



**DO WE HAVE
THE MOST
UPDATED
COUNTRY
POLICIES TO
END TB?**

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Introduction

There is a dream of ending the scourge of TB, a leading infectious disease killer. The steady decline in TB incidence and mortality was reversed between 2020 and 2021 by the Covid pandemic. The pandemic resulted in an excess of half a million deaths. In 2022 an all-time high in notification (7.5 million) was reported. However, the world is off track to achieving the End-TB targets. The net reduction in deaths from TB, from 2015 to 2022 was 19%, far from the WHO End-TB strategy milestone of a 75% reduction by 2025. The net reduction in incidence from 2015 to 20221 was 8.7%, far from WHO End-TB strategy milestone of a 50% reduction by 2025 the world was, therefore, only halfway to the first milestone of the End TB Strategy. Strong TB policies along with strong health systems, leadership and governance are important for Ending TB. To close the gaps for diagnosis and treatment of DS-TB, DR-TB and TB infection it is important to rapidly adapt national policies based on recent evidence and embrace new technologies with promise of greater capability for diagnosis and treatment adherence. Countries are expected to rapidly develop or adopt policies and interventions that are based on best evidence for adequate person-centred care in a variety of geographical, economic and social settings.



AIM

In this report we present the findings of Step Up For TB (SUFT) 2023 survey, the aim of which was a landscape analysis of recent global TB guidelines adopted by the national TB programs (NTP) and their alignment with global best practices. The analysis presents the perspective and opinion of Stop TB Partnership (STP).



Methodology

SCOPE AND PERIOD OF SURVEY

For SUFT 2023 the TB diagnostic, treatment and prevention guidelines considered were those issued by WHO between 2020 and 2022, except for one which was issued in 2015. Thus, at the time of conducting the survey, the countries had at least a year's time to adapt the global guidelines. The survey assessed the adoption of the recent global guidelines by countries and did not assess the process of implementation. The survey was conducted during February – April 2023.

DEVELOPMENT OF THE SURVEY QUESTIONNAIRE

A questionnaire developed by Stop TB Partnership included eight questions on screening and diagnosis^{2,3,4,5,6,7}, four on treatment^{4,8,9,10}, two on model of care and patient support¹¹, and three on treatment of TB infection^{10,12,13,14}. The questionnaire was placed on the SUFT portal (<https://suft.stoptb.org/>) of Stop TB Partnership (STP). All 17 questions were multiple choice with the instructions to select one or multiple options, to indicate whether policies had been adopted and if yes, then was it for entire population or only for a particular group (high risk or specific age group). The respondents were requested to upload supporting documentation.

SURVEY QUESTIONNAIRE

17 QUESTIONS

4 questions on
treatment

2 questions on
**model of care and
patient support**

8 questions on
**screening and
diagnosis**

3 questions on
**treatment of TB
infection**



30 COUNTRIES

initially invited to participate in the survey

responses from

20 were considered complete and analysed

All 20 participating countries were considered

high burden for TB or TB/HIV or MDR-TB

by WHO

9 from Africa

6 from Asia

5 from Eastern Europe

DATA COLLECTION

A total of 30 countries were initially invited to participate in the survey. Responses from 20 were considered complete and analysed further for this 2023 SUFT survey. All 20 participating countries were considered high burden for TB or TB/HIV or MDR-TB by WHO. Nine countries were from Africa, six from Asia and five from Eastern Europe*.

Countries could also revert any time and update their data on the SUFT portal or request the STP Secretariat staff to do so. In some instances, the civil society network of the country supported the NTP in this process.

Responses were reviewed by the STP team and NTPs were contacted for clarifications through messaging on the SUFT portal and calls. After confirmation the final responses were coded and analysed in Microsoft Excel. The results were double-checked by two staff of the STP Secretariat.

The results of this survey were not comparable with past SUFT surveys because of rapid updates in WHO TB guidelines. In other words, the policies assessed have differed in each SUFT survey. The readers are advised to visit the [SUFT portal](#) to see year-wise SUFT data for each country by generating tables, trend lines and fact sheets.



* 20 SUFT surveyed countries: Bangladesh, Democratic Republic of the Congo, Ethiopia, Indonesia, India, Kenya, Kyrgyzstan, Kazakhstan, Mozambique, Nigeria, Philippines, Pakistan, Tajikistan, Ukraine, Uganda, Uzbekistan, Viet Nam, South Africa, Zambia, Zimbabwe

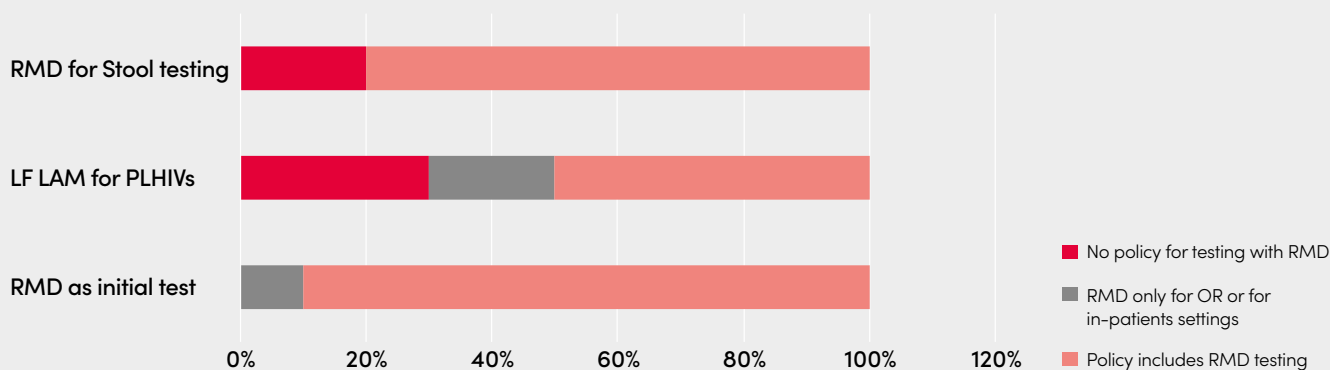
Results

Detailed results for the 20 surveyed countries are presented in Table 1. Of all the policies assessed in different age groups (36 combinations in 17 questions), 18 of 20 (90%) countries had adopted at least 18 (50%) policies; seven (35%) countries, Ethiopia, India, Kazakhstan, Kyrgyzstan, Tajikistan Ukraine and Viet Nam had adopted 28 (80%) or more of the policies.

SCREENING

All countries had a policy for screening of household contacts (adults and children) of bacteriologically confirmed DS-TB and DR-TB cases. Tajikistan additionally included close contacts outside the household in its national screening algorithm (Table 1).

CHART 1: Countries' policies with RMD included into TB diagnostic algorithm



TESTING WITH RAPID MOLECULAR DIAGNOSTICS

All countries had a policy of rapid molecular diagnostics (RMD) as an initial test for those with presumptive TB though one country uses it only in high-risk groups; Only 50% of the countries had included LF-LAM for

PLHIVs in their national policies for both in-patients and out-patients, 10% had included it for in-patients only and 10% for operational research (OR). Eleven of 20 countries were considered high-burden for TB/HIV - eight (72.7%) of these had adopted the policy for LF-LAM whereas 44% countries that were not high-burden for TB/HIV had also adopted it. A majority of the countries (80%) had the policy for stool based RMD testing for TB diagnosis in children. (Please see chart 1).

CHART 2: Countries' policies for resistance testing among all those confirmed to have TB

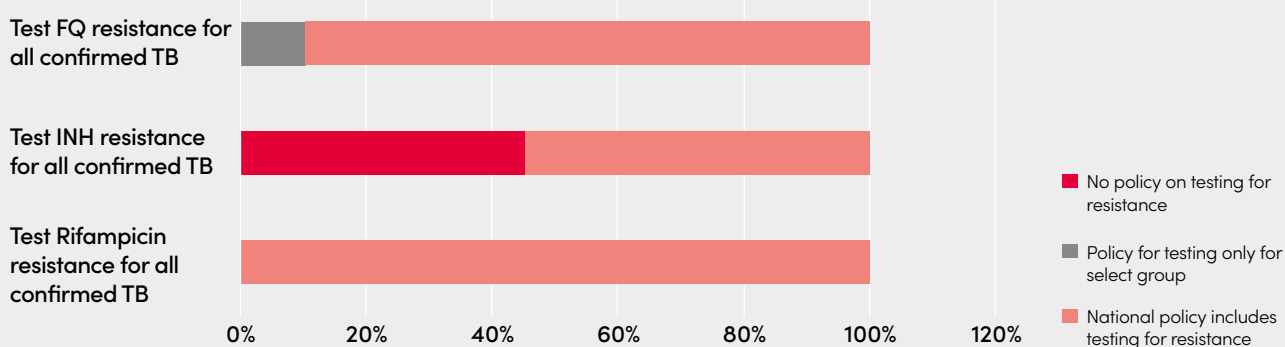


TABLE 1

	Countries	Diagnostics														4mo regimen (2HPMZ/2HPM) for DS-TB	9mo oral regimen DR/RR adults	BPqLM-6mo-RR&preXDR adult	4mo(2HRZ(E)/2HR) for DS-TB child
		HHC screening for DS-TB		HHC screening for DR-TB		RMD initial test	LF LAM in PLHIVs	RMD for Stool testing	DST for Rifampicin for all confirmed TB	DST for INH for all confirmed TB	DST for FQ for all confirmed TB	DST methods available routinely for							
		U5	A5	U5	A5							BDQ	Delamanid	Linezolid					
1	Bangladesh	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	
2	CongoDR	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes	No	Yes	No	No	No	No	Yes	Partially	Partially	
3	Ethiopia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	
4	India	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	
5	Indonesia	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	
6	Kazakhstan	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	
7	Kenya	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No	No	
8	Kyrgyzstan	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	
9	Mozambique	Yes	Yes	Yes	Yes	Yes	Partially	No	Yes	No	Partially	Yes	Yes	Yes	No	Partially	No	No	
10	Nigeria	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Partially	Yes	
11	Pakistan	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	
12	Philippines	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	No	
13	South Africa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Partially	No	No	No	No	Yes	Partially	No	
14	Tajikistan	Yes	Yes	Yes	Yes*	Yes	Yes	Yes	Yes*	Yes	Yes	Yes	Yes	Yes	No	Partially	Partially	Yes	
15	Uganda	Yes	Yes	Yes	Yes	Partially	Yes	No	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No	
16	Ukraine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Partially	No	
17	Uzbekistan	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Partially	No	
18	Viet Nam	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	
19	Zambia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	Yes	Yes	Partially	
20	Zimbabwe	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	Yes	No	No	

U5 under 5 years of age

A5 aged 5 years or above

N/A not answered (Note- These were not included in the analysis)

D/K don't know (Note- These were not included in the analysis)

No absence of the policy

Partially policy for operational research (OR) or for select group of people (please see text)

Yes existence of the policy

Yes* existence of the policy and additionally included contacts outside the household

HHC Household contact

RMD Rapid Molecular Diagnostics

LF LAM Lateral Flow Urine Lipoarabinomannan assay

DST Drug sensitivity testing

INH Isoniazid

FQ Fluoroquinolone

mo months

RR Rifampicin resistance

DR Drug resistant

DS Drug sensitive

Do we have the most updated country policies to End TB?

Treatment and Model of Care								Prevention										
Model of care	Care and support interventions							TB Infection Treatment target population				Test TB infection			Short regimen for treating TB Infection			
Hospitalization for DR-TB treatment initiation	Patient Education	Staff Education	Material Support	Psychological support	Tracers	VOT-Video-observed-treatment	Digital medication monitor	U5-PLHIV	A5-PLHIV	U5HHC of DS-TB	A5HHC of DS-TB	TST	IGRA	New generation skin test	3HP	4R	3RH	1HP
No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No
No	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Partially	Partially	No	Yes	No	No	No
Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No
No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a	Yes	No	Yes	No
Partially	Yes	Yes	Yes	Yes	Yes	Yes	n/a	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Partially	No	Yes	No	Yes	No
Partially	Yes	Yes	Yes	Yes	No	Yes	DK	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Partially	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No
Partially	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	No
Partially	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	No	Yes	No	No	Yes	No	No	No
No	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Partially	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
No	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No
Partially	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
Partially	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Partially	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	Yes	No	Yes	No

DRUG SENSITIVITY TESTING

A national policy for testing for resistance among all people starting TB treatment was available –for rifampicin resistance in 100%, for isoniazid resistance in 55%, and for fluoroquinolone resistance in 90% countries. (Please see chart 2). National policy for drug sensitivity testing was available –for Bedaquiline in 80%, for Delamanid in 55%, and for Linezolid in 70% countries. (Please see chart 3).

ADOPTION OF SHORT REGIMENS

Only 5% countries had included four-month regimen (2HPMZ/2HPM) for treatment of DS-TB in adults in national policy. 80% countries included the 9-month all-oral regimen for treatment of MDR/RR-TB in adults. 40% countries included routine use of 6-month BPaLM regimen for treatment of MDR/RR-TB and pre-XDR TB in adults. 10% countries included the 4-month regimen of 2HRZ(E)/2HR for treatment of non-serious drug-susceptible TB in children. (Please see chart 4)

CHART 3: Countries' policies indicate DST

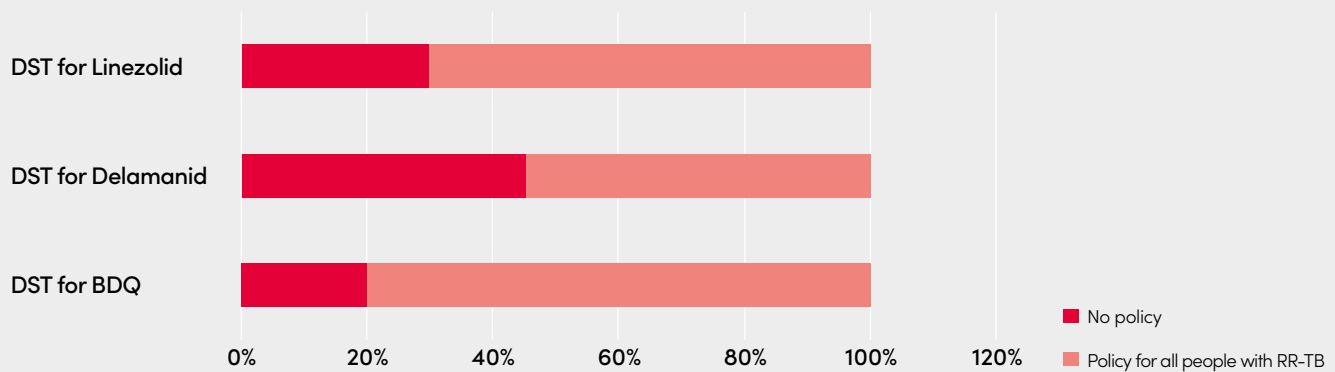


CHART 4: Countries' policies with shorter TB treatment regimens

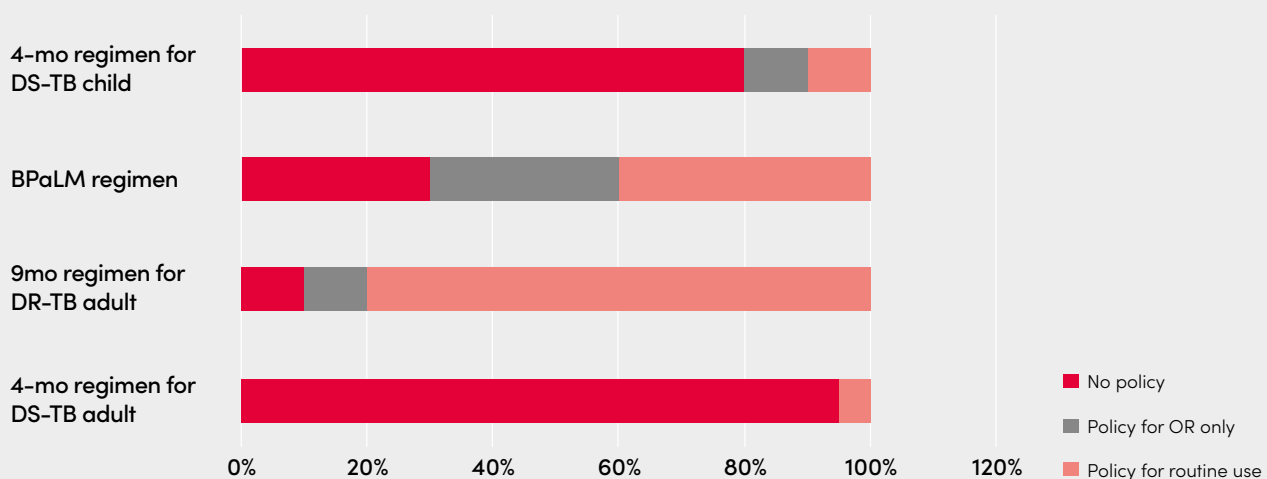
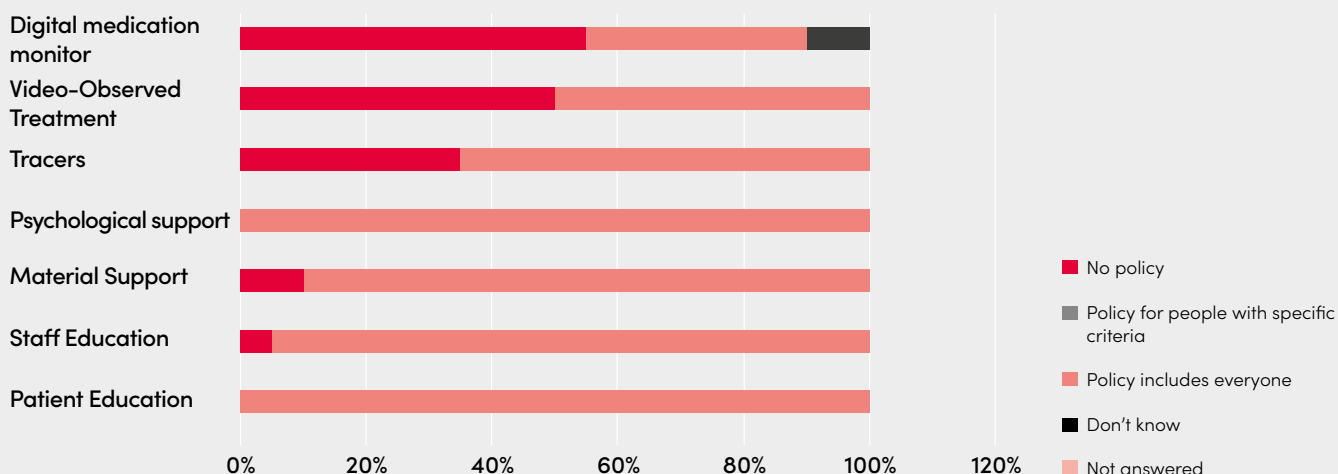


CHART 5: Countries on policies for model of care



TREATMENT MODEL

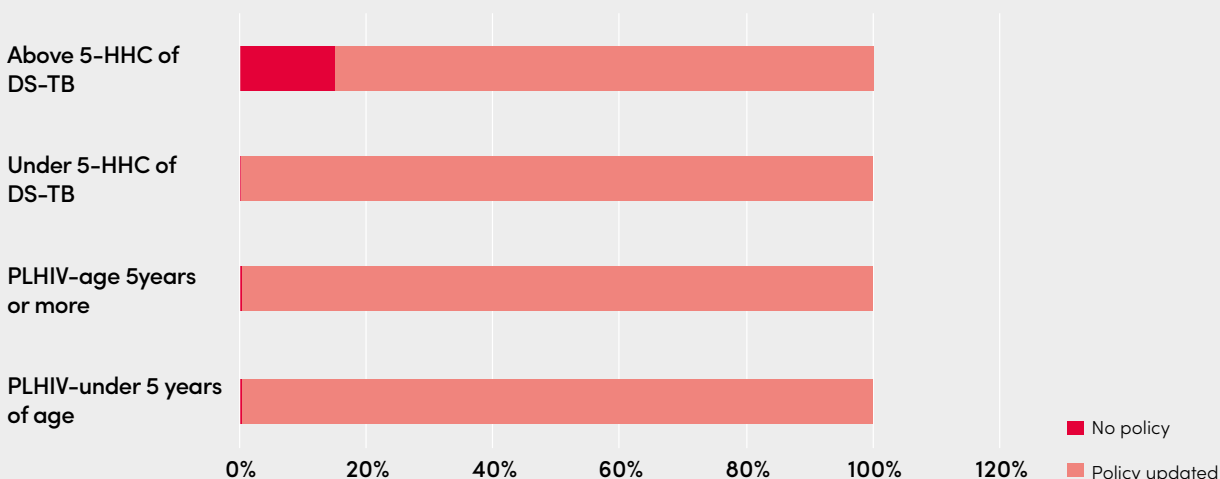
50% countries did not recommend hospitalization for initiation of treatment for DR-TB in their national policies.

SUPPORTING PEOPLE ON TREATMENT

Although national policies of all countries included patient education, staff education and psychosocial

support but material support i.e., nutrition or financial support was included only in 18 (90%) countries. Tracers were included in 13 (65%) countries. Video-observed treatment (VOT) was included in half of the countries and digital monitoring was included in the national policy of seven (35%) countries. Four (20%) countries did not include tracers (communication, home visit, SMS or call by mobile phone) or VOT or digital medication monitor support for people on TB treatment in their national policy. These are Democratic Republic of Congo, Mozambique, Nigeria, South Africa. (Please see chart 5)

CHART 6: Countries' policies to treat TB infection among targeted populations



DETECTION AND TREATMENT OF TB INFECTION

All PLHIVs, of all age groups were included in the target group for TPT in all countries. Seventeen (85%) countries had included people aged 5 years and above who were not living with HIV and who were household contacts of people with bacteriologically confirmed DS-TB –in the target group for TPT in their national

policies. The countries who did not include adults in the target group for TPT were Bangladesh, India and South Africa. However, Bangladesh included the elderly (Please see chart 6). Interferon Gamma Release Assay (IGRA) was included by 70% of the countries and 30% had included new generation skin test (MTb specific antigen) for diagnosis of TB infection (Please see chart 7). All countries had adopted one or more of the recommended short regimens. The shortest regimen of one month of INH and Rifapentine was adopted by seven countries (Table 1) (Please see chart 8).

CHART 7: Countries' policies for testing TB infection

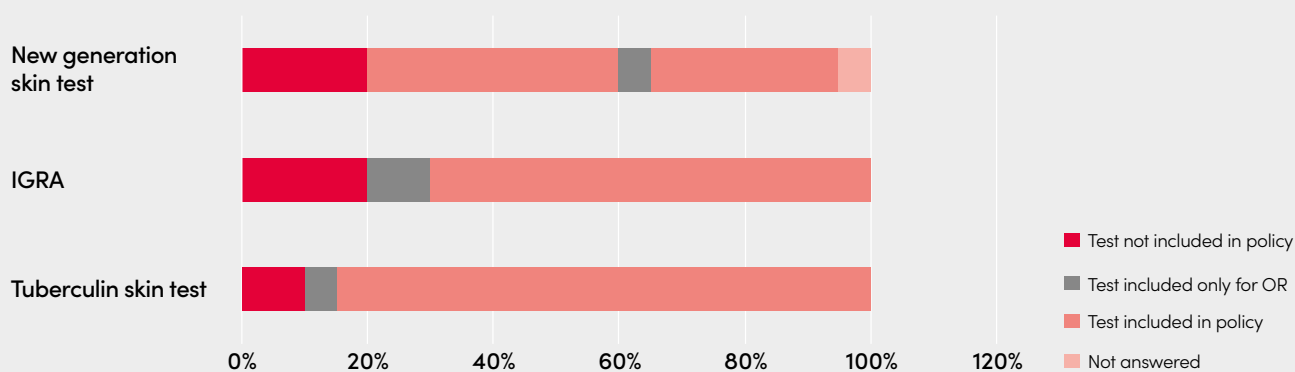
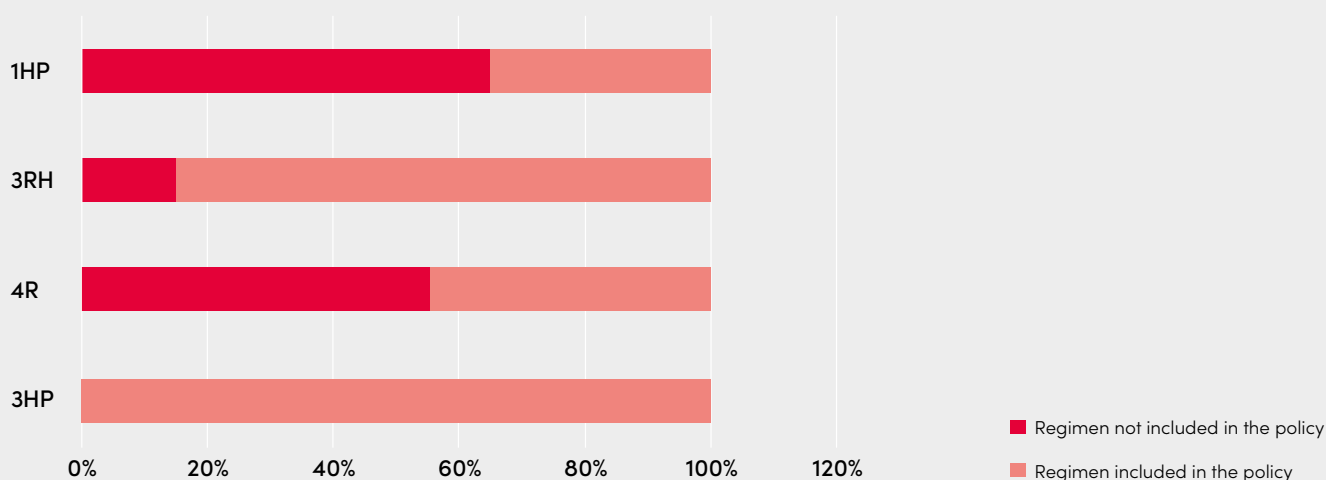


CHART 8: Countries' policies for shorter TPT regimens





Discussion

A change in policy could mean a change in medical management guidelines leading to changes in the procurement guidelines, information strategy, monitoring and evaluation system, and training of staff. These changes test the capacity and governance of health systems as well as political leadership. Countries adopt international guidelines and recommendations at a different pace. This diversity in policy uptake across countries underscores the importance of understanding the factors that influence such decisions and requires further understanding of the process. Global and national stakeholders should consider technical assistance where required. For political support for adoption and implementation of policy, greater partnership with civil society would be paramount.

In general, all the surveyed countries showed good adoption of recent policies on diagnostics. Most of the countries had adopted the policy for testing with RMD including with stool-based diagnosis for children. However, LF-LAM for PLHIVs had relatively lesser uptake but its adoption was higher in countries with high burden of TB/HIV compared to those who were not high burden.

For treatment, the 9-month treatment regimen for DR-TB had been adopted for adults in most of the countries along with sensitivity testing for Bedaquiline. Concern was for slow adoption of short treatment regimens for DS-TB. The slow adoption of adult regimens can be explained

by lack of availability of FDCs and Rifapentine high market price, but there is no reason for a lack of adoption of short regimens (2HRZ(E)/2HR) for non-serious TB in children. Combined with the low notification seen globally for children this is an unwelcome situation and needs advocacy and attention of all stakeholders.

Half of the countries still have a policy of hospitalization for initiation of DR-TB treatment for people with specific criteria or routinely. These are a mix of countries from different geographies and with widely different prevalence of DR-TB. This survey does not match the policy with the actual hospitalization rates.

Knowing that hospitalization diverts domestic resources and contributes to loss of income and stigma for people on treatment, this issue needs more in-depth review. Harmonization of global criteria for hospitalization including pre-treatment weight/BMI, lung function, co-morbidities, and personal factors, is imperative.

Of concern was the fact four (20%) countries reported not having policies on tracers (communication, home visit, SMS or follow up by mobile phone) or video supported treatment or digital medication monitor support for people on TB treatment in their national policy. These are Democratic Republic of Congo, Mozambique, Nigeria, South Africa.

Limitation of the survey

This survey only considered the adoption of policies at the national level. Countries which adopted the policies but did not implement them or implemented them only in a small area would have impact no different from the countries that did not adopt the policies. This survey does not differentiate between such countries. Nevertheless, adopting appropriate policies is the first step and this survey assesses this aspect.

Recommendations

The NTPs would achieve greater impact by accelerating the adoption of diagnostic and treatment policies.

Secondly, NTPs would benefit by analyzing how well the policies are being practiced. As an example, a

review of hospitalization rates and its trends over the last few years would inform if the hospitalization policy is being followed as per the national guidelines.

Third, the NTPs can prioritize adoption of policies based on their program performance. Policies with potentially greater impact should be prioritized for adoption to achieve maximum impact. For example, if childhood notification is low adoption and scale up of stool based RMD could be prioritized.

Fourth, the TB community and civil society can work with NTP/MoH and other national stakeholders and use this SUFT 2023 report as an advocacy tool for rapid adoption and implementation of policies.

Fifth, for the global TB community, this survey has important learnings with regard to the key vulnerable populations (PLHIVs and children, in particular). Global partners need to plan technical assistance and other support for countries that for various reasons have not been able to adopt/adapt the recent guidelines.





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