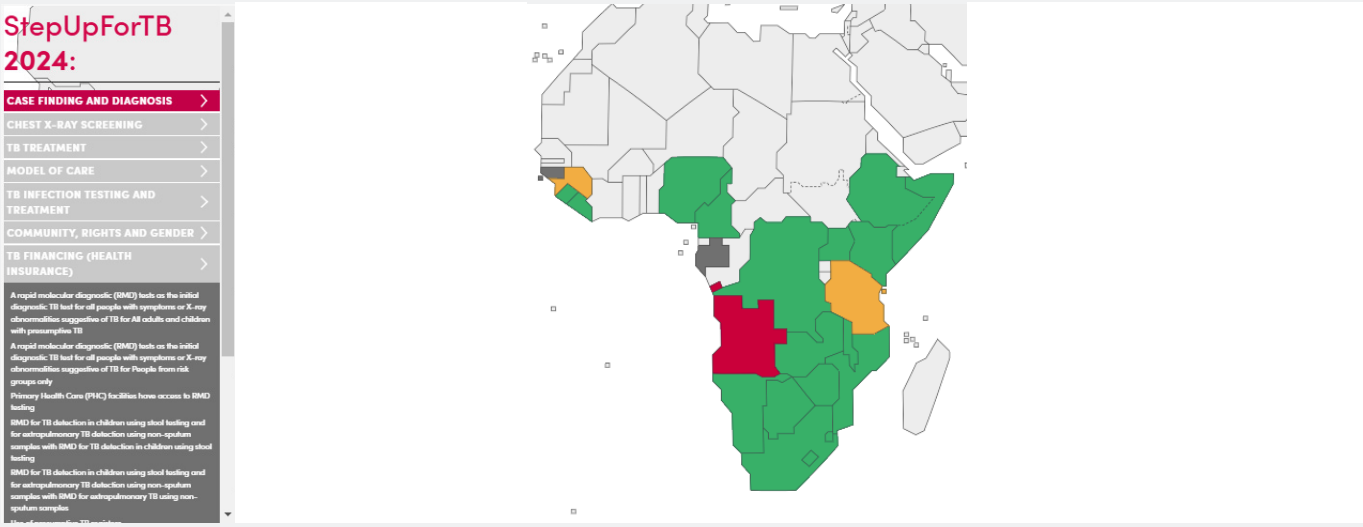
65%

had **non-sputum samples for detection of extrapulmonary TB in children and adults** cited in national policies.

The End TB Strategy prioritizes the early diagnosis of TB, especially in at-risk populations like people living with HIV (PLHIV). The TB lateral flow urine lipoarabinomannan (LF-LAM) assay, a urine-based, rapid point-of-care test, offers a simple way to save lives by rapidly detecting TB in PLHIV. However, unlike traditional diagnostic methods, urinary LAM assays demonstrate improved sensitivity for the diagnosis of TB among individuals coinfected with HIV[13]. Sixty five percent of countries surveyed (4 partially met, 2 no data) reported the LF-LAM assay as an initial test in combination with RMD for PLHIV in in-patient facilities is included in national policy. This figure decreased to 58% in out-patient facilities (7 partially met and 2 no data) for the 2024 survey. This is a slight improvement from the 2023 survey, where 55% of countries surveyed recommended LF-LAM in in-patient facilities.

[13] World Health Organization, "Lateral Flow Urine Lipoarabinomannan Assay (LF-LAM) for the Diagnosis of Active Tuberculosis in People Living With HIV, 2019 Update."

Picture. 2 Step Up for TB. Indicator: Lateral flow urine lipoarabinomannan (LF-LAM) assay as an initial test in combination with RMD for PLHIV in out- and in-patient facilities / departments, African region.



The percentage of people with a new diagnosis of TB who are living with HIV is highest in countries in the African Region, exceeding 50% in parts of southern Africa[14]. The SUFT survey found that only one country in the African region (2 partially met and 2 no data) has not included LF-LAM in policy or documents, showing a strong commitment in the region to international best diagnostic practices. LF-LAM policy inclusion for use in any setting (in- or out-patient) is significantly lagging in the South Asian and Western Pacific regions.

Seventy percent of countries reported use of presumptive TB registers stipulated in policy documents, with the African region reporting the highest uptake of this indicator at 100% of countries (no data for 3 countries). The South Asian region reported the least uptake in use of presumptive TB registers with 4 out of 7 countries reporting Yes to this indicator.

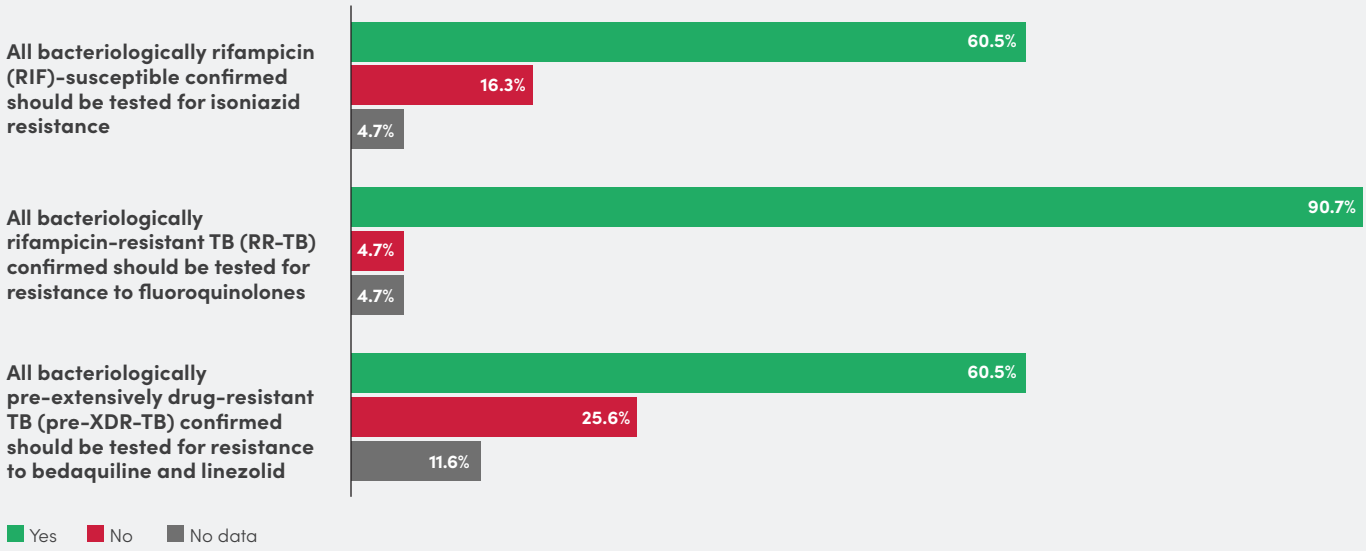
Regarding comprehensive drug susceptibility testing (DST), national policies in the vast majority of countries surveyed indicate some level of DST, but far from the universal DST called for by the End TB Strategy. Universal DST is necessary to ensure that the most effective treatment regimens are used and that people with active TB disease are not treated with medicines against which their bacteria are resistant. Only 60% of high-burden TB countries surveyed have a policy on isoniazid resistance testing for people with bacteriologically confirmed rifampicin-susceptible TB.

UNIVERSAL DST...

is defined as testing all patients with bacteriologically confirmed TB for resistance to rifampicin, all patients with RR-TB for resistance to fluoroquinolones and all patients with pre-XDR-TB for resistance to bedaquiline and linezolid. These are minimum requirements, and testing for resistance to drugs according to the regimen used is preferred.

[14] World Health Organization, Global Tuberculosis Report 2024.

Picture 3. National TB policies on drug susceptibility testing



In comparison, only 2 countries surveyed indicated that they have not enacted a TB policy indicating a test for resistance to fluoroquinolones for people with bacteriologically confirmed rifampicin-resistant TB (RR-TB).

Results for the indicator on bedaquiline and linezolid resistance tests for people with bacteriologically confirmed pre-XDR-TB were much more grim. Over a quarter of countries reported no policy on DST for bedaquiline or linezolid. Of the 8 included high MDR/RR-TB burden countries, 6 reported consideration in local TB policies of bedaquiline and linezolid resistance tests for people with bacteriologically confirmed pre-XDR-TB (1 no-data and 1 not met out of the 8). Among countries overall who responded to the survey, 60% met this indicator. To continue progress in closing this gap, improvements in the TB policies around universal DST coverage and access to treatment are needed in these countries.

1/43 OF COUNTRIES SURVEYED

indicated that they **do not have** Country TB policies that mention **Chest X-ray (CXR) as a primary tool in TB screening** in all districts.

51% OF COUNTRIES REPORTED

that they **do not include CXR in national TB screening and diagnostic algorithms** (3 countries no data).

ii. Chest X-ray screening indicators

Only 1 country out of 43 surveyed indicated that they do not have national TB policies that mention chest X-ray (CXR) as a primary tool in TB screening in all districts. However, 51% of countries reported that they do not include CXR in national TB screening and diagnostic algorithms (3 countries no data). An emerging tool in the diagnostic arsenal is computer-aided detection (CAD) software powered by artificial intelligence used to interpret CXR for TB. Over 60% of countries surveyed (no data in 12 countries, partially met in 5 countries) reported having this technology in national policies, however only 28% of countries report CAD software to screen and triage TB in place of human readers/ radiologists in country policies (no data in 12 countries).

BOX 1 Change in domestic TB policies brought innovations into community active TB case finding in Nigeria

Nigeria remains the country with the highest burden of TB in Africa. Despite multiple funded interventions targeted at finding the missing TB cases, access to TB diagnostic services remains elusive, especially for disadvantaged rural populations. The USAID-funded flagship project, LON 1 & LON 2, introduced updates to the national TB screening and diagnostics policy that increased case detection by bringing services to people's doorsteps.

The project built the Wellness on Wheels (WoW) truck, a 20-foot shipping container retrofitted as a mobile detection unit with a digital X-ray machine equipped with CAD, two 4 modular GeneXpert machines and a level 2 biosafety cabinet. As a result of the WoW, TB screening services saw a ten-fold increase in the number screened for TB over a 7 year period (2017-2024).

Building on the success of previous mobile TB detection units, the need to deploy a less expensive alternative to the WOW truck and to traverse less motorable difficult terrain where the truck could not go led to the introduction of the localized Wellness on Keke (WoK) tricycle model. The WoK innovation is a rickshaw assembled in Nigeria, housing a portable digital x-ray with CAD, and either a TB-LAMP or Truenat molecular diagnostic machine, which are less temperature sensitive and run on rechargeable batteries. The portable x-ray with CAD and Truenat machines were provided by the Stop TB Partnership's introducing New Tools Project (iNTP) funded by USAID. This cost-effective model can reach people in remote areas without motorable roads- previously a major barrier to improving case detection rates in Nigeria. During the first 3 years of the project, the number of people screened for TB increased almost seven times from 2022-2024.

Through updating the national TB diagnostic and screening policy, new innovations have emerged to meet the needs of rural communities in Nigeria and contributed to finding the missing cases in previously hard to reach areas.

The WoW truck set up for TB active case finding

The WoK working in a community

The WoK working in a community

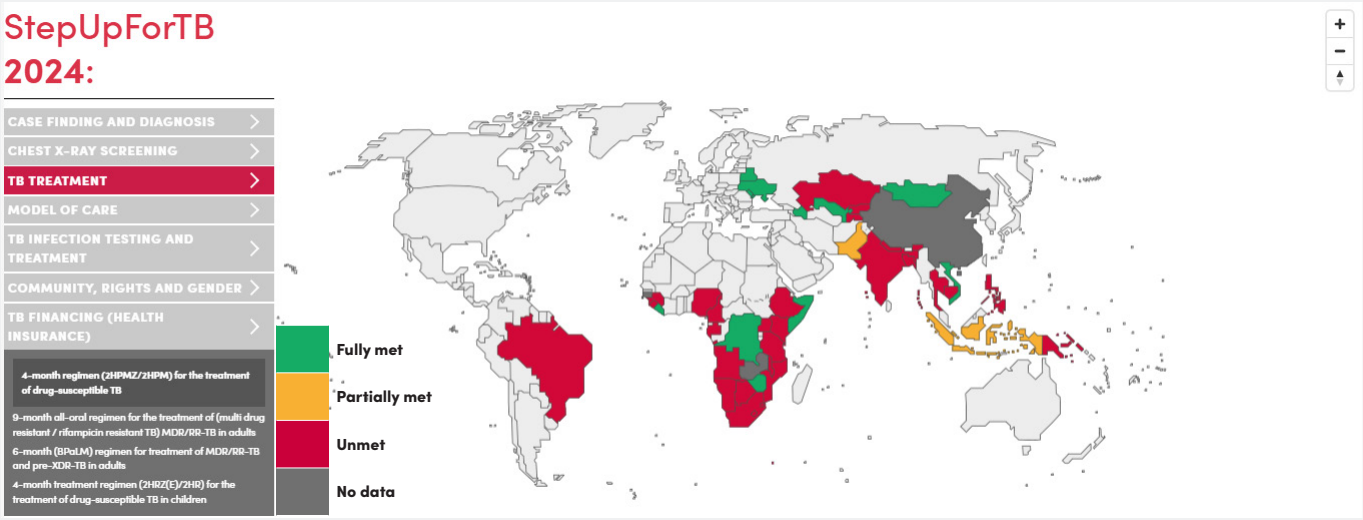
Pictures from KNCV Nigeria

B. TB TREATMENT

i.Treatment

Significant progress has been made in the last two decades in the development of new, more effective TB treatments with fewer side effects, fewer pills, and shorter regimens. In the 2023 survey only 5% of surveyed countries included a 4-month regimen (2HPMZ/2HPM) for the treatment of drug-susceptible TB in adults in national policy. This has increased in the 2024 survey to 26% of countries (2 partially met and 3 with no data) including the 4-month regimen (2HPMZ/2HPM) for the treatment of drug-susceptible TB in adults in national policy.

Picture. 4 Step up for TB indicator: 4-month regimen (2HPMZ/2HPM) for the treatment of drug-susceptible TB



Uptake of this recommendation was highest in the Eastern Europe & Central Asia region (62.5% of countries reported including this policy) and lowest in the Africa region (only 20% of countries reported adopting this policy).

The Step Up for TB 2024 survey findings also suggest that adults with DR-TB in many countries can now benefit from policy changes in adoption of the 9-month all-oral regimen for the treatment of multi-drug resistant / rifampicin-resistant TB (MDR/RR-TB) in adults. Over 76% of responding countries indicated the 9-month all-oral regimen is included in national policy.

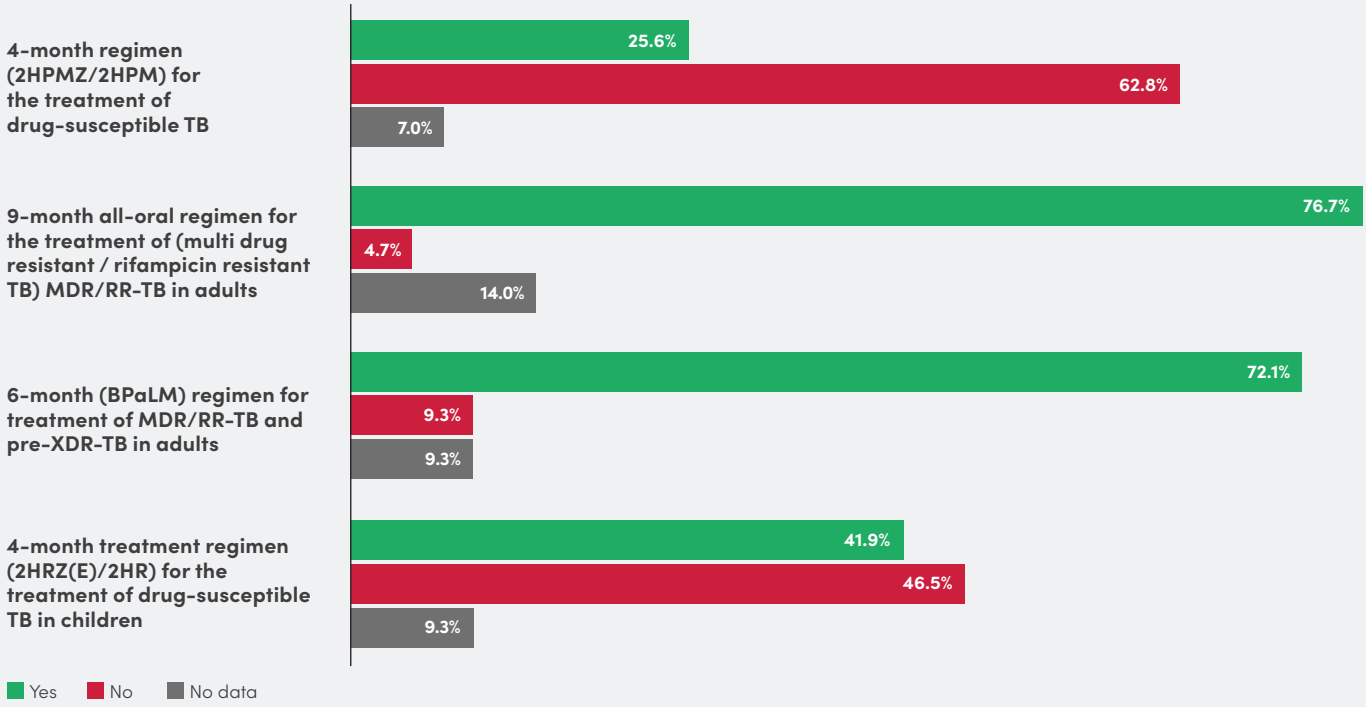
Out of all the countries surveyed only 2 countries reported they did not have a 9-month all-oral regimen in policy documents (2 countries partially met and no data provided in 6 of the 43 countries).

Survey findings for the 6-month (BPaLM) regimen for treatment of MDR/RR-TB and pre-XDR-TB in adults is equally positive with 72% of countries reporting they met this indicator (4 countries partially met and 4 countries with no data). This is a vast improvement from the 2023 survey where only 40% of countries included the BPaLM regimen for treatment of MDR/RR-TB and pre-XDR-TB in adults in national policy. Opportunities continue to exist in the Africa region (72% met this indicator) to step up their efforts to reach people with optimal treatment regimens and do so in ways that allow people to best fit TB care into their lives.

Less than half of countries (42% met, 1 country partially met and 4 countries with no data) reported including a 4-month treatment regimen (2HRZ(E)/2HR) for the treatment of drug-susceptible TB in children in policy documents. This is an improvement from the 2023

survey where only 10% of countries reported this policy. Eastern Europe/Central Asia and Africa regions are leading the way in adoption of this treatment regimen with 4 out of 8 countries in Eastern Europe/Central Asia and 11 out of 19 countries in Africa including this treatment regimen in their policies. While survey results show encouraging signs in countries' adoption of policies related to adult and child treatment regimens, the responsibility is on governments to ensure all people with TB disease receive optimal treatment.

Picture. 5 National policies on short TB treatment regimens



BOX 2 Advancing Tuberculosis Care Standards During Humanitarian Crisis: Successes in Ukraine

In January 2023, the Ministry of Health of Ukraine approved Order No. 102, establishing the "Standards of Medical Care for Tuberculosis." Despite Russian aggression, Ukraine has made significant strides in updating its national policies for TB care. "It is essential that every doctor in our country can rely on national standards developed based on the principles of evidence-based medicine, reflecting the latest international recommendations. Our physicians are equipped with the knowledge to diagnose TB cases promptly, prevent disease progression, and treat patients with the newest TB medications in a relatively shorter timeframe of 4 - 6 months," stated Yana Terleieva, Head of the Department of Management and Counteraction of TB Diagnosis and Treatment Programs at the Public Health Center of the Ministry of Health of Ukraine.

Ukraine became the first country in the WHO European region to revise its national TB care standards in alignment with the latest international recommendations. A multidisciplinary working group crafted clear and precise standards that facilitate adherence for healthcare providers and TB specialists—a key aspect of closing the MDR-TB treatment gap. The National Guidelines encompass six key areas: prevention, systematic screening for TB, diagnosis, treatment, management of TB/HIV co-infection and related diseases, and management of TB in children and adolescents.

To ensure the successful implementation of these National Standards, the TB Center has organized multiple training sessions for healthcare workers, familiarizing them with the new guidelines and enhancing the capabilities of TB doctors at both central and regional levels, particularly concerning TB care policies. The TB Center's team remains committed to ensuring that every individual in Ukraine suffering from TB receives high-quality medical care, regardless of the ongoing challenges and threats.

ii.Model of Care

When it comes to the care of people with TB disease, many countries have attempted decentralization of TB treatment by scaling up people-centered models of care. Not only are the policies around which regimens to use to treat TB important, but also the way in which treatment is delivered to better fit TB treatment into people's lives.

The 2024 survey found that 8 out of 43 countries (29 partially met and 3 countries with no data) did not require hospital admission for initiation of drug-resistant TB treatment. This is a drastic change from the 2023 report where 50% countries did not recommend hospitalization for initiation of treatment for DR-TB in their national policies.

C. TB PREVENTION

All countries in the survey (1 country with no data) included the target populations of HIV-positive children (any age), adolescents and adults for TB preventive treatment (TPT) in national policies. Household contacts under 5 years of age of confirmed drug-susceptible TB cases were endorsed as a target for TPT in 93% of countries (1 country no data), however, household contacts over age 5 (including adolescents and adults) were only included as TPT targets in 74% of countries (Table 2). This figure further reduces for people who are receiving dialysis (42%), people who are preparing for an organ or hematological transplant (44%) and people who have silicosis (40%) endorsed in national policy as a target for TPT.

Table. 2 National TB policies on eligibility for TB Preventive Treatment

	People living with HIV		HH contacts of drug-sensitive TB cases		People who are receiving dialysis	People who are preparing for an organ or hematological transplant	People who are have silicosis	Other population
	HIV-positive children (age <5 years)	HIV-positive children (aged 5 years and above), adolescents and adults	Children (aged <5 years)	Children, adolescents and adults (aged 5 years and above)				
Percentage Yes	97.7%	97.7%	93%	74.4%	41.9%	44.2%	39.5%	44.2%
Percentage No	0.0%	0.0%	4.7%	23.3%	55.8%	53.5%	58.1%	53.5%
Percentage No data	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%

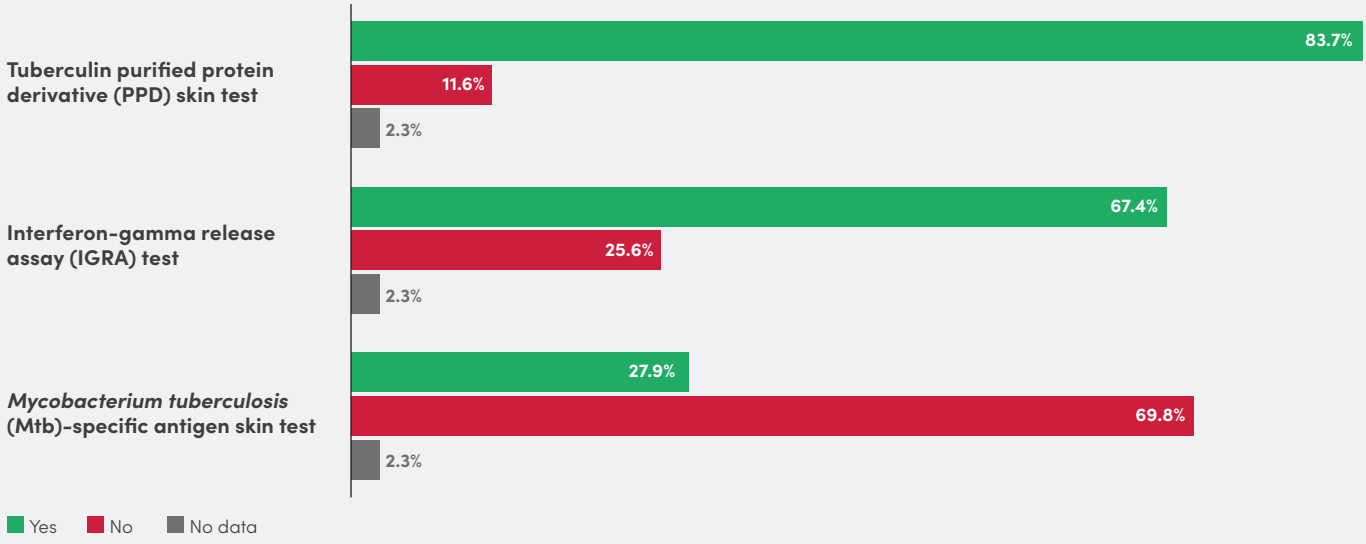
National guidelines on TPT indicate most frequently giving TPT to all such contacts without TB infection testing after active TB disease is excluded in 46% of surveyed countries. The least common policy indicated that TPT was given to contacts who tested positive with a TB infection test only when a TB infection test is available; otherwise, contacts are given TPT without TB infection testing in 39% of countries. 41% of countries only indicate giving TPT to contacts tested positive with a TB infection test in their national policies.

ii.TB infection tests

Despite TB infection testing being a best practice recommendation since 2011, only 84% of countries have a policy in place for tuberculin skin tests (TST) and 67% for IGRA (interferon-gamma release assay). The Africa region is lagging behind the other regions in policy inclusion, with only 52% reporting IGRA inclusion in national policy recommendations (2 countries partially met and 1 country no data).

Mycobacterium tuberculosis (Mtb) antigen-based skin tests (TBST) measure the cell-mediated immunological response to Mtb-specific antigens and are a new class of tests to diagnose TB infection. TBST have been a recommended best practice since 2022 and have been found to be accurate, feasible, cost-effective and represent an alternative to TST and IGRAs[15]. Despite the recommendations, 70% of countries have not yet included these tests in their policies for the diagnosis of TB infection (1 country no data). This is particularly important for the Africa region where less than 10% of countries reported a policy on TBST (1 country no data).

Picture. 6 National policies on TB infection testing

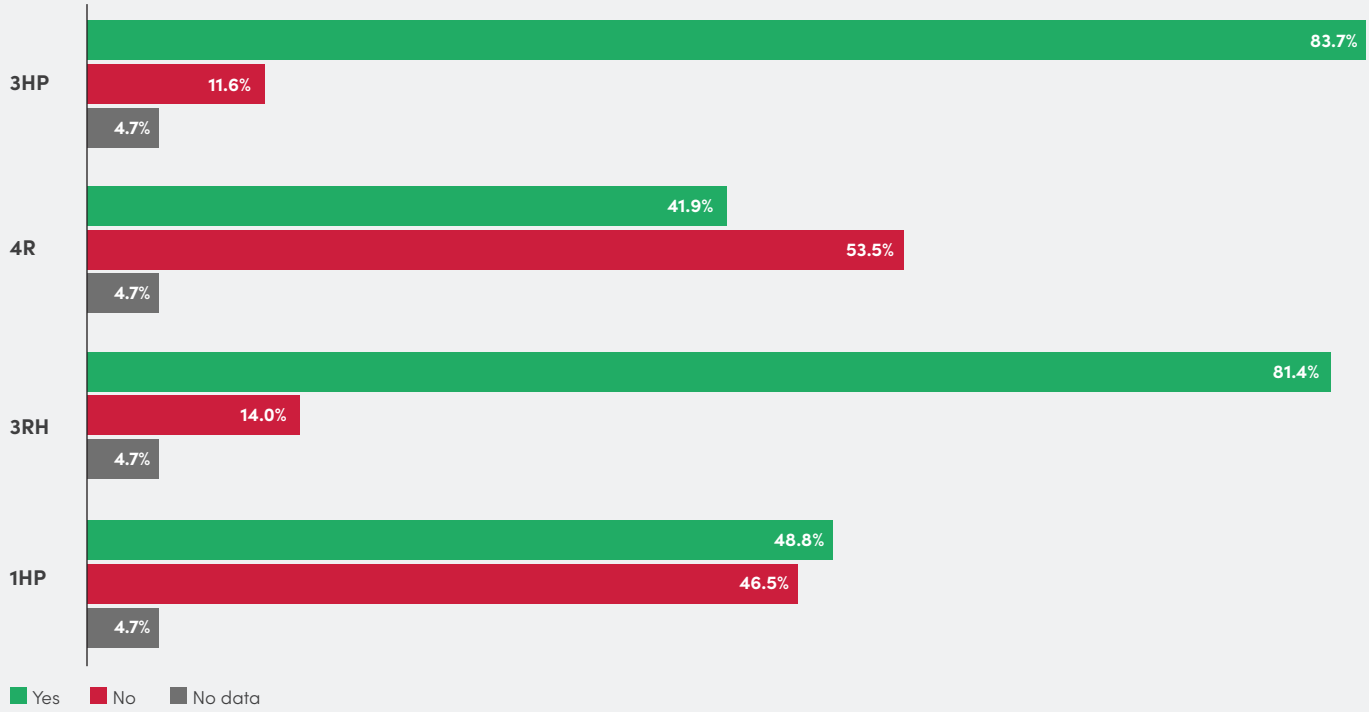


iii. Treatment of TB infection

Treatment of TB infection or TPT, remains a critical element to achieve global targets of the Global Plan to End TB. Some key findings from this report indicate positive developments in treatment of TB infection. Only 2 countries out of 41 with data available did not include the routine implementation of a short regimen (3HP/4R/3RH/1HP) for treatment of TB infection in national policy (13 yes, 26 partially met, 2 no countries no data). The top cited TPT regimens were 3HP and 3RH. Almost 84% of countries include 3HP TPT in their national policies and over 81% of countries include 3RH in their policies. 4R and 1HP were the TPT regimens least included in national policies at 42% and 49% respectively. 4R and 1HP are more widely adopted in Eastern Europe and Central Asia countries' policies, whereas the other regions rarely included 4R and 1HP as TPT treatment in national policies.

[15] World Health Organization "WHO Announces Updates on New TB Antigen-Based Skin Tests for the Diagnosis of TB Infection."

Picture. 7 National policies on Treatment of TB infection



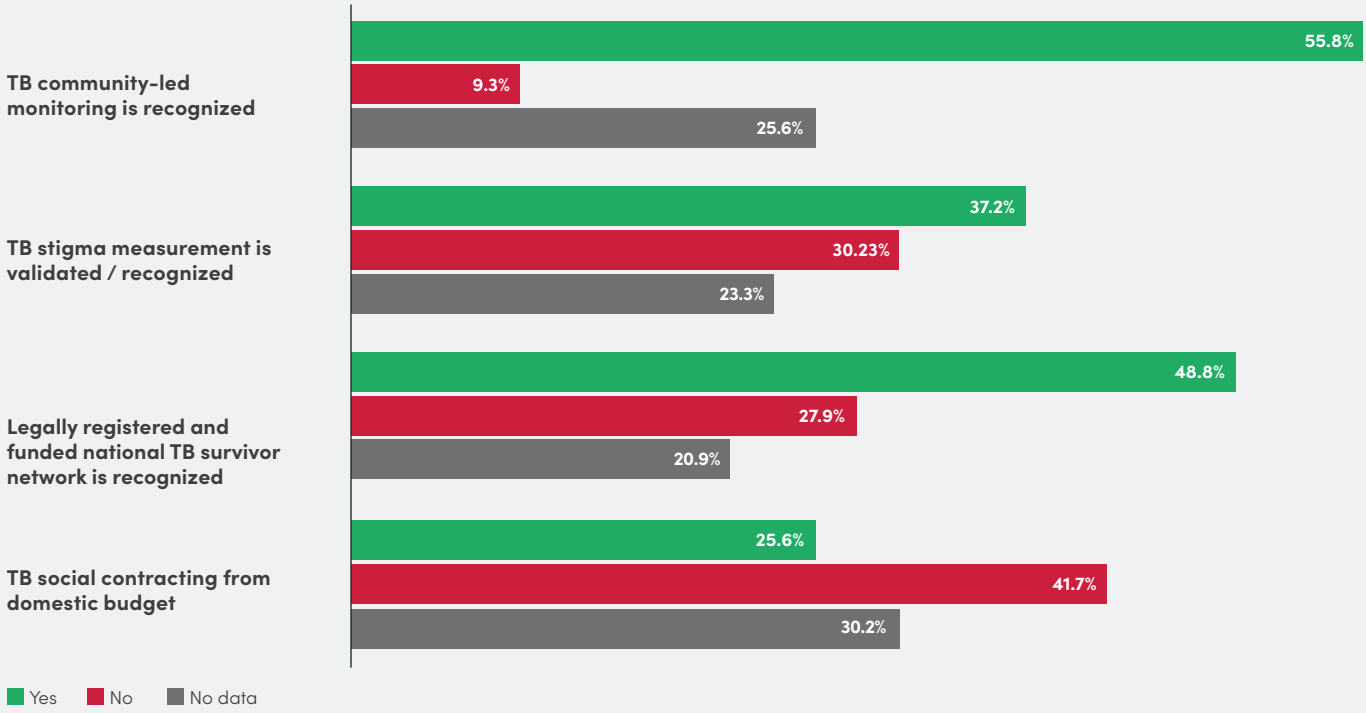
D. TB STIGMA AND COMMUNITY

Community-led monitoring (CLM) country policies for access to TB screening and diagnostic testing enables communities to monitor the availability, accessibility, and quality of TB services. TB community-led monitoring is recognized by national policies in 56% of countries (4 countries partially met and 11 countries with no data), the lowest being the South Asia region at 67% of countries. The results are not as positive for a TB stigma measurement that is validated / recognized in national policies; only 37% of NTPs have adopted these policies.

Without focusing on TB stigma and its drivers, we risk alienating affected people from TB care before they even enter the health system. Of the 6 countries who reported data in the Eastern Europe/Central Asia region, all reported inclusion of a TB stigma measurement that is validated / recognized in national policies, illustrating their commitment to make the TB response rights-based, equitable and stigma-free.

Overall countries reported a lack of a legally registered and funded national TB survivor network in national policies with only 49% meeting this indicator. The regions leading the way with a legally registered and funded national TB survivor network in national policies are Eastern Europe/Central Asia (63%) and Africa (55%). Compassionate support for those recovering from TB disease is vital to empower survivors to break the stigma.

Picture. 8 Social TB responses



BOX 3 Creating Easy-to-Use National TB Management Guidelines Through a Collaborative Approach in Pakistan

Beginning in December 2023, Pakistan began the revision of the National TB Management Guidelines, exemplifying a collaborative, precise, and implementation-focused approach. Guideline updates were led by a Technical Working Group comprised of governmental representatives from National and Provincial TB Programs, technical experts from the Pakistan Chest Society, Pakistan Pediatric Association, Family Medicine, and implementing international and local partners: Mercy Corps, Association for Social Development, Association for Community Development, Dopasi Foundation, John Snow, Inc, WHO and USAID. The collaborative process was remarkably straightforward and created comprehensive and accessible guidelines that improve the diagnosis, treatment and prevention of TB nationwide.

The process was facilitated by local consultants through consultative meetings across four provinces that fostered broad stakeholder engagement from both provincial and district levels. These processes urged key updates and the need for alignment with best practice recommendations, followed by focused, point-by-point discussions, refining the draft for clarity and actionable steps to simplify their implementation.

The final consultation meeting in Islamabad in April 2024 gathered key stakeholders for final feedback, after which the National TB Program team reviewed and shared the finalized guidelines. Allowing for a diversity of perspectives and ideas by utilizing a collaborative approach, the working group produced several exemplary training materials including desk guides, training modules, facilitator guides, and presentations.

This practical, results-oriented approach highlights Pakistan's commitment to streamlined, clear policy processes for TB management, in line with the UN high-level meeting on TB commitment made to include the active involvement of stakeholders to address barriers and enable universal access to quality TB services.

E. TB FINANCING AND SOCIAL CONTRACTING

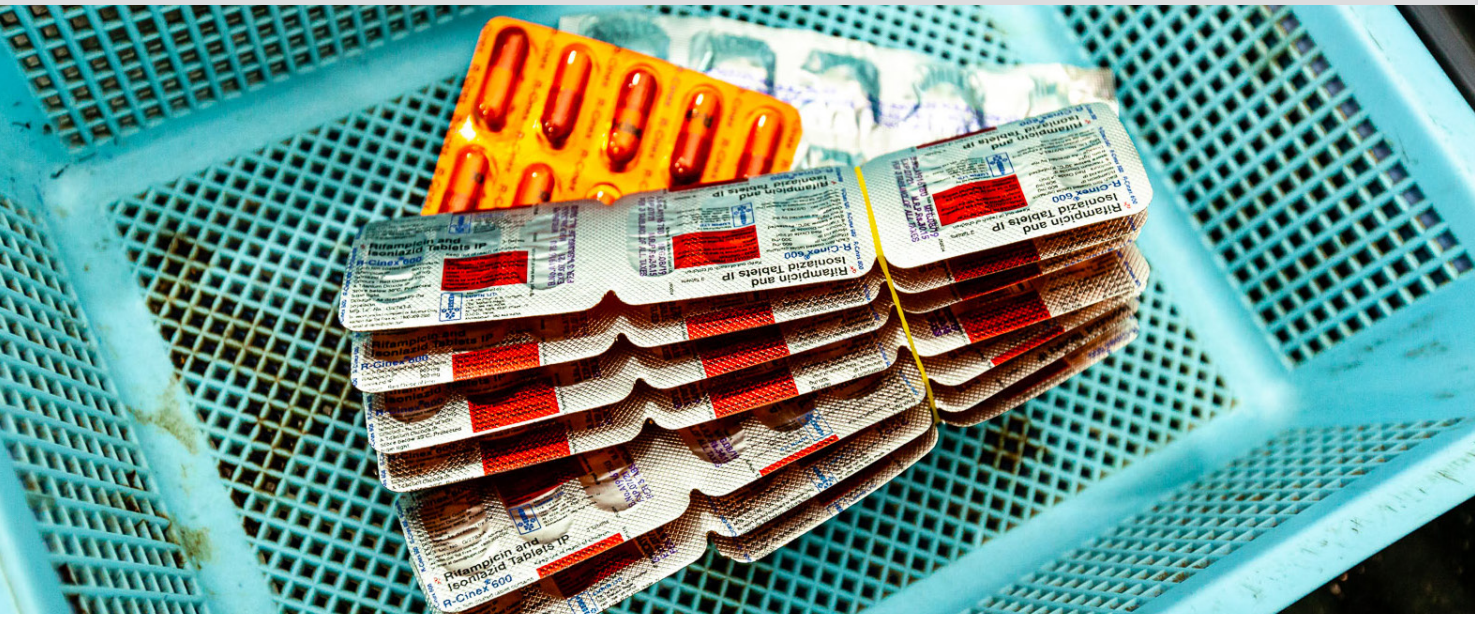
Social contracting is an efficient and cost-effective way to link civil society organizations (CSOs) with government funding for TB programs, allowing CSOs to provide services that strengthen TB disease response and reach those who may otherwise be left behind. Despite the recognized vital role TB social contracting can play, only 26% of countries in the SUFT 2024 survey reported TB social contracting from the domestic budget in national policies. Despite the overall results, Eastern Europe/Central Asia is leading the way with all countries (3 with no data) reporting TB social contracting from the domestic budget in national policies.

Reducing the burden of TB disease requires adequate funding, a problem faced in a majority of LMICs where funding was not sufficient for full implementation of their national strategic plans for TB[16]. In the 2024 SUFT survey, 25.6% of countries reported that TB services are covered by a Government supported health insurance scheme (6 countries partially met and 5 countries with no data). The regions where TB services are covered by a Government supported health insurance scheme are highest in the Eastern Europe/Central Asia and South Asia and lowest in the Africa region.

BOX 4 Leading the Way in the Africa Region: National Health Insurance in Zambia and Cameroon

Out of the 21 countries in Africa that responded to the survey, it is only Zambia and Cameroon with National Health Insurance Schemes (NHIS) that fund TB services. The services covered by these schemes include TB screening and diagnosis. The insurance coverage applies when one is registered with the NHIS.

The NHIS in Zambia was established in 2018 through the National Health Insurance Act No. 2; the one in Cameroon was launched in January 2023. These two schemes were established to provide comprehensive healthcare to all citizens and legal residents, and to reduce the risk of catastrophic health expenditure.



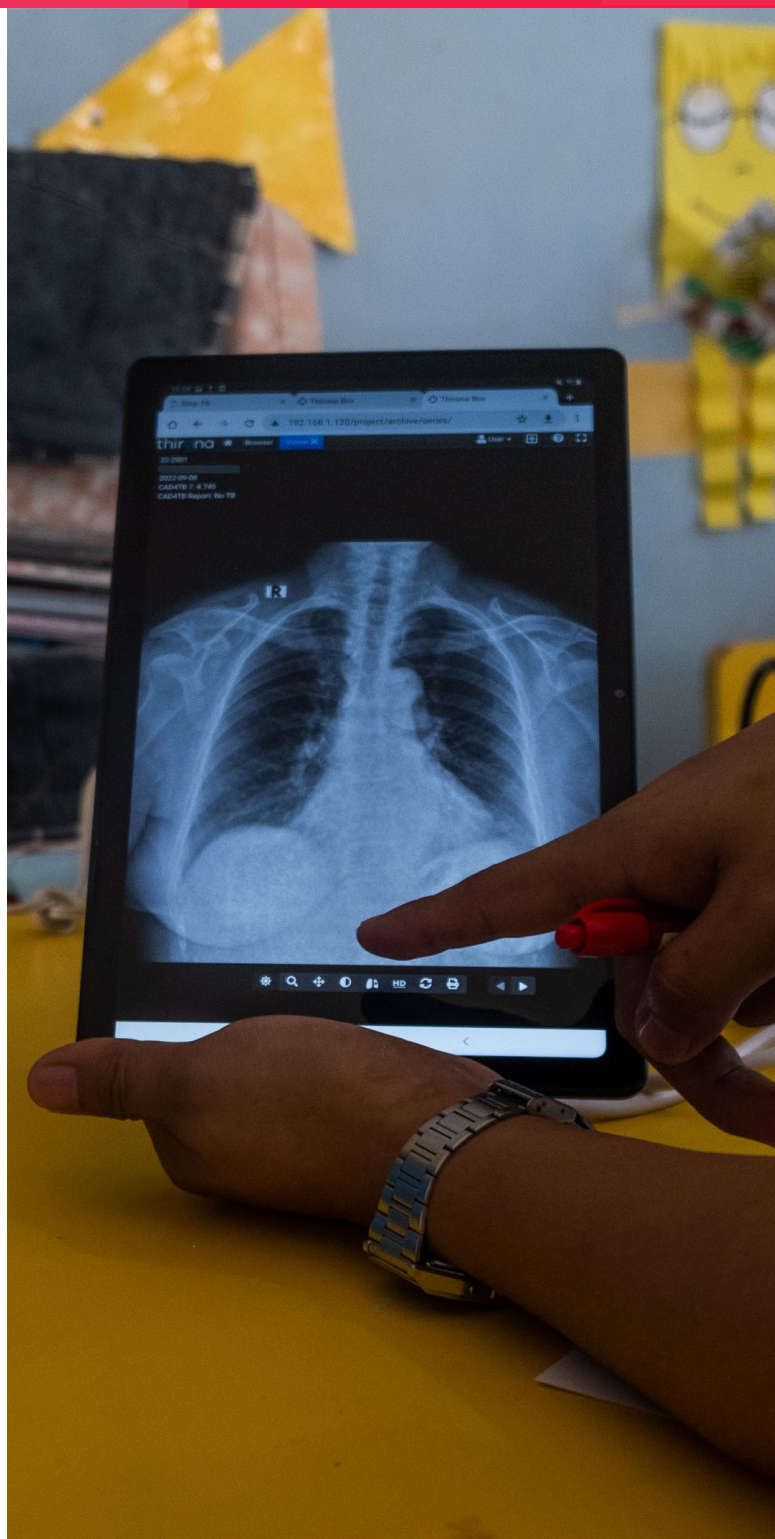
[16] World Health Organization, Global Tuberculosis Report 2024.

DISCUSSION

TB Diagnosis

The Step Up for TB 2024 report offers resources to trace and monitor progress and ensure accountability to UNHLM on TB goals (2023-2027). Bringing TB diagnosis closer to key populations to equitably screen people for TB and link them to care is vital to close the global gap of 2.7 million missing cases of TB and to meet the global target set at the UNHLM of 100% of those diagnosed with TB tested with a RMD by 2027[17]. This gap is down from 4 million in 2021, due to innovations in TB diagnosis and the adoption of international best practices- like the use of RMDs[18]. This report finds the widespread adoption of national policies on RMDs as the initial diagnostic test for all people with symptoms or X-ray abnormalities suggestive of TB underscoring widespread political commitment to this target. Despite the frequency of policies on RMDs, SUFT does not monitor policy implementation.

Further highlighting the UNHLM commitment to integrate systematic screening, prevention, treatment and care of TB, and related health conditions, within primary health care, including community-based health services, all but one country in the survey (33 met, 6 partially met and 3 no data) indicated that primary health care (PHC) facilities have access to RMD testing.



[17] World Health Organization, "Tuberculosis Resurges as Top Infectious Disease Killer"

[18] World Health Organization, "Tuberculosis Resurges as Top Infectious Disease Killer"

The End TB Strategy and Stop TB Partnership's Global Plan to End TB prioritizes the early diagnosis of TB, especially in at-risk populations like PLHIV. The LFLAM assay, a urine-based, rapid point-of-care test, offers a simple way to save lives by rapidly detecting TB in PLHIV. The 2024 Step Up for TB survey shows an immense improvement in the adoption of this diagnostic tool in national policies compared to earlier SUFT surveys. Regional results of this survey further indicate positive news for PLHIV. Only one country in the Africa region (2 partially met and 2 with no data) has not included LF-LAM in policy or documents based on our survey results, showing a strong commitment to international best diagnostic practices.

Addressing the crisis of drug-resistant TB is vital to meet the UNHLM commitment of universal, equitable and affordable access to RMDs and drug susceptibility tests, and all-oral shorter-duration treatment regimens for people with drug-resistant TB, complemented by monitoring and management of side-effects, together with care and support to improve treatment outcomes. National policies in the vast majority of countries surveyed indicate some level of DST, but far from the universal DST recommended by international best practice. Only 60% of high TB burden countries surveyed have developed a policy on isoniazid resistance testing for people with bacteriologically confirmed rifampicin-susceptible TB. Furthermore, 26% reported no policy on DST for bedaquiline or linezold. Universal DST is necessary to ensure that the most effective treatment regimens are used and that people with active TB disease are not treated with medicines against which their bacteria are resistant. By not utilizing truly up-to-date diagnostic policies, countries will not be able to reach those people still being missed by health systems, which risks undermining program effectiveness.

Despite an estimated decline in the proportion of people with TB who have MDR/RR-TB, global targets set at the UNHLM for the number of people to be treated for drug-resistant TB were not reached[19]. Of the five countries that accounted for over half of the global number of people estimated to have developed MDR/RR-TB in 2023, 4 were included in our survey (India, Indonesia, China and the Philippines)[20].

Unless the policies outlined in this report are updated and implemented, millions of people with TB disease are at risk of being lost along the diagnostic pathway, risk being diagnosed late, risk being prescribed ineffective treatments, worsening treatment outcomes and spreading disease further.

TB Treatment

Significant progress has been made in the last two decades in the development of new, more effective TB treatments with fewer side effects, fewer pills, and shorter regimens. Shorter regimens have numerous benefits: treatment is easier to complete, less expenditures for health staff and supportive expenditures, and fewer hospital stays with all-oral regimens, allowing patients to continue to be with family and work.

Despite the UNHLM commitment to all oral shorter TB treatment regimens, only a quarter of countries include the 4-month regimen (2HPMZ/2HPM) for the treatment of drug-susceptible TB in adults in national policy. While this is an increase from previous surveys, there is still progress to be made. Regional differences in uptake of the 4 month regimen indicate that with strong action behind political commitments, countries can achieve the ambitious and comprehensive time-bound targets they agreed to in order to ensure equitable access to TB services and fast-track progress towards the Sustainable Development Goals .

Rifapentine is the backbone of shorter regimens, providing the ability to prevent TB in less than one month and to treat TB in four months. These shorter regimens reduce the duration of treatment instead of other standard courses that have been in place for decades. The rifapentine market price has been higher than other TB medicines on the market, creating a barrier for shorter regimen adoption and policy endorsement in some countries. Despite price agreements, the cost may become one of the obstacles for the policy adoption of TB prevention and treatment using short courses in countries with a high TB burden. Lower demand for the medicine prevents downward pressure in pricing, resulting in limited price reductions over time.

Almost half of countries (42% met, 1 country partially met and 4 countries with no data) reported including a 4-month treatment regimen (2HRZ(E)/2HR) for the treatment of drug-susceptible TB in children in policy documents. This is in light of the UNHLM commitment to

[19] World Health Organization, Global Tuberculosis Report 2024

[20] World Health Organization, Global Tuberculosis Report 2024

provide comprehensive care to all people with TB and scale-up comprehensive efforts to close longstanding gaps in the prevention, diagnosis, treatment and care of children. While this is an improvement from the 2023 survey where only 10% of countries reported this policy, despite strong best practice recommendations based on evidence from the SHINE trial, it is still far from the UNHLM goals made in the treatment of childhood TB[21].

Over 72% of countries reported a national policy using a 6-month BPaLM regimen for patients with MDR/RR-TB in the 2024 SUFT survey. This was a vast improvement from the prior SUFT survey. This regimen should be the initial choice for all eligible patients diagnosed with MDR/RR-TB as recommended by international best practice guidelines[22].

Delays in integrating new best practice treatment recommendations into national policy mean that people continue to miss out on the most effective treatments and governments have more budget allocations.

TB Prevention

One fourth of the world's population is estimated to have been infected with the TB bacilli, and about 5–10% of those infected develop TB disease in their lifetime[23]. To meet UNHLM commitments and ensure no person is left behind, countries must update their policies and need to intensify and expand TB infection testing efforts to improve diagnosis of TB infection and prevent active TB disease. Tests to identify TB infection like TST, IGRA and Mtb antigen-specific skin tests are vital in reducing the TB burden. Despite being a best practice recommendation for TB infection testing since 2011, only 84% of countries have a policy in place for TST and 67% for IGRA. Even with developments in TB infection testing like Mtb-antigen skin tests, 70% of countries do not include these tests in policies for the diagnosis of TB infection (1 country no data).

The primary intervention available to reduce the risk of TB infection progressing to active TB disease is TPT. TPT is recommended for people living with HIV, household contacts of people diagnosed with bacteriologically confirmed pulmonary TB and clinical risk groups (e.g. those receiving dialysis).

A comprehensive package of interventions to deliver TPT effectively and safely involves identifying high risk individuals, screening and ruling out TB disease, testing for TB infection, and choosing the TPT option that is best suited to an individual. Evidence shows that short-course TB preventive therapies are effective in preventing progression to active disease and people are up to three times more likely to complete their course of treatment than those on longer regimens, leading to better outcomes and more lives saved[24]. Some key findings from this report indicate positive developments in treatment of TB infection. Only 2 countries out of 41 with data available did not include the routine implementation of a short regimen (3HP/4R/3RH/1HP) for treatment of TB infection in national policy (13 yes, 26 partially met, 2 no countries no data). Treatment of TB infection remains a critical element to achieve global targets of the Global Plan to End TB.

To meet the target of 90% of people at high risk of developing TB disease are provided with TPT by 2027 set at the UNHLM, countries must develop national policies to include household contacts and clinical risk groups. While this report shows that TPT coverage is on target in PLHIV and children under 5 years, SUFT 2024 demonstrates the need to improve coverage for household contacts over 5 years and clinical risk groups like those on dialysis, organ transplant and people with silicosis.

[21] Verkuijl, "The 4-Month Regimen for Treatment of Non-Severe TB in Children and Adolescents."

[22] World Health Organization consolidated guidelines on tuberculosis. Module 4: treatment - drug-resistant tuberculosis treatment

[23] World Health Organization consolidated guidelines on tuberculosis Module 1: prevention - tuberculosis preventive treatment, second edition.

[24] IMPAACT4TB, "Short Course Preventive Treatments - IMPAACT4TB."

TB Stigma and Community led Monitoring

While anyone can be vulnerable to TB, it does not impact everyone equally. TB is not just about disease incidence and prevalence, it stems from the social determinants of health and inequities that are beyond a person's direct control. These factors can make some of us more vulnerable to TB and/or more likely to face barriers to accessing TB services. .

Community-led monitoring is recognized in 56% of in-country policies to allow communities access to TB screening and diagnostic testing and the ability to monitor the availability, accessibility, and quality of TB services.

TB stigma refers to a social process where individuals are devalued, discredited, or labelled as undesirable due to TB disease. Thirty percent of NTPs have not yet endorsed policies on a TB stigma measurement that is validated/recognized. Without focusing on TB stigma and its drivers, we risk alienating affected people from TB care before they even enter the health system. In order to reach the UNHLM commitment to intensify national efforts to eliminate all forms of TB-related stigma, countries need to galvanize the political will and efforts required to achieve the goal and targets of the End TB Strategy.

TB Financing

Reducing the burden of TB disease requires adequate funding, a problem faced in a majority of LMICs where funding has not been sufficient for full implementation of their national strategic plans for TB[25]. The 2023 UNHLM on TB committed to mobilize US$22 billion per year for TB care and prevention[26]. To address the full cost of TB program needs, countries must increase domestic financing, which can be addressed for example by UHC and AMR related financing.

In the 2024 SUFT survey, only 26% of countries reported that TB services are covered by a Government supported health insurance scheme (6 countries partially met and 5 countries with no data). This is far from the UNHLM target of 100% coverage of the health and social benefits package for people with TB by 2027 and $22 billion dollars annual funding for universal access to quality prevention, diagnosis, treatment and care for TB.

Only

US$5.7 billion

ANNUAL FUNDING WAS AVAILABLE IN 2023

US$22 billion

PER YEAR

The 2023 UNHLM on TB committed to mobilize for **TB care and prevention**

Health insurance

is an option to reduce this huge funding gap

26% **OF COUNTRIES REPORTED**

that TB services are **covered by government supported health insurance schemes**

[25] World Health Organization, "Financing for TB Prevention, Diagnostic and Treatment Services," 2023.

[26] World Health Organization, "Financing for TB Prevention, Diagnostic and Treatment Services," 2023.

CHALLENGES

There were several limitations and challenges faced during the survey. Since the last SUFT survey there was a rapid turnover of NTP personnel, which was a challenge as countries do not notify or update the contact information of newly appointed NTP managers. This led to incorrect information on who and how to reach in-country contacts for the survey. In addition, NTP managers and focal point officers were often difficult to reach and did not respond promptly to emails from the SUFT team. This caused delays in obtaining necessary information and validating the survey.

Similarly, not all NTP officers were willing or motivated to cooperate with the SUFT consultants' survey or respond to emails. In some cases, participation required direct instructions from the Ministry of Health or higher authorities. At times, it was necessary to engage alternative contacts to prompt NTP officers to respond. This challenge was compounded by the multi-step review and validation process, making it particularly difficult to ensure timely cooperation. As a result, the SUFT team had to make numerous follow-up calls and send repeated emails to secure the required detailed information that significantly delayed the review and analyses.

Countries also did not always have time to adopt new best practice guidelines and incorporate them into their national policies.

Finally, incomplete information was an issue during the survey. NTP officers may not know all of the national policies and some had difficulty referencing them. NTPs continue to blend implementation and policy decisions on the ground while answering the SUFT questionnaire.

The SUFT 2024 survey encountered several instances where policies changed during the survey process. In such cases, the SUFT team had to revisit the respective country cases and reanalyze the responses to ensure accuracy and alignment with the updated policies.

04 CONCLUSION

The Step Up for TB 2024 report highlights the successes and opportunities for improvement of national policy responses to TB. The Stop TB Partnership Board recommended SUFT for regular monitoring of TB policies in HBCs to show the possibility of swiftly turning existing tools and scientific breakthroughs into policies and practices that have the potential to save lives and end TB.

It is clear that countries should make relevant policy reforms a central part of their national TB response. With the rise of antimicrobial resistance (AMR) posing a significant and growing threat to public health, TB is a prime example of the intersection between AMR and infectious diseases.

Achieving global and UNHLM targets for reductions in TB disease and improved access to TB prevention, diagnosis and treatment services requires progress towards UHC. UHC ensures that people with TB can obtain quality, accessible prevention, diagnosis and treatment care services without suffering financial hardship. Countries have committed to the End TB Strategy and to achieving UHC by 2030 through the SDGs.

TB is preventable and curable, but the growth of DR-TB will continue to exacerbate the TB crisis if appropriate TB policies are not endorsed in a timely fashion based on international recommendations and best practices. MDR-TB and XDR-TB highlight the urgent need to address AMR within the context of TB control and prevention efforts and updates to national policy.

The full Step Up for TB dataset, country factsheets and additional advocacy tools can be accessed online. This report should serve as a call for action. Fundamentally, governments are responsible for updating national policies, and they must now step up for TB to deliver on their UNHLM commitments and meet the SDGs.

This report was created to identify gaps in national TB policies, ensure policies have been adapted to reflect international guidelines and monitor progress towards ending TB. While countries have made progress since the 2023 SUFT report, much more work needs to be done to make sure that these policies are fully implemented across all communities, so that they will make a real difference to people affected by TB.

Governments, advocates and TB-affected communities can use this report to measure and compare countries' progress, including towards political commitments made at the UNHLM in 2023, and to help identify priority areas for policy change and advocacy.

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ANNEXES

Annex 1: Questionnaire

Step Up for TB 2024

A survey of key national policies for TB prevention, diagnosis, treatment, care and financing

SURVEY QUESTIONNAIRE

Project Objectives

The Stop TB Partnership is conducting this survey to assess if, and to what extent, the key international best practices for TB diagnostics, treatment, models of care, prevention and drug procurement and regulation have been formally adopted at national level.

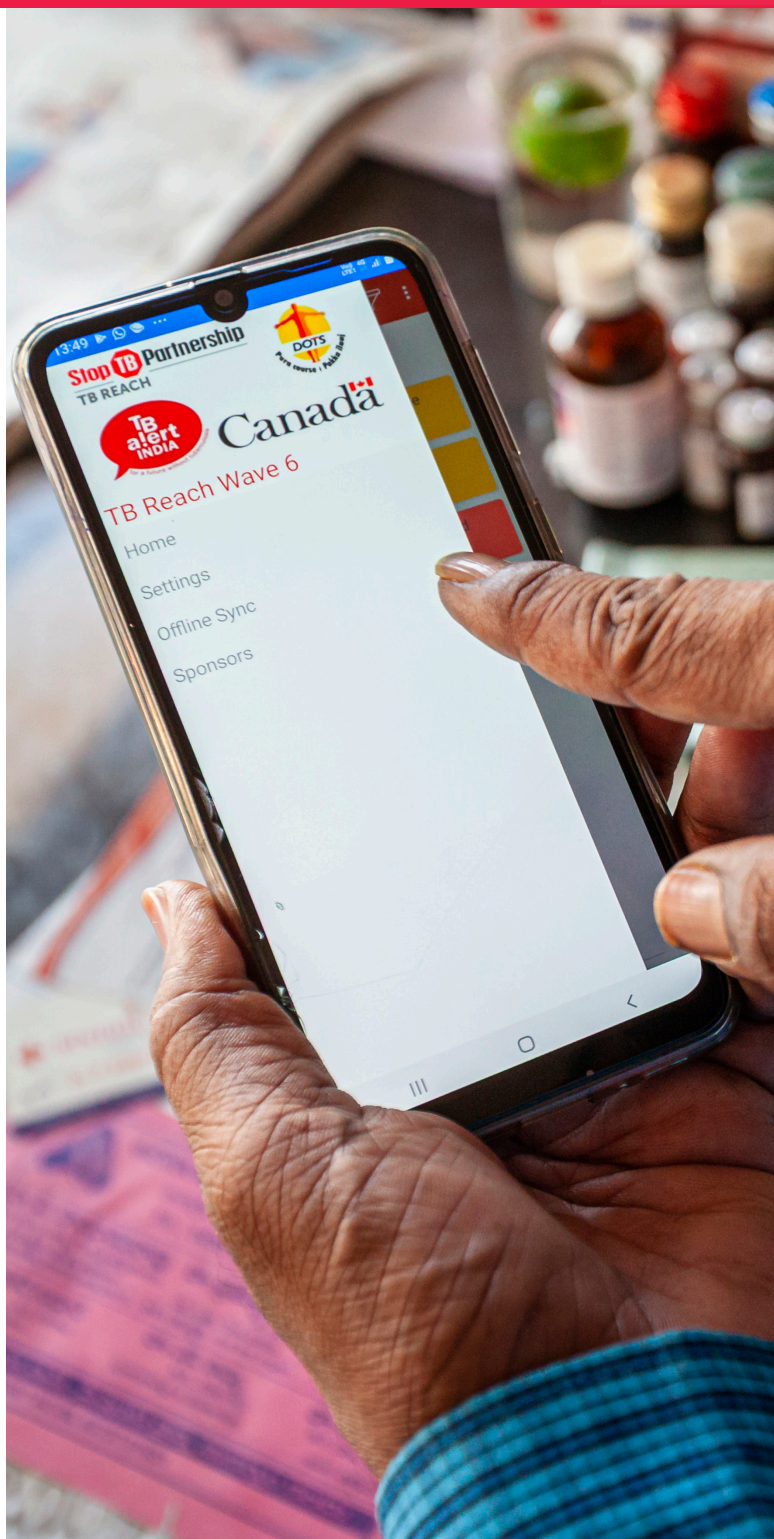
Definition of 'adopted national policies'

This survey asks for policies that are formally adopted. Criteria for formal policy adoption are:

- A formal written document is published with the government's title or logo on it, and/or signed by a Minister or other national government official, for example: national policy documents, frameworks or statements, technical manuals, guidelines or protocols.

OR

- A written communication has been issued and/or circulated by the national government (e.g. MoH or NTP) to a range of national stakeholders with an accompanying statement of guidance or action required, including orders, prikazs, memorandums, circulars, MoH letters, etc.



Contact details

Date of completing the questionnaire	
Name, position and email of the person completing the questionnaire	

Questions are on national policy or guidelines for prevention, diagnosis, treatment, model of care, and finance for TB. Please add any relevant comments, including reference to specific documents, in the 'Comments' section, which is available for each question.

IMPORTANT NOTE:

All questions should be answered for the status at the end of 2023.

However, please feel free to indicate relevant developments in 2024 (work completed, ongoing or planned) in 'Comments'

Please, provide supporting documents

		1. CASE FINDING AND DIAGNOSIS
1.1	**Question:**	**According to national policies, a screening for TB should be conducted for the following population groups:**
	Explanation	WHO TB diagnostic standards benchmark 1: All household (HH) contacts of people with TB, all people living with HIV (PLHIV), and other locally relevant high-risk groups are screened for TB according to the available national screening algorithm. Country TB policies should clearly indicate which population groups should be screened. The list of high-risk groups can be assessed in the latest WHO consolidated screening guidelines and operational handbook (2.4.). Prioritization of high-risk groups for screening should be specified in country plans.
	Instruction	Please select ☑ ALL that apply.
	Answers	HH contacts of drug-sensitive bacteriologically confirmed TB cases, including: ☐ Children (aged <5 years) ☐ Children, adolescents, and adults (aged 5 years and above) HH contacts of drug-resistant bacteriologically confirmed TB cases, including: ☐ Children (aged <5 years) ☐ Children, adolescents and adults (aged 5 years and above) ☐ All PLHIV ☐ Others (please specify) ..... ☐ None of the above are indicated in national policies ☐ Do not know / Difficult to answer
	Comments	
1.2	**Question:**	**Do national policies indicate a requirement to use rapid molecular diagnostic (RMD) tests as the initial diagnostic TB test for all people with presumptive TB?**
	Explanation	WHO TB diagnostic standard benchmark 3: all individuals with presumptive TB (all adults and children), should be tested with accurate, rapid tools. In TB diagnostic algorithms, RMDs are to be used as the initial diagnostic test for all patients with presumptive TB.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ All adults and children with presumptive TB ☐ Adults and children with presumptive TB from risk groups only ☐ Initial diagnostic testing using RMD not indicated in national policies ☐ Do not know / Difficult to answer
	Comments	

1.2.1.	**Question:**	**Do national policies indicate that all Primary Health Care (PHC) facilities have access to RMD testing (on site or through sample referral)?**
	Explanation	WHO TB diagnostic standard benchmark 4: Focus is on access for PHC facilities, where access to RMD is feasible onsite or through sample referral.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ Yes, access to RMD testing for all PHC facilities is indicated in national TB policies ☐ Yes, access to RMD testing for specific PHC facilities is indicated in national TB policies. Please, specify: ..... ☐ Access to RMD testing at PHC facilities is not indicated in national policies ☐ Do not know / Difficult to answer
	Comments	
1.3.	**Question:**	**Does the country have a multiyear plan to achieve universal use of RMDs as the initial test to diagnose TB for all people with presumptive TB?**
	Explanation	The Global Fund's 2023 Toolkit for Tuberculosis Program Essentials includes a TB Program Essential (TB Screening and Diagnostics 1.2) that countries have a multiyear plan to achieve universal use of RMDs as the initial test to diagnose TB for all people with presumptive TB.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ Yes, a multiyear plan exists to achieve universal use of RMDs ☐ No, a multiyear plan does not exist to achieve universal use of RMDs ☐ Do not know / Difficult to answer
	Comments	
1.4.	**Question:**	**Do national policies indicate use of RMD for TB detection in children using stool testing and for extrapulmonary TB detection using non-sputum samples?**
	Explanation	WHO TB diagnostic standard benchmark 8: Pediatric cases are paucibacillary, contribute a large proportion of the TB burden, and are difficult to diagnose definitively. The use of non-sputum sample types that are easy to collect and child-friendly is recommended. Recommendations for testing extrapulmonary specimens with RMDs are also available.
	Instruction	Please select ☑ ANSWER(s) as appropriate.
	Answers	☐ YES, RMD for TB detection in children using stool testing are indicated. ☐ YES, RMD for TB detection in children using stool testing are indicated, but only in specific conditions. ☐ YES, RMD for extrapulmonary TB using non-sputum samples are indicated. ☐ YES, RMD for extrapulmonary TB using non-sputum samples are indicated but only in specific conditions. ☐ NO, both are not indicated. ☐ Do not know / Difficult to answer
	Comments	
1.4.1	**Question:**	**Do national policies indicate use of presumptive TB registers?**
	Explanation	WHO TB diagnostic standard benchmark 8: The actual number of individuals with presumptive TB and the number tested should be reported, i.e. quantified at the level of patients and not samples as the data are essential in the diagnostic cascade.
	Instruction	Please select ☑ ANSWER(s) as appropriate.
	Answers	☐ YES, presumptive TB registers are indicated by national policies. ☐ YES, presumptive TB registers are indicated for specific groups of population or districts. ☐ No, presumptive TB registers are not indicated by national policies. ☐ Do not know / Difficult to answer
	Comments	
1.5	**Question:**	**Is the urinary Lateral Flow LAM (LF LAM) test indicated in national policies as an initial test in combination with RMD for PLHIV?**
	Explanation	WHO TB diagnostic standard benchmark 3: Specifically, for PLHIV, as per WHO guidelines, the algorithm includes use of LF-LAM in the diagnosis of TB in combination with RMD
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ Yes, the test indicated in national policies for programmatic implementation in in-patient and out-patient facilities/departments. ☐ Yes, the test indicated in national policies for programmatic implementation only in in-patient facilities / departments. ☐ Yes, the test indicated in national policies but only under operational research conditions. ☐ Test not indicated in national policies. ☐ Do not know / Difficult to answer
	Comments	

1.6	**Question:**	**Do national policies indicate that people with bacteriologically confirmed TB starting treatment should be tested for RIF resistance?**
	Explanation	WHO TB diagnostic standard benchmark 9: All patients with bacteriologically confirmed TB should undergo universal drug susceptibility testing. Universal DST for this benchmark is defined as testing of all patients with bacteriologically confirmed TB for resistance to RIF, all patients with RR-TB for resistance to FQ, and all patients with pre-XDR-TB for resistance to bedaquiline and linezolid. These are minimum requirements, and testing for resistance to drugs according to the regimen used is preferred. If national policies indicate that Xpert/Truenat is an initial diagnostic test for all presumptive TB cases, everyone will automatically receive a RIF resistance result and the answer should be YES (first answer). If Xpert/Truenat is not an initial diagnostic test for all presumptive TB cases, the answer here should be YES if national policies indicate that all people with TB who were bacteriologically confirmed with other TB diagnostic tests (microscopy, LAMP or culture) should be tested for RIF resistance (second answer). This includes RIF testing by any method, i.e. molecular diagnostic tests or phenotypic DST. "Selected groups" could be based on certain socio-demographic characteristics or locations.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ YES, Xpert/Truenat is an initial diagnostic test for all people with presumptive TB, therefore all bacteriologically confirmed TB cases will automatically receive a RIF resistance result ☐ YES, all bacteriologically confirmed TB cases diagnosed with tests other than Xpert/Truenat should also be tested for RIF resistance. ☐ YES, only in selected conditions bacteriologically confirmed TB cases, diagnosed with tests other than Xpert/Truenat, should also be tested for RIF resistance (please specify): ..... ☐ NO, the policies do not indicate RIF resistance testing for bacteriologically confirmed cases with TB ☐ Do not know / Difficult to answer
	Comments	
1.7	**Question:**	**Do national policies indicate that people with bacteriologically confirmed RIF-susceptible TB starting treatment should be tested for resistance to Isoniazid (INH)?**
	Explanation	WHO TB diagnostic standard benchmark 9: All patients with bacteriologically confirmed TB should undergo universal drug susceptibility testing. Universal DST for this benchmark is defined as testing of all patients with bacteriologically confirmed TB for resistance to RIF, all patients with RR-TB for resistance to FQ, and all patients with pre-XDR-TB for resistance to bedaquiline and linezolid. These are minimum requirements, and testing for resistance to drugs according to the regimen used is preferred. Among patients with RIF-susceptible TB, testing for isoniazid resistance is increasingly important, especially in settings where the prevalence of resistance to this drug is > 5%. This includes testing by any method, including molecular or phenotypic DST. "Selected groups" could be based on certain socio-demographic characteristics or locations.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ YES,RIF-susceptible TB starting TB treatment should be tested for resistance to INH ☐ YES, only in selected conditions RIF-susceptible TB starting TB treatment should be tested for resistance to INH(please specify): ☐ NO, the policies do not indicate INH testing for people starting TB treatment ☐ Do not know / Difficult to answer
	Comments	Gender
1.8	**Question:**	**Do national policies indicate that all people with RR-TB should be further tested for resistance to Fluoroquinolones?**
	Explanation	WHO TB diagnostic standard benchmark 9: All patients with bacteriologically confirmed TB should undergo universal drug susceptibility testing. Universal DST for this benchmark is defined as the testing of all patients with bacteriologically confirmed TB for resistance to RIF, all patients with RR-TB for resistance to FQ, and all patients with pre-XDR-TB for resistance to bedaquiline and linezolid. These are minimum requirements, and testing for resistance to drugs according to the regimen used is preferred. Among patients with RIF-susceptible TB, testing for FQ resistance is increasingly important, especially in settings where the prevalence of resistance to this drug is > 5%. This includes testing by any method, including molecular or phenotypic DST. "Selected groups" could be based on certain socio-demographic characteristics or locations.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ YES, all RR-TB cases should be tested for resistance to Fluoroquinolones ☐ YES, only in selected conditions RR-TB cases should be tested for resistance to Fluoroquinolones (please specify): ☐ NO, the policies do not indicate Fluoroquinolones testing for RR-TB cases. ☐ Do not know / Difficult to answer
	Comments	

1.9	**Question:**	**Do national policies indicate that all people with bacteriologically confirmed pre-XDR-TB should be further tested for resistance to bedaquiline and linezolid?**
	Explanation	WHO TB diagnostic standard benchmark 9: All patients with bacteriologically confirmed TB should undergo universal drug susceptibility testing. Universal DST for this benchmark is defined as testing of all patients with bacteriologically confirmed TB for resistance to RIF, all patients with RR-TB for resistance to FQ, and all patients with pre-XDR-TB for resistance to bedaquiline and linezolid. These are minimum requirements, and testing for resistance to drugs according to the regimen used is preferred. "Selected groups" could be based on certain socio-demographic characteristics or locations.
	Instruction	Please select ☑ ONE answer for each row.
	Answers	

	Included	Not included	Do not know / Difficult to answer
Bedaquiline	☐	☐	☐
Linezolid	☐	☐	☐

	Comments	

2. CHEST X-RAY SCREENING

2.1	**Question**	**According to the country TB policies is Chest X-Ray (CXR) included as a primary tool in TB screening algorithms?**
	Explanation	WHO TB diagnostic standard benchmark 2: CXR for TB screening in every district is defined as its use as the primary tool for TB screening with or without CAD in high-risk groups. The proposed benchmark may have to be adapted to the local context. Consolidated guidelines on TB, Module 2 state CXR as a recommended screening tool that can be used in combination with others.
	Instruction	Please provide the latest TB screening and diagnostic algorithm. You may leave details in the comments section. Please select ☑ ANSWER(s) as appropriate.
	Answers	☐ YES, CXR is included as a primary screening tool for TB in all districts. ☐ YES, CXR is included in the national TB screening and diagnostic algorithm as a screening tool for TB ☐ YES, CXR is included in the national TB diagnostic algorithm to assist clinical diagnosis. ☐ Yes, CXR is included in the national TB screening and diagnostic algorithm to screen for TB in parallel to symptom screening (aka, among individuals with or without symptom(s) presumptive TB). ☐ Yes, CXR is included in the national TB screening and diagnostic algorithm to screen for TB among the individuals with symptom(s) presumptive TB. ☐ Other. Please specify: ..... ☐ NO, the policies do not indicate CXR use in country screening activities. ☐ Do not know / Difficult to answer
	Comments	
2.2	**Question**	**Do national TB policies indicate which population groups are targeted for systematic TB screening using CXR?**
	Explanation	WHO TB diagnostic standard benchmark 2: CXR for TB screening in a district is defined as its use as the primary tool for TB screening with or without CAD in high-risk groups. The proposed benchmark may have to be adapted to the local context. WHO consolidated guidelines on TB, Module 2 recommends using CXR during systematic screening for TB in various populations.
	Instruction	Please provide the country's latest TB screening and diagnostic guidelines. You may leave details in the comments section. Please select ☑ ANSWER(s) as appropriate.
	Answers	☐ YES, Household, and close contacts of people with TB ☐ YES, Migrants and internally displaced persons ☐ YES, Prisoners ☐ YES, Miners exposed to silica dust. ☐ YES, People living with HIV. ☐ YES, All targeted groups of population. ☐ YES, Other targeted populations. Please specify: ☐ NO, the policies do not indicate targeted groups. ☐ Do not know / Difficult to answer
	Comments	

2.3	**Question**	**According to national policies, is computer-aided detection (CAD) software used to interpret CXR for TB, with or without human readers /radiologists?**
	Explanation	WHO TB diagnostic standard benchmark 2: CXR for TB screening in a district is defined as its use as the primary tool for TB screening with or without CAD in high-risk groups. The proposed benchmark may have to be adapted to the local context. WHO consolidated guidelines on TB, Module 2 recommends the use of specialized software to interpret abnormalities on chest radiographs that are suggestive of TB. The results are expressed as abnormality scores. CAD software programmes may be used in place of human readers to interpret digital chest X-rays.
	Instruction	Please provide the country's latest TB screening and diagnostic guidelines. You may leave details in the comments section. If the answer is "No/Do not know", move to the next question. If the answer is "Yes", attempt subset questions. Please select ☐ ANSWER(s) as appropriate.
	Answers	☐ CAD software CXR interpretation is indicated in national TB policies. ☐ CAD software screens and triages TB in place of human readers /radiologists are indicated in national TB policies. ☐ CAD software screens and triages TB alongside human readers/radiologists are indicated in national TB policies for all. ☐ CAD software is indicated alongside human readers /radiologists in national TB policies for specific cases [please specify cases]: ..... ☐ Do not know / Difficult to answer
	Comments	

3. TREATMENT

3.1	**Question:**	**Do national policies indicate the use of the 4-month regimen (2HPMZ/2HPM) for the treatment of drug-susceptible TB?**
	Explanation	WHO's updated guidelines (2022) recommend that people aged 12 years or older with drug-susceptible pulmonary TB may receive a 4-month regimen of isoniazid, rifapentine, moxifloxacin and pyrazinamide (2HPMZ/2HPM).
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ YES, it is indicated for use in national TB policies ☐ YES, it is indicated for use in national TB policies but only under operational research conditions. ☐ NO, it is not indicated for use in national TB policies. ☐ Do not know / Difficult to answer
	Comments	
3.2	**Question:**	**Do national policies indicate the use of the 9-month all-oral regimen for the treatment of MDR/RR-TB in adults?**
	Explanation	WHO's updated guidelines (2022) suggest the use of the 9-month all-oral regimen rather than longer (18-month) regimens in patients with MDR/RR-TB in whom resistance to fluoroquinolones has been excluded. The 9-month all-oral regimen consists of bedaquiline (used for 6 months), in combination with levofloxacin / moxifloxacin, ethionamide, ethambutol, isoniazid (high-dose), pyrazinamide and clofazimine (for 4 months, with the possibility of extending to 6 months if the patient remains sputum smear positive at the end of 4 months), followed by treatment with levofloxacin/moxifloxacin, clofazimine, ethambutol and pyrazinamide (for 5 months). Ethionamide can be replaced by 2 months of linezolid (600 mg daily).
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ YES, for routine use ☐ YES, but only under operational research conditions ☐ NO ☐ Do not know / Difficult to answer
	Comments	
3.3	**Question:**	**Do national policies indicate the use of the 6-month (BPaLM) regimen for treatment of MDR/RR-TB and pre-XDR-TB in adults?**
	Explanation	WHO's updated guidelines (2022) suggest the use of the 6-month treatment regimen composed of bedaquiline, pretomanid, linezolid (600 mg) and moxifloxacin (BPaLM) rather than 9-month or longer (18-month) regimens in MDR/RR-TB patients. This recommendation applies to treatment of MDR/RR-TB or MDR/RR-TB and resistance to fluoroquinolones (pre-XDR-TB) in adults and adolescents aged 14 years and older, with confirmed pulmonary TB and all forms of extrapulmonary TB except for TB involving the CNS, osteoarticular and disseminated (miliary) TB.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ YES, for routine use ☐ YES, but only under operational research conditions ☐ NO ☐ Do not know / Difficult to answer
	Comments	

3.4	**Question:**	**Do national policies indicate the use of the 4-month treatment regimen (2HRZ(E)/2HR) for the treatment of drug-susceptible TB in children?**
	Explanation	WHO's updated guidelines (2022) recommend that in children and adolescents between 3 months and 16 years of age with non-severe TB (without suspicion or evidence of MDR/RR-TB), a 4-month treatment regimen (2HRZ(E)/2HR) should be used. Non-severe TB is defined as: peripheral lymph node TB; intrathoracic lymph node TB without airway obstruction; uncomplicated TB pleural effusion or paucibacillary, non-cavitary disease, confined to one lobe of the lungs, and without a miliary pattern; Children and adolescents who do not meet the criteria for non-severe TB should receive the standard six-month treatment regimen (2HRZE/4HR), or recommended treatment regimens for severe forms of extrapulmonary TB; The use of ethambutol in the first two months of treatment is recommended in settings with a high prevalence of HIV, or of isoniazid resistance.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ YES, for routine use ☐ YES, but only under operational research conditions ☐ NO ☐ Do not know / Difficult to answer
	Comments	

4. MODELS OF TB CARE

4.1	**Question:**	**According to national guidelines, does initiation of drug-resistant TB treatment require hospital admission?**
	Explanation	Hospital admission for treatment initiation is defined as admission for one day or longer. This question concerns only treatment initiation of clinically stable people with TB but excludes admission based on clinical needs. "Specific criteria": if admission is only required for people with bacteriologically confirmed TB (e.g. sputum smear positive), please select the second YES option and indicate "smear positive". Examples: clinically serious, serious adverse reactions, children, elderly, other comorbidities.
	Instruction	Please select ☑ ONE ANSWER.
	Answers	☐ YES, treatment initiation requires admission to a hospital for all DR-TB patients ☐ YES, treatment initiation requires admission to a hospital, but only for DR-TB patients with specific criteria (please specify the criteria): .... ☐ NO, the policies do not indicate a requirement of hospital admission for DR-TB treatment initiation. ☐ Do not know / Difficult to answer
	Comments	

4.2	**Question:**	**Do national policies include treatment support and adherence interventions for people with TB?**
	Explanation	Treatment adherence and support may include, but are not limited to, the following in the table below interventions.
	Instruction	Please select ☑ appropriate boxes per each intervention type

Answers

Intervention	Yes	No	Do not know / Difficult to answer
Patients education	☐	☐	☐
Financial support	☐	☐	☐
Psycho-social counseling	☐	☐	☐
Patients outreach	☐	☐	☐
Digital adherence tools	☐	☐	☐
Nutrition support	☐	☐	☐
Other (specify):	☐	☐	☐

Comments

5. TB INFECTION TESTING AND TREATMENT

5.1

Question: **Which of the following groups are indicated in national policies as target populations for TB infection treatment (TPT)?**

Explanation

Treatment of (latent) TB infection is called TB preventive treatment (TPT).

Target groups are people who are considered at risk for TB infection as per national policy and should be considered for TPT after ruling-out active TB disease.

WHO guidelines include specific categories of populations who are eligible for TB infection treatment.

Ruling-out active TB may follow any procedures defined in national policies, including symptom screening and/or testing for TB disease / TB infection; the detailed procedures for bacteriological evaluation are not covered by this question.

Instruction

Please select ☑ ALL that apply.

Answers

People living with HIV:

☐ HIV-positive children (age < 5 years)

☐ HIV-positive children (aged 5 years and above), adolescents and adults.

HH contacts of drug-sensitive TB cases, including:

☐ Children (aged <5 years)

☐ Children, adolescents and adults (aged 5 years and above)

☐ People who are initiating anti-TNF treatment, receiving dialysis, preparing for an organ or hematological transplant, or who have silicosis.

☐ People who are receiving dialysis

☐ People who are preparing for an organ or hematological transplant.

☐ People who are have silicosis.

☐ Other population (please, specify (examples - prisoners)):

.....

☐ None of the above are indicated in the national policies

☐ Do not know / Difficult to answer

Comments

5.2

Question: **According to the national guidelines on TPT, which of the statements below is true after active TB disease is excluded among contacts?**

Explanation

According to the country's TB control policies, please indicate proposed approach(es) for contacts of TB patients after excluding the active disease

Instruction

Please select ☑ ALL that apply.

Answers

Yes, national policies indicate:

☐ TPT is given to contacts tested positive with a TB infection test.

☐ TPT is given to contacts tested positive with a TB infection test only when a TB infection test is available; otherwise, contacts are given TPT without TB infection testing.

☐ TPT is given to all such contacts without TB infection testing

☐ No, national policies do not indicate any of the above

☐ Do not know / Difficult to answer

Comments

5.3

Question: **Which of the following tests are indicated in national policies for testing for TB infection?**

Explanation

WHO's updated guidelines (2022) recommend use of IGRAs or skin tests, including tuberculin PPD or newer Mtb-specific antigen skin tests, for detection of TB infection

Instruction

Please select ☑ one answer per row.

Answers

Test	Indicated in national policies for routine use	Indicated in national policies but only under operational research conditions	Not indicated in national policies
Tuberculin PPD (Mantoux tuberculin skin test, TST)	☐	☐	☐
IGRA (interferon-gamma release assay)	☐	☐	☐
Mtb-specific antigen skin test (newly recommended by WHO in 2022: example - Diaskin)	☐	☐	☐

Comments

5.4	**Question:**	**Do national policies indicate the use of a short regimen for treatment of TB infection (TPT)?**
	Explanation	"Short" regimen: < 6 months.
	Instruction	Please select ☑ ALL that apply.
	Answers	YES, national policies indicate the use of the following TB infection short regimen: ☐ 3HP ☐ 4R ☐ 3RH ☐ 1HP ☐ NO, national policies do not indicate the use of any short TB infection regimen. Only long regimens, such as 6/9/36 month IPT, are indicated ☐ NO, national policies do not indicate the use of any TB infection regimen at all ☐ Do not know / Difficult to answer
	Comments	

6. TB STIGMA, COMMUNITY AND SOCIAL CONTRACTING

6.1	**Question:**	**Are national TB responses equitable and socially responsive?**
	Explanation	Community responses such as programs to assess, monitor and mitigate human rights and gender related barriers to the TB program and community-led social accountability are vital in making sure that all people affected by TB can access quality TB services. People-centeredTB responses are a vital component in support of ending TB by 2030. National laws, policies and programs are informed by intentionally recognized community centered TB guidance and practices.
	Instruction	Please select ☑ appropriate boxes per each community TB interventions
	Answers	

Intervention	Yes	No	Pilot or trial status	Do not know / Difficult to answer
TB community-led monitoring is recognized	☐	☐	☐	☐
TB stigma measurement is validated / recognized	☐	☐	☐	☐
Legally registered and funded national TB Survivor network is recognized	☐	☐	☐	☐
TB social contracting from domestic budget	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐

	Comments	

7. TB FINANCING (HEALTH INSURANCE)

7.1.	**Question**	**Does the country's Government supported Health Insurance scheme cover TB-related services?**
	Explanation	Domestic TB services can be included into Government supported Health Insurance schemes and be a part of the standard Health services package covered by Public Health Insurance.
	Instruction	Please select ☑ ONE ANSWER only.
	Answers	☐ No, there is no Government supported Health Insurance scheme yet. ☐ YES, TB services are covered by the Government supported Health Insurance scheme. ☐ YES, TB services are covered by the Government supported Health Insurance scheme in specific regions or for specific groups of population (please specify): ☐ Other, please specify: ☐ Do not know / Difficult to answer
	Comments	

7.2.	**Question**	**What of the following costs are included in the national Government supported Health Insurance scheme?**
	Explanation	Domestic TB and TB infection screening, detection, TPT needs of TB contacts, TB treatment and care can be included into Government supported Health Insurance scheme and be a part of the standard Health services package covered by Public Health insurance. Even if TB services are integrated into general health services, there should be managerial instructions on how Public Health Insurance is covering TB and TB infection services.
	Instruction	Please select ☑ ALL that apply.
	Answers	

TB service costs	Yes	No	Pilot or trial status	Do not know / Difficult to answer
TB screening	☐	☐	☐	☐
TB diagnosis	☐	☐	☐	☐
TB treatment	☐	☐	☐	☐
DR-TB treatment	☐	☐	☐	☐
TPT	☐	☐	☐	☐
TB treatment support and adherence interventions for people with TB. Please specify as stated in Q4.2:	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐

	Comments

Thanks for your important contribution to Ending TB!

Annex 2:
Indicators

Section	Questionnaire Ref.	Key TB Policies indicators	
Case finding and diagnosis	1.2	A rapid molecular diagnostic (RMD) tests as the initial diagnostic TB test for all people with symptoms or X-ray abnormalities suggestive of TB	All adults and children with presumptive TB
			People from risk groups only
	1.2.1	Primary Health Care (PHC) facilities have access to RMD testing	
	1.4	RMD for TB detection in children using stool testing and for extrapulmonary TB detection using non-sputum samples	RMD for TB detection in children using stool testing
			RMD for extrapulmonary TB using non-sputum samples
	1.4.1	Use of presumptive TB registers	
	1.5	Lateral flow urine lipoarabinomannan assay (LF-LAM) test as an initial test in combination with RMD for people living with HIV (PLHIV) in	In-patient facilities / departments
			Out-patient facilities / departments
	1.7	All bacteriologically rifampicin (RIF)-susceptible confirmed should be tested for isoniazid resistance	
	1.8	All bacteriologically rifampicin-resistant TB (RR-TB) confirmed should be tested for resistance to fluoroquinolones	
	1.9	All bacteriologically pre-extensively drug-resistant TB (pre-XDR-TB) confirmed should b tested for resistance to bedaquiline and linezolid	
Chest X-Ray screening	2.1	Country TB policies include Chest X-Ray (CXR) as a primary tool in TB screening	CXR is included as a primary screening tool for TB in all districts
			CXR is included in the national TB screening and diagnostic algorithm to screen for TB in parallel to symptom screening among individuals with or without symptom(s) presumptive TB
	2.3	Computer-aided detection (CAD) software used to interpret CXR for TB	CAD software CXR interpretation is indicated
			CAD software screens and triages TB in place of human readers /radiologists
TB Treatment	3.1	4-month regimen (2HPMZ/2HPM) for the treatment of drug-susceptible TB	
	3.2	9-month all-oral regimen for the treatment of (multi drug resistant / rifampicin resistant TB) MDR/RR-TB in adults	
	3.3	6-month (BPaLM) regimen for treatment of MDR/RR-TB and pre-XDR-TB in adults	
	3.4	4-month treatment regimen (2HRZ(E)/2HR) for the treatment of drug-susceptible TB in children	
Model of care	4.1	Initiation of drug-resistant TB treatment does not require hospital admission	
	5.3	TB infection tests	Tuberculin purified protein derivative (PPD) skin test / interferon-gamma release assay (IGRA) test / Mycobacterium Tuberculosis (Mtb)-specific antigen skin test
	5.4	A short regimen for treatment of TB infection can be routinely implemented	3HP/4R/3RH/1HP
Community, Rights and Gender	6.1	Social TB responses	TB community-led monitoring is recognized
			TB stigma measurement is validated / recognized
			Legally registered and funded national TB Survivor network is recognized
			TB social contracting from domestic budget
TB financing (health insurance)	7.1	TB services are covered by the Government supported Health Insurance scheme	

Section	Questionnaire Ref.	TB Policies Indicators		
Case finding and diagnosis	1.1	A screening for TB should be conducted for the following population groups	Household (HH) contacts of drug-sensitive bacteriologically confirmed TB cases	All Children (aged <5 years)
				All Children, adolescents, and adults (aged 5 years and above)
			HH contacts of drug-resistant bacteriologically confirmed TB cases	All Children (aged <5 years)
				All Children, adolescents, and adults (aged 5 years and above)
			ALL people living with HIV (PLHIV)	
			Others	
	1.3	A multiyear plan to achieve universal use of RMDs as the initial test to diagnose TB		
	1.6	All bacteriologically TB confirmed starting treatment should be tested for RIF resistance		Xpert/Truenat is an initial diagnostic test for all people with presumptive TB, all bacteriologically confirmed TB cases will automatically receive a RIF resistance result
				TB cases diagnosed with tests other than Xpert/Truenat should be tested for RIF resistance
	2.2	Population groups targeted for systematic TB screening using CXR		HH, and close contacts of people with TB
				Migrants and internally displaced persons
				Incarcerated population (Prisoners)
				Miners exposed to silica dust
				PLHIV
				All targeted groups of population
				Other targeted populations
TB infection testing and treatment	5.1	Target populations for people with TB infection treatment (TPT)	PLHIV	HIV-positive children (age < 5 years)
				HIV-positive children (aged 5 years and above), adolescents and adults
			HH contacts of drug-sensitive TB cases	HH contacts of drug-sensitive TB cases - Children (aged <5 years)
				HH contacts of drug-sensitive TB cases - Children, adolescents and adults (aged 5 years and above)
			People who are initiating anti-TNF treatment, receiving dialysis, preparing for an organ or hematological transplant	
			People who are receiving dialysis	
			People who are preparing for an organ or hematological transplant	
			People who are have silicosis	
			Other	

Section	Questionnaire Ref.	TB Policies Indicators	
Model of care	4.2	Treatment support and adherence interventions for people with TB	Patients education
			Financial support
			Psycho-social counseling
			Patients outreach
			Digital adherence tools
			Nutrition support
			Other
TB infection testing and treatment	5.2	TPT approach(es) to contacts of people with TB after excluding the active disease	TPT is given to contacts tested positive with a TB infection test
			TPT is given to contacts tested positive with a TB infection test only when a TB infection test is available; otherwise, contacts are given TPT without TB infection testing
			TPT is given to all such contacts without TB infection testing
TB financing (health insurance)	7.2	Costs included in the national Government supported Health Insurance scheme	TB screening
			TB diagnosis
			TB treatment
			DR-TB treatment
			TPT
			TB treatment support and adherence interventions for people with TB

Annex 3:
Countries Included in Survey

1	Angola
2	Azerbaijan
3	Bangladesh
4	Belarus
5	Botswana
6	Brazil
7	Cambodia
8	Cameroon
9	China
10	Congo (the Democratic Republic of the)
11	Eswatini
12	Ethiopia
13	Gabon
14	Guinea
15	Guinea-Bissau
16	India
17	Indonesia
18	Kazakhstan
19	Kenya
20	Kyrgyzstan
21	Liberia
22	Malawi
23	Moldova (the Republic of)
24	Mongolia
25	Mozambique
26	Namibia
27	Nepal
28	Nigeria
29	Pakistan
30	Papua New Guinea
31	Philippines (the)
32	Sierra Leone
33	Somalia
34	South Africa
35	Tajikistan
36	Tanzania, United Republic of
37	Thailand
38	Uganda
39	Ukraine
40	Uzbekistan
41	Viet Nam
42	Zambia
43	Zimbabwe

Annex 4:
National Documents Checklist

Documents used for reference to support the responses to the survey questions included:

a. National TB Guidelines

b. National TB Prevention Guidelines

c. Annual Reports/Assessments of the country

d. National PMDT Guidelines

e. National TB/HIV Guidelines

f. National Childhood TB guidelines

g. National Strategic Plans (NSPs)

h. Standard Operating Procedures (SOPs) of the country

i. National Laboratory Guidelines and manuals

j. Any relevant prikaz/memos on TB, PMDT, new drugs etc. which contain policy decision of the country

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