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Governance of TB Programs:

SECOND ASSESSMENT OF PRACTICES IN 18 COUNTRIES

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Acknowledgments

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The core team carried out the conceptualisation, finalisation of the methodology, data collection, desk review, analysis of the survey and writing of the report. Interviews, where required, were conducted by the consultant (Alka) and staff of Stop TB Partnership. Alka did the preliminary analysis and wrote the first draft of the report, which was finalised with inputs from the core team.

Disclaimer: The findings in this publication do not necessarily represent the views of the U.S. Agency for International Development or the U.S. Government.

National respondents who contributed were:

The country-wise list includes the NTP managers and the civil society respondents. The contribution of the NTP staff is recognised though individual members are not listed here.

Country	NTP respondent	Civil society respondents
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Zimbabwe	Fungai Kavenga	Walter Chikanya | Tariro Kutadza | Ronald Rungoyi

The **regional networks** provided coordination support for the participation of civil society and affected community members in the survey. These were: APCASO and Activists' Coalition on TB Asia Pacific (ACT! AP); African Coalition on Tuberculosis (ACT); and, PAS Center.

Abbreviations

CAD	Computer-aided Detection
CCM	Application
CRG	Community, Rights and Gender
CS	Tuberculosis-affected Communities and Civil Society
GDF	Global Drug Facility
JEPR	Joint External Programme Review
KP	Key Population
MDR-TB	Multidrug-resistant Tuberculosis
MoH	Ministry of Health
NAAT	Nucleic Acid Amplification Testing
nEML	National Essential Medicines List
NGO	Nongovernmental Organization
NSP	National Strategic Plan
NTP	National Tuberculosis Programme
STP	Stop TB Partnership
TB	Tuberculosis
TPT	Tuberculosis Preventive Treatment
UNHLM	United Nations High-Level Meeting
USAID	United States Agency for International Development
WHO	World Health Organization

Highlights

This is the second report on the assessment of governance of tuberculosis (TB) programmes at the national level. An essential difference from the first survey is the inclusion of partners from TB-affected communities and civil society (collectively referred to as CS partners in the text) as respondents giving a robust report.

The questionnaire from the first survey was provided for self-administration through Google forms after slight adjustments. Like the first report in 2021, **the assessment covered activities and policies under the four themes:**

- Transparency
- Inclusiveness
- Legal Framework
- Process Efficiency and Effectiveness

Each theme had five benchmarks. The total score of all components for each benchmark was 4, leading to a maximum score of 20 for each theme (please see Annexes 2 and 3 for the benchmarks and scoring methodology). Considering a score of 20 to be 100%, a theme index score was calculated. The countries were (i) assessed on whether or not they had achieved the benchmarks of a particular theme and (ii) given an index score for each of the four themes. The detailed methodology and results are presented in the subsequent chapters of this report.

Summary results are presented in this section. A total of 22 countries were approached. The CS partners from all countries and national TB programme (NTP) partners from 18 countries responded. Results of these 18 countries are presented in the main report, whereas the results of the four countries for which only the CS partner responded are given in Annex 4. Information mostly pertained to the year 2021 except for the transparency theme and a few other components.

Results

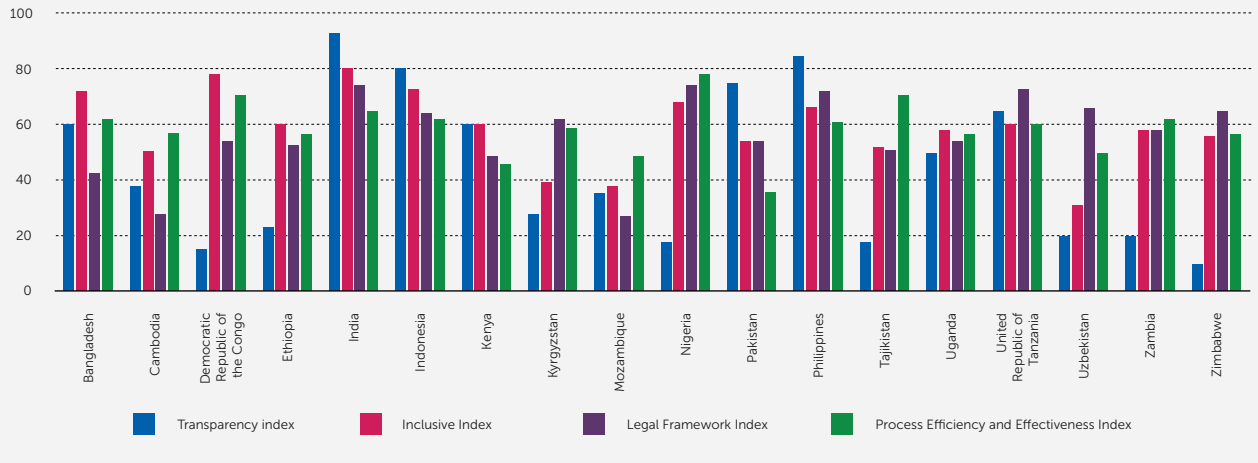
1. Benchmarks achieved by countries

	Transparency					Inclusiveness					Legal Framework					Process Efficiency & Effectiveness					Total number of benchmarks achieved by countries
	Benchmark 1: A working NTP website	**Benchmark 2:** Case notification data on the website	**Benchmark 3:** Latest TB technical guidelines on website	**Benchmark 4:** NSP and annual budget on the website	**Benchmark 5:** External programme review	**Benchmark 1:** Social contracting with govt. funds	**Benchmark 2:** Inclusion of key populations in NSP	**Benchmark 3:** Inclusion of civil society/ TB survivors	**Benchmark 4:** Inclusion of TB community and subnational entities	**Benchmark 5:** Gender inclusiveness	**Benchmark 1:** Mandatory TB notification	**Benchmark 2:** DR-TB medicines in nEML and free	**Benchmark 3:** Social protection	**Benchmark 4:** Law/Policy on Human rights for TB	**Benchmark 5:** Policy framework to reduce TB stigma	**Benchmark 1:** Approval process efficiency	**Benchmark 2:** NTP manager empowerment	**Benchmark 3:** Capacity of NTP	**Benchmark 4:** Ability to adopt/adapt international guidelines	**Benchmark 5:** NTP's capacity for fund absorption	
Bangladesh	■							■	■		■							■			5
Cambodia									■			■									2
Democratic Republic of the Congo									■			■							■		3
Ethiopia								■	■			■									3
India	■	■	■		■	■			■		■					■				■	9
Indonesia			■		■			■	■		■	■				■					6
Kenya			■						■		■										3
Kyrgyzstan											■	■									2
Mozambique									■												1
Nigeria								■	■		■	■				■			■		6
Pakistan	■		■									■									3
Philippines	■		■	■					■		■	■		■					■		8
Tajikistan									■		■					■			■		4
Uganda			■		■			■	■		■										3
United Republic of Tanzania											■	■									4
Uzbekistan	■										■	■					■				4
Zambia					■				■		■										3
Zimbabwe									■		■	■				Data NA					3
Number of countries that achieved the benchmarks	5	1	6	1	4	1	0	5	14	0	13	11	0	1	0	3	1	1	4	1	

■ Note: Indonesia did not procure in the last 2 years and Zimbabwe did not respond to this question.

2. Theme Indices achieved by countries

Country Name	Transparency Index	Inclusiveness Index	Legal Framework Index	Process Efficiency and Effectiveness Index
Bangladesh	60%	72%	43%	62%
Cambodia	38%	51%	28%	57%
Democratic Republic of the Congo	15%	78%	54%	71%
Ethiopia	23%	60%	53%	57%
India	93%	80%	74%	65%
Indonesia	80%	73%	64%	62%
Kenya	60%	60%	49%	46%
Kyrgyzstan	28%	39%	62%	59%
Mozambique	35%	38%	27%	49%
Nigeria	18%	68%	74%	78%
Pakistan	75%	54%	54%	36%
Philippines	85%	66%	72%	61%
Tajikistan	18%	52%	51%	71%
Uganda	50%	58%	54%	57%
United Republic of Tanzania	65%	60%	73%	60%
Uzbekistan	20%	31%	66%	50%
Zambia	20%	58%	58%	62%
Zimbabwe	10%	56%	65%	57%



3. Dashboard with score for individual benchmarks

	Bangladesh	Cambodia	Democratic Republic of the Congo	Ethiopia	India	Indonesia	Kenya	Kyrgyzstan	Mozambique	Nigeria	Pakistan	Philippines	Tajikistan	Uganda	United Republic of Tanzania	Uzbekistan	Zambia	Zimbabwe
Transparency																		
A working NTP website	4	1.5	0	0.5	4	3	3	1.5	1	0.5	4	4	3.5	2	2	4	0	0
Case notification data on the website	1	0	0	0	4	2	0	0	0	0	1	2	0	0	0	0	0	0
Latest TB technical guidelines on the website	2	0	0	2	4	4	4	1	3	0	4	4	0	2	4	0	0	0
NSP and annual budget on the website	3	3	0	0	2.5	3	3	0	0	0	3	4	0	3	3	0	0	0
External programme review	2	3	3	2	4	4	2	3	3	3	3	3	0	3	4	0	4	2
Theme Score for Transparency	12.0	7.5	3.0	4.5	18.5	16.0	12.0	5.5	7.0	3.5	15.0	17.0	3.5	10.0	13.0	4.0	4.0	2.0
Inclusiveness																		
Social contracting with government funds (NGOs/ private sector)	2	0	2	0	4	1	0	1	0	0	2.5	2.5	1.5	1	0	2	2	0.5
Inclusion of key populations in NSP	2	1.5	3.5	2	2.5	2.5	3	2.5	1	3	2	1	1.5	1	3	0.5	1	1.5
Inclusion of civil society/TB survivors	4	3	3.5	4	3	4	2.5	1	1	4	2	3.5	2	4	3.5	2	3	3.5
Inclusion of TB community and subnational entities	4	4	4	4	4	4	4	2	4	4	3	4	4	4	3	0	4	4
Gender inclusiveness	2.4	1.7	2.7	2	2.4	3.1	2.4	1.3	1.6	2.5	1.3	2.3	1.5	1.6	2.4	1.6	1.6	1.7
Theme Score For Inclusiveness	14.4	10.2	15.7	12.0	15.9	14.6	11.9	7.8	7.6	13.5	10.8	13.3	10.5	11.6	11.9	6.1	11.6	11.2
Legal Framework																		
Mandatory TB notification	4	0	0	0	4	4	4	4	0	4	2	4	4	4	4	4	4	4
DR-TB medicines in nEML and available for free	2.5	4	4	4	2.5	4	1	4	1	4	4	4	2.5	1	4	4	2.5	4
Social protection	1	0.7	0.7	1.3	3.2	1.3	0.7	2	1	0.7	0.7	1.3	1	1.3	1.3	1	1.7	0.7
Law/policy on human rights for TB	0	0	3.2	3.2	3.2	2.4	3,2	2.4	2.4	3.2	3.2	4	1.6	2.4	3.2	3.2	2.4	2.4
Policy framework to reduce TB stigma	1	1	3	2	2	1	1	0	1	3	1	1	1	2	2	1	1	2
Theme Score for Legal Framework	8.5	5.7	10.9	10.5	14.9	12.7	9.9	12.4	5.4	14.9	10.9	14.3	10.1	10.7	14.5	13.2	11.6	13.1
Process Efficiency & Effectiveness																		
Approval process efficiency	3	2	0	0	4		2	2	3	4	1	2	4	2	2	3	3	
NTP manager empowerment	3	3	3.5	3	2.5	3.5	2.5	3	3.5	3	2	2	2.5	2.5	2.5	4	2.5	2
Capacity of NTP	4	2.8	3.8	2.8	1.3	3.8	2.8	3.3	1.3	3.8	3.3	2.3	3.8	2.3	3.3	1.8	1.3	2.8
Ability of NTP to rapidly adopt/adapt international policies	1.3	2.6	3.9	2.6	1.3	2.6	0	2.6	0	3.9	0	3.9	3.9	2.6	1.3	1.3	2.6	1.3
Capacity of NTP for fund absorption	1	1	3	3	4	0	2	1	2	1	1	2	0	2	3	0	3	3
Theme Score For Process Efficiency & Effectiveness	12.3	11.4	14.2	11.4	13.1	12.3	9.3	11.9	9.8	15.7	7.3	12.2	14.2	11.4	12.1	10.1	12.4	11.3
Complete Score	47.2	34.8	43.7	38.4	62.3	55.6	43.0	37.6	29.8	47.6	44.0	56.8	38.2	43.7	51.5	33.4	39.5	37.6

Green (score of 4) indicates the benchmark has been achieved

Yellow (score of more than 2 but less than 4)

Light Orange (score of 2)

Dark Orange (score of more than 0 but less than 2)

Red (score of 0) indicates meaningful action is yet to be initiated

Transparency

8 countries (44%)

did not achieve any benchmark in the transparency theme. These were Cambodia, the Democratic Republic of Congo, Ethiopia, Kyrgyzstan, Mozambique, Nigeria, Tajikistan, Uganda.

5 countries (28%)

achieved the benchmark for 'a working NTP website' - Bangladesh, India, Pakistan, Philippines and Uzbekistan.

1 country (6%)

achieved the benchmark for 'case notification data on the website' - India.

6 countries (33%)

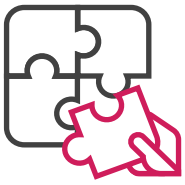
achieved the benchmark for 'Latest TB technical guidelines on the website' - India, Indonesia, Kenya, Pakistan, Philippines and United Republic of Tanzania.

1 country (6%)

achieved the benchmark for 'NSP and annual budget on the website' - Philippines.

4 countries (22%)

achieved the benchmark for 'External program review' – India, Indonesia, United Republic of Tanzania and Zambia.



Inclusiveness

4 countries (22%)

did not achieve any benchmark in this theme. These were Kyrgyzstan, Pakistan, Tajikistan and Uzbekistan.

1 country (6%)

achieved the benchmark for 'social contracting with government funds' - India.

None of the countries

achieved the benchmark for 'inclusion of key populations in NSP'.

5 countries (28%)

achieved the benchmark for 'inclusion of civil society/ TB survivors' - Bangladesh, Ethiopia, Indonesia, Nigeria and Uganda.

1 country (6%)

achieved the benchmark for 'Inclusion of TB community and subnational entities'. The four countries that did not achieve this benchmark were Kyrgyzstan, Pakistan, United Republic of Tanzania and Uzbekistan.

None of the countries

achieved the benchmarks for 'Gender inclusiveness'.

Legal Framework

13 countries (72%)

achieved the benchmark for "mandatory TB notification". The five countries that did not achieve this benchmark were Cambodia, the Democratic Republic of the Congo, Ethiopia, Mozambique and Pakistan.

11 countries (61%)

achieved the benchmark for including multidrug-resistant (MDR-) TB medicines in the National Essential Medicines List (nEML) and making them available for free to people receiving TB treatment. The seven countries that did not achieve this benchmark were Bangladesh, India, Kenya, Mozambique, Tajikistan, Uganda and Zambia.

None of the countries

achieved the benchmark for availability of social protection schemes and social health insurance for all people with TB.

1 country (6%)

achieved the benchmark for inclusion of human rights issues in TB training modules or guidance documents: the Philippines.

None of the countries

achieved the benchmark for "policy framework to reduce TB stigma".

Process Efficiency and Effectiveness

10 countries (56%)

did not achieve any benchmark in the process efficiency and effectiveness theme.

Note that Indonesia and Zimbabwe were not evaluated for the achievement of first benchmark.

3 countries (32%)

achieved the benchmark for approval efficiency, as assessed for the last Global Drug Facility (GDF) quote approved in the country: India, Nigeria and Tajikistan.

1 country (6%)

achieved the benchmark for NTP manager empowerment: Uzbekistan.

1 country (6%)

achieved the benchmark for NTP capacity: Bangladesh.

4 countries (22%)

achieved the benchmark for the ability to rapidly adopt/adapt international guidelines as national policies: the Democratic Republic of the Congo, Nigeria, the Philippines and Tajikistan.

1 country (6%)

achieved the benchmark for the NTP's capacity to absorb funds from different sources: - India.

Introduction

Governance is a critical yet neglected aspect of a strong national tuberculosis programme (NTP).

It determines effective and efficient operationalisation of the programme – not just at the national level, but also at the peripheral level – by individuals, the tuberculosis (TB) community, civil society and governmental subnational entities. Governance encompasses a set of processes: institutions, rules, customs, policies or laws that formally and informally distribute roles and responsibilities or accountability among various actors[1].

Good governance promotes transparency, inclusiveness and a supportive legal framework. It ensures process efficiency and effectiveness. These elements enable free expression of views and healthy negotiations and, thus, can be a bedrock for effective and accountable partnerships.

Significant investments have been made to strengthen the technical capacity of NTPs. However, engaging in a systematic and holistic approach to improve governance has not been a priority, nor has progress in this area been tracked.

The first report on assessment of the governance of NTPs at the national level was published in 2021[2]. The assessment was conducted from a programme management perspective for the purpose of (i) enabling policy-makers and NTP managers to take actions to achieve the benchmarks identified in the report and scale up good practices, and (ii) serving as a tool for NTP managers and civil society to advocate for improved governance. This is the second report in the series. Annual or biennial publication of such reports will reveal the trends in the governance of NTPs in the selected countries. However, the lessons are expected to be useful for the NTPs of all countries and likely for other health programmes as well.

Note: The acronym CS is used in the text to collectively refer to "TB-affected communities and civil society".

Methodology

Selection of Countries

As with the first report, the second governance survey also sought to include countries with high disease burden and with significant investments in TB. A total of 22 countries were initially selected: Bangladesh, Cambodia, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Kyrgyzstan, Malawi, Mozambique, Nigeria, Pakistan, the Philippines, South Africa, Tajikistan, Uganda, Ukraine, the United Republic of Tanzania, Uzbekistan, Viet Nam, Zambia and Zimbabwe. Cambodia and the United Republic of Tanzania were new to the governance survey. They were also selected in the first survey, but were excluded due to lack of response.

All 22 countries, except for Cambodia, were defined by the World Health Organization (WHO) as high-burden for TB and/or TB/HIV and/or multidrug-resistant (MDR-) TB for the period 2021–2025[3]. All 22 countries are TB priority countries for the United States Agency for International Development (USAID)[4]. Through the Global Accelerator to End TB initiative, USAID facilitates increased public and private investment and builds local commitment and capacity to achieve the targets of the 2018 United Nations High-Level Meeting (UNHLM) on TB[5]. All countries are supported by grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria; all but five countries are supported by additional funding from the Global Fund through the second phase (2021–2023) of its TB Strategic Initiative to find and successfully treat people with TB who face barriers and who are currently missed at different points in the TB care cascade[6,7]. As per the Global Fund's categorisation, Kyrgyzstan, Tajikistan and Uzbekistan are "focused" countries, Ukraine is a "core" country and the 18 others are "high-impact" countries.

Development and Content of the Questionnaire

A semi-structured questionnaire was developed by Stop TB Partnership (STP) and USAID experts in May–August 2020 for the first survey to assess the governance structure and functions of NTPs in four thematic areas: (i) transparency, (ii) inclusiveness, (iii) legal framework, and (iv) process efficiency and effectiveness. Details of the questionnaire and the development process are described in the first report[2]. Based on feedback from the NTP and CS partners of the participating countries, the questionnaire was reviewed in the last quarter of 2021 and finalised for the second survey in February 2022.

The first questionnaire remained largely unchanged, except for a few unavoidable adjustments as follows:

In the first survey, seven components of transparency were analysed. These have been retained. Similarly, the themes of inclusiveness and legal framework retained the same 15 and six components, respectively[2].

The process efficiency and effectiveness theme had nine components in the first survey. Of these, two components measured the approval efficiency for training. During the first survey, a lack of clarity was noticed in the reporting of these components, as countries' approval processes differ for training supported by donors and training supported by domestic funds. Therefore, to reduce ambiguity, these two components were replaced by one component on the number of days required for approval of GDF quotes. In the first survey, external partners were asked about the NTP manager's empowerment and capacity. The external partners' response was used as a multiplier to the score obtained from the NTP's response. This time, the CS partners' perception of the NTP manager's empowerment and capacity was asked as a subcomponent. The adjustments to these two components were made to improve measurement. The component on "policies to be adopted/adapted by the NTP" was adjusted to reflect updated global recommendations.

The components were regrouped/rearranged according to their benchmarks and renumbered. Therefore, each of the four themes had five components corresponding to the theme's five benchmarks. A component could have multiple subcomponents, but the maximum score for all components of one benchmark was four. Accordingly, each theme had a maximum score of 20. This adjustment helped to streamline the scoring process and, more importantly, gave clear indication of the constitution of each benchmark.

The original 20 benchmarks, five in each of the four themes, mostly remained the same, as did the scoring methodology.

1. WHO. 2021. WHO global lists of high burden countries for tuberculosis (TB), TB/HIV and multidrug/rifampicin-resistant TB (MDR/RR-TB), 2021–2025: Background document
2. Countries | U.S. Agency for International Development (usaid.gov)
3. tb_2021-quarterly-tuberculosis_update_en.pdf (theglobalfund.org)
4. First governance survey report - Governance of TB programs | Stop TB Partnership

Process for Data Collection

Based on the lessons learned and feedback from the first survey, the data collection process for the second survey was modified as follows:

- While the first survey was restricted to NTP managers, CS partners of the 22 selected countries were requested to respond to the second survey.
- The questionnaire was self-administered as a Google form and was not administered by the STP team.

The Google form/questionnaire was same for the NTP and the CS partners, except that (i) the NTP managers were asked about their perception of their empowerment, whereas CS partners did not respond to this; and (ii) CS partners were asked about their perception of the NTP's capacity and their perception of the NTP manager's empowerment, whereas the NTP managers did not respond to these two questions.

Selection of Civil Society Partners

Regional CS networks in Africa, Asia-Pacific and Eastern Europe, namely Africa Coalition on TB, APCASO and the Center for Health Policies and Studies, respectively, were briefed in November 2021 on plans for engagement for the governance survey. They then took the lead in selecting three civil society or affected community partners in each of the survey countries based on certain selection criteria (see Annex 1). The CS partner respondents engaged in their individual capacity.

Data Collection

Webinars were held on the Zoom platform to explain the survey process. Separate webinars were held for NTP managers and CS partners. Four webinars were held to enable participation of all participants from different regions. Webinars were held in English with translations available in French and Russian. The four groups for the webinars were: (i) CS partners in countries in Eastern Europe and Central Asia, (ii) NTP managers in countries in Eastern Europe and Central Asia, (iii) CS partners in the rest of the world, and (iv) NTP managers in the rest of the world. The aim of the webinars was to familiarise the respondents with the questionnaire and emphasise the importance of providing supporting information for their responses. The contents of the webinars included: (i) the purpose, themes and main results of the first governance survey; (ii) a walk-through of the questionnaire, explaining the adjustments to the second survey; (iii) specification that the information mostly pertained to the year 2021 except for transparency theme and a few other components. (iv) (for the CS partner webinar) the in-country process to complete the form (see below); (v) the process for resolving any differences between the CS partner and NTP responses; and (vi) the timeline for completing the survey. The respondents were informed

that all these processes would be further reiterated by email close to the start of the survey and that the webinar would also be accessible later.

The process conveyed to the CS partners was as follows. The three respondents in each country were expected to review the questions and the relevant supporting information, followed by drafting of proposed answers by a focal person. These draft answers were to be discussed with the other two partners and, after negotiation of a shared position or explanation of differences, the focal person was to complete and submit the survey. The regional networks were engaged to provide coordination and clarification across the participating countries in their region.

In terms of the process of resolving differences in responses, it was explained to the NTP and CS partners that a quick interview or email exchange would be done by STP. The answer, supported by information, would be considered and, where required, both viewpoints would be considered in the narrative.

A pilot run with the Google form questionnaire was done by the STP team to double-check that Google Drive would accept all the attachments (supporting information) in a way that would be convenient to access.

The STP team sent an email simultaneously to the NTPs and CS partners of the 22 countries on 15 March 2022 with a request to respond to the survey in the Google form by 31 March 2022. The email included a link to the webinars and three attachments in English, French, Portuguese and Russian. The attachments were: (i) "Questionnaire in Word format" for easy reference in case the Internet connection was suboptimal, (ii) "Aid to filling the questionnaire", which presented an indicative list of documents that could be cited, and (iii) "Instructions for filling the Google form". The email to CS partners of a country was copied to their regional network contact person.

Scoring of Components, Analysis and Interpretation of Results

As in the first survey, each of the four themes had five benchmarks. The total score for all components in one benchmark was 4, leading to a maximum score of 20 for each theme. A theme index score was also presented, like last time, which considers the maximum theme score of 20 to be 100%.

The starting point of analysis was to validate the NTP's responses with the supporting documentation. This was then compared to the CS partner responses, which sometimes provided additional documentation. The next step was comparison with the first survey. This process of validation and cross-checking was followed by email communications with the NTPs and CS partners to seek additional supporting documentation and clarification of any differences. To the extent possible, the respondents were informed of why the final response considered in the analysis differed from their original response.

Results show each country's achievement in terms of the benchmarks and the four theme indices.

Challenges and Limitations

The limitations of the survey are mentioned in detail in the first report. However, the inclusion of the CS partners' perspectives for each country has given a more robust response in the second survey. For instance, in a few countries, the CS partners presented information on policy and guidelines that the NTP had missed in the first survey.

Responses were received from the CS partners of all countries, including Ukraine, which was impressive. At the same time, responses were not received from the NTPs of Malawi, South Africa and Viet Nam, despite multiple follow-up efforts. The NTP of Ukraine also did not respond, but this was not followed up by the STP team because of the ongoing conflict in the country.

The majority of the countries responded through the Google form, with a few exceptions. The NTP of Kyrgyzstan responded via a Microsoft Word questionnaire, and the NTPs of Uganda and Zambia responded via interviews. An interview was also held with the NTP of Mozambique to seek a few clarifications. In a couple of countries, the CS partners had to resubmit their survey response, as the initial response was provided without joint consultation of all three partners. This was of no consequence.

Email exchanges were sometimes drawn out because of the requirement for documentation. For the NTP of India and CS partners of Bangladesh, this process could not be completed. In these cases, the STP team had to use the evidence available from the CS partners and NTP, respectively, in these countries, and corroborate responses with information on the Internet or consult with people with knowledge of the situation to interpret the results. Almost all discrepancies were resolved.

Data collection was planned until March 2022, but this timeline was extended because of delay in responses from a few NTPs and CS partners. However, this extension gave no unfair comparative advantage or disadvantage to any country, as the reference period continued to be the 2021 calendar year, as originally planned for the survey. The responses from all the countries were reviewed for completeness in August 2022. Because of the delay, the STP team reviewed the information on the transparency theme on the Internet for all countries in November 2022.

CS partners were required to respond independently, but, in some instances, they consulted with the NTP.

A few questions were based on the country's National Strategic Plan for TB (NSP). The NSP of Kyrgyzstan was not available, as it was under submission; consequently, there was less confidence around their responses, as these could not be verified by their CS partners or by the STP team. A few countries had an NSP in draft form (Democratic Republic of the Congo, India and Tajikistan).

A few countries had the same NSP as in the first survey (Bangladesh, India, Kenya, Philippines and Tajikistan) because the period covered by the plan spanned both surveys. As a result, these countries' findings did not change from the first survey, which could potentially put them at a disadvantage compared to those countries with an updated NSP (Democratic Republic of the Congo, Ethiopia, Indonesia, Nigeria and Pakistan) or a new NSP (Kyrgyzstan, Mozambique, Uganda, Uzbekistan, Zambia and Zimbabwe). The countries with new or updated NSPs could have potentially improved their NSP in the areas identified as weak in the first survey. However, the two countries participating for the first time, Cambodia and the United Republic of Tanzania, may not have had this potential advantage.

Organisation of this Report

The chapters are organised by theme. Each chapter begins with a brief introduction of the theme, followed by the benchmarks for the theme and findings of the survey. Key findings, reported as percentages, are provided for each thematic area for each of the 18 countries. The findings for the four countries for which only the CS partners responded to the survey are included in Annex 4. The scoring is included in Annex 2.

THEME

Transparency

Theme 1: Transparency

Key Findings

27% **5 of the 18 countries achieved the benchmark for a working website:** Bangladesh, India, Pakistan, the Philippines and Uzbekistan.

6% **1 of the 18 countries achieved the benchmark for availability of the latest case notification data on the website:** India.

33% **6 of the 18 countries achieved the benchmark for availability of the latest TB guidelines on the website:** India, Indonesia, Kenya, Pakistan, the Philippines and the United Republic of Tanzania.

6% **1 of the 18 countries achieved the benchmark for availability of the NSP and annual budget on the website:** the Philippines.

22% **4 of the 18 countries achieved the benchmark for conducting a JEPR and finalizing the report:** India, Indonesia, the United Republic of Tanzania and Zambia.

Theme Index

10%-93% Range of the index for transparency

44% (8/18) countries had an index of 50% or more in transparency, three of which achieved an index of 75% or more: India, Indonesia and the Philippines.

Transparency is a hallmark of good governance. Timely, impartial, complete and equitable sharing of information creates an enabling environment for the community and all stakeholders, within and outside the government, to understand and contribute to overall objectives.

It promotes optimal and timely use of resources, compliance with procedures and standards, and improvement in performance. It helps to enhance communication and collaboration across ministries, civil society, private sector, media, academia, members of parliament and people affected by TB. It allows for joint accountability to achieve the common goal of TB elimination.

Four of five components of an NTP's transparency were measured based on information in the public domain. The fifth component was related to joint external programme review (JEPR) and the participation of stakeholders. Although publication of the JEPR report on the website was considered ideal, only the report's availability was scored for this survey.

Scores for Individual Components

1. A Working NTP Website

Benchmark: A working NTP website, owned by the NTP/Ministry of Health (MoH), with the latest relevant information, including the latest NTP organogram with the contact details (phone number and email) of individual officials and their functions to enable the public to give feedback or ask a question to the NTP.

Website:

- **Eight (44%) NTPs of the 18 countries had their own functional website** (Bangladesh, India, Indonesia, Kenya, Pakistan, Philippines, United Republic of Tanzania and Uzbekistan) (score 1).
- **Two (11%) NTPs had their webpage on the MoH website** (Mozambique and Uganda) (score 1).
- **Three (17%) NTPs (Democratic Republic of the Congo, Zambia and Zimbabwe) had no website/ webpage (score 0).** For Zambia, an Internet search yielded information on a TB manual (on the FHI 360 website) and a joint monitoring mission in 2020 (STP website); Zimbabwe had a webpage on the MoH website, but the website itself had not been updated since 2017. Both Zambia and Zimbabwe had a score of 0.5 in the first survey.
- **Five (28%) NTPs had either a website (Kyrgyzstan, Nigeria and Tajikistan) or a webpage (Cambodia and Ethiopia) that functioned inconsistently** between April and November 2022 (score 0.5).
  - Nigeria's website was functional only for some of the time and was very basic, i.e., it had only a TB message and bidding documents for 2022.
  - Ethiopia's website was not working in April but started working in August.

Organogram:

- **Nine (50%) countries** (Bangladesh, India, Indonesia, Kenya, Pakistan, Philippines, Tajikistan, Uganda and Uzbekistan) **had an organogram or a list of NTP officials with their designation on the website** (score 1).
- **Nine (50%) countries did not have an organogram** or equivalent information, or it was placed inside a document and thus was not easily accessible. These were Cambodia, the Democratic Republic of the Congo, Ethiopia, Kyrgyzstan, Mozambique, Nigeria, the United Republic of Tanzania, Zambia and Zimbabwe (score 0).

Contact Details (e-mail and phone number):

- **Eleven (61%) countries had the contact details of at least one NTP official on their website (score 1).** These were Bangladesh, Cambodia, India, Indonesia, Kenya, Kyrgyzstan, Pakistan, the Philippines, Tajikistan, the United Republic of Tanzania and Uzbekistan.
- **Seven (39%) countries did not have the contact details of any NTP official on their website (score 0).** These were the Democratic Republic of the Congo, Ethiopia, Mozambique, Nigeria, Uganda, Zambia and Zimbabwe.
- **An additional score of 1 was given to six (33%) countries** (Bangladesh, India, Pakistan, Philippines, Tajikistan and Uzbekistan) that had the contact details of multiple NTP officials on their website. Commendably, a few countries (India, Pakistan, Philippines and Uzbekistan) included the contact details of the subnational TB programme managers.

The benchmark for a working website was achieved by five (28%) countries: Bangladesh, India, Pakistan, the Philippines and Uzbekistan.

2. Case Notification Data on the Website

Benchmark: Publicly available real-time TB notification data are available on the website (real-time means at least daily updates for national- and provincial-level data).

Case notification data were taken as a marker for the availability of programme data on the website. In November 2022, when data were last checked, the situation was as follows:

- **Fourteen (78%) of the countries either did not have any case notification data on their website or had old data.** These were Cambodia, the Democratic Republic of the Congo, Ethiopia, Kenya, Kyrgyzstan, Mozambique, Nigeria, Pakistan, Tajikistan, Uganda, the United Republic of Tanzania, Uzbekistan, Zambia and Zimbabwe.
- **Two (11%) countries had data only up to 2021 on their website (score 1).** For Bangladesh, the national-level case notification report was available for all of 2021, but not for any quarter of 2022. Provincial-level data were also not seen (Reports – National Tuberculosis Control Programme (ntp.gov.bd)). For Pakistan, the annual TB data (2021) were available by province: Resource Center - National TB Control Programme - Pakistan: National TB Control Programme – Pakistan (ntp.gov.pk).
- **Two (11%) countries had data for 2022 in addition to 2021 (score 2).** For Indonesia, the case notification data up to 18 October 2022 were available on the website (Dashboard TB - TBC Indonesia (tbindonesia.or.id)). For the Philippines, treatment enrollment data were available up to June 2022 (TB Dashboard Live (doh.gov.ph)). Neither country had provincial-level data available on their website.
- **One country, India, achieved the benchmark with a score of 4.** Up-to-date state-level (provincial) case notification data were on the website (Dashboard:Nikshay Reports (nikshay.in).

Provisional TB notification reports to WHO were submitted by these countries in 2022 (as checked on 9 December 2022):

- **Quarterly notifications** were submitted by Uzbekistan up to the first quarter of 2022, by Bangladesh and Zimbabwe up to the second quarter, and by Ethiopia, Nigeria, Pakistan and Uganda up to the third quarter.
- **Monthly notifications** were submitted by Cambodia and Kyrgyzstan up to June 2022, by India, the Philippines and the United Republic of Tanzania up to September, by Indonesia and Mozambique up to October, and by Kenya and Zambia up to November 2022.
- **No notification** reports were submitted to WHO in 2022 by the Democratic Republic of the Congo or Tajikistan. They submitted their last reports in 2021 and 2020, respectively.

Provisional TB notification did not count towards scoring in this survey.

Scores for Individual Components (Cont'd)

3. Latest TB Technical Guidelines on the Website

Benchmark: Within three months of the release of global technical guidelines, national guidelines are updated, and within six months, national guidelines are available on the NTP website and easily accessible.

Note: Easily accessible means that the relevant information on the website is categorised appropriately and easy to find. The element of timing in this benchmark was assessed less stringently for this survey.

This component had two subcomponents: for recent MDR-TB guidelines and for recent TB preventive treatment (TPT) guidelines, each with a maximum score of 2. These two technical guidelines were considered markers for the availability of relevant technical material on the NTP website.

- **Seven (39%) countries had neither of the technical guidelines on the Internet (score 0).** These were Cambodia, the Democratic Republic of the Congo, Nigeria, Tajikistan, Uzbekistan, Zambia and Zimbabwe.
- **Five (28%) countries had a score ranging from 1 to 3:**
  - Mozambique scored 3 for having an updated version of its TPT guidelines and older version of its MDR-TB guidelines on its website.
  - Three countries had a score of 2: Bangladesh had the latest MDR-TB guidelines only, while Ethiopia and Uganda had older versions of both guidelines.
  - Kyrgyzstan had a score of 1, as it had an older version of the MDR-TB guidelines only on its website.
- **Six (33%) countries achieved the benchmark (score 4)** for availability of the latest TB technical guidelines on their website: India, Indonesia, Kenya, Pakistan, the Philippines and the United Republic of Tanzania.

4. NSP and Annual Budget on the Website

Benchmark: Final and approved three- to five-year budgeted NSP is on the NTP website and is easily available at least a quarter before the NSP comes into effect. This document is supplemented with a detailed approved annual budget for the NTP for the year, which is available on the NTP website in the first quarter of the financial year and is easily accessible.

NSP:

- **Eight (44%) countries had a final version of the budgeted NSP on their website (score 3).** These were Bangladesh, Cambodia, Indonesia, Kenya, Pakistan, the Philippines, Uganda and the United Republic of Tanzania.
- **India had the NSP until 2025 on its website, but it was budgeted until 2020 (score 2).**
- **Nine (50%) countries did not have the NSP on their website (score 0).** These were the Democratic Republic of the Congo, Ethiopia, Kyrgyzstan, Mozambique, Nigeria, Tajikistan, Uzbekistan, Zambia and Zimbabwe

Annual Budget:

All countries except Uzbekistan had their reported annual budgets (2022) included in the WHO database, but unlike in the first survey, this was not given any score.

- Sixteen (89%) countries did not have the annual TB budget on their website (score 0).
- The Philippines was the only country to have an annual TB budget for 2022 on its website (score 1).
- India had an annual TB plan for 2021 in its annual TB report published in March 2022 (score 0.5).

Only the Philippines achieved the benchmark for this component.

5. External Programme Review

Benchmark: The NTP provides an opportunity for all stakeholders to provide organised and systematic feedback through a JEPR at least every three years and has the final review reports available on the website within three months of the review. (The timeline has not been considered in scoring for this report.)

Note: JEPR has various names, e.g., joint monitoring mission or external programme review. In this report, JEPR denotes a process whereby national and international stakeholders jointly review the programme and make recommendations to the government. Country missions by the Green Light Committee are not considered JEPRs.

This component had two subcomponents: one for conducting the JEPR and the other for availability of the JEPR final report.

Conducting JEPR:

- **Six (33%) countries had conducted a JEPR in 2020 or later (score 2).** These were India, Indonesia, Kenya, Nigeria, the United Republic of Tanzania and Zambia. Kenya was the only country to have conducted a JEPR in 2022.
- **Ten (56%) countries had conducted a JEPR in 2018 or 2019 (score 1).** These were Bangladesh, Cambodia, the Democratic Republic of the Congo, Ethiopia, Kyrgyzstan, Mozambique, Pakistan, the Philippines, Uganda and Zimbabwe.
- **Two (11%) countries had conducted a JEPR prior to 2018 (score 0).** These were Tajikistan and Uzbekistan. In Tajikistan, the last JEPR was conducted in 2013, and in Uzbekistan, the last JEPR was conducted in 2014, although Green Light Committee missions have been carried out recently.

Availability of JEPR report:

- **The final JEPR report was available for 11 (61%) countries (score 2).** These were Cambodia, the Democratic Republic of the Congo, India, Indonesia, Kyrgyzstan, Mozambique, Pakistan, the Philippines, Uganda, the United Republic of Tanzania and Zambia.
- **A draft report or PowerPoint presentation was available for four (22%) countries (score 1).** These were Bangladesh, Ethiopia, Nigeria and Zimbabwe.
- **Three countries (17%) – Kenya, Tajikistan and Uzbekistan – had no report (score 0).** Kenya's JEPR took place in early 2022, and Tajikistan's and Uzbekistan's JEPRs were conducted in 2013 and 2014, respectively.

Four countries achieved the benchmark. These were India, Indonesia, the United Republic of Tanzania and Zambia.

Scores for Individual Components (Cont'd)

Table 1. Transparency Benchmarks Achieved by 18 Countries

Country Name	Achievement of Transparency Benchmarks (Yes/No)				
	Benchmark 1: A Working NTP Website	**Benchmark 2:** Case Notification Data on the Website	**Benchmark 3:** Latest TB Technical Guidelines on Website	**Benchmark 4:** NSP & Annual Budget on the Website	**Benchmark 5:** External Programme Review
Bangladesh	■				
Cambodia					
Democratic Republic of the Congo					
Ethiopia					
India	■	■	■		■
Indonesia			■		■
Kenya			■		
Kyrgyzstan					
Mozambique					
Nigeria					
Pakistan	■		■		
Philippines	■		■	■	
Tajikistan					
Uganda			■		■
United Republic of Tanzania					
Uzbekistan	■				
Zambia					■
Zimbabwe					
Number of countries that achieved the benchmarks	**5**	**1**	**6**	**1**	**4**

Transparency Index

10%-93%

Range of the index for transparency

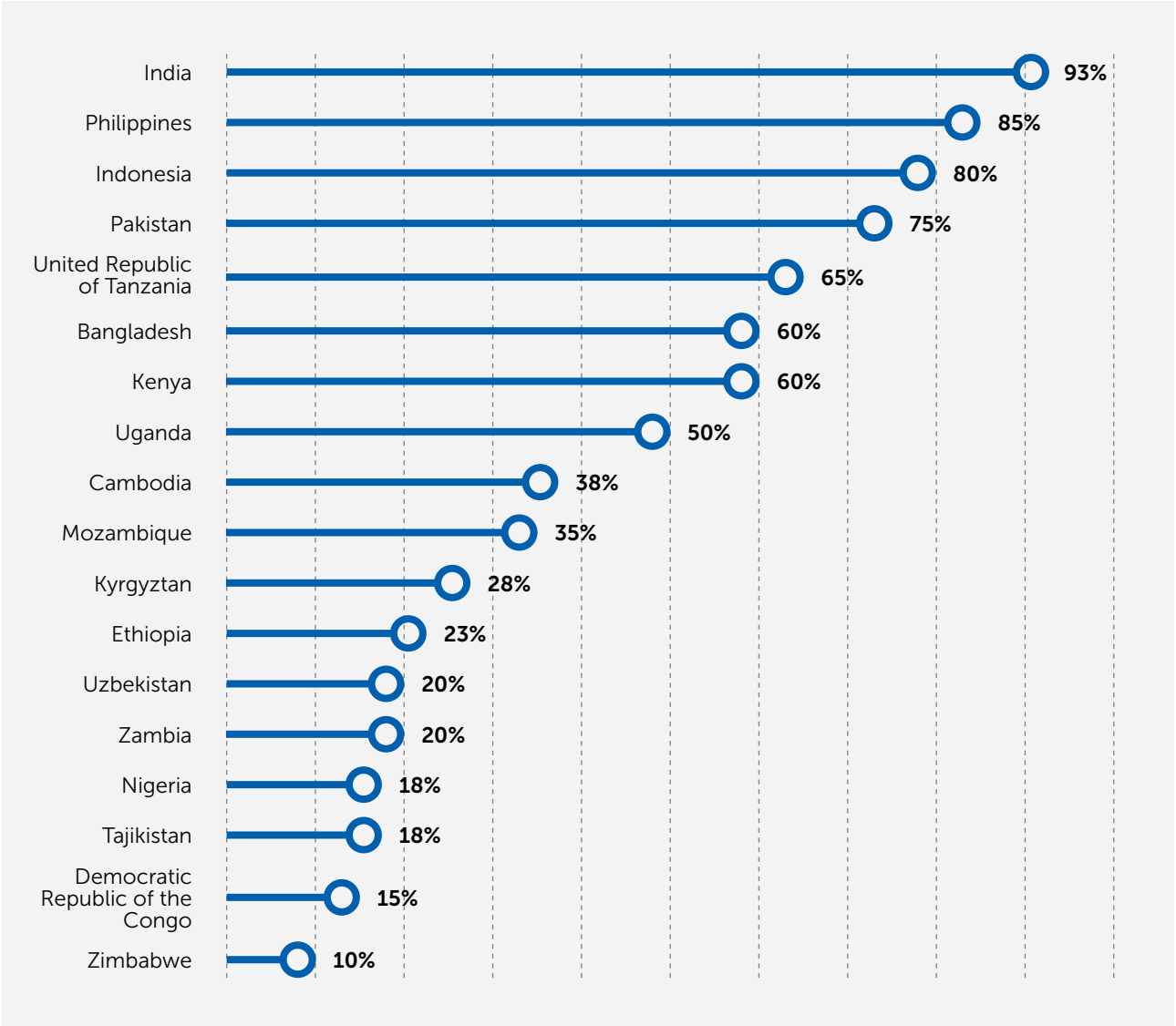
44% (8/18)

of countries had an index of 50% or more in transparency (Bangladesh, India, Indonesia, Kenya, Pakistan, Philippines, United Republic of Tanzania and Uganda)

3 of these 8

countries achieved an index of 75% or more: Indonesia (80%), the Philippines (85%) and India (93%).

Figure 1: Transparency index in the second survey



THEME 2

Inclusiveness

Theme 2: Inclusiveness

Key Findings

6% **1 of the 18 countries achieved the benchmark for having a mechanism and practice** for the social contracting of NGOs and the private sector using government funds: India.

0% **None of the countries achieved the benchmark for including key populations (KPs) in their NSP.**

28% **5 of the 18 countries achieved the benchmark for including TB civil society/TB survivors:** Bangladesh, Ethiopia, Indonesia, Nigeria and Uganda.

78% **14 of the 18 countries achieved the benchmark for having a platform in the country** to collect feedback from the TB community and subnational entities – all except Kyrgyzstan, Pakistan, the United Republic of Tanzania and Uzbekistan.

0% **None of the countries achieved the benchmark for gender inclusiveness in various NTP activities.**

Theme Index

31%-80% Range of the index for social inclusiveness

83% (15/18) countries had an index of 50% or more in social inclusiveness, two of which had an index of 75% or more - the Democratic Republic of the Congo and India.

Inclusiveness in NTPs is crucial to ensure that all individuals, regardless of their socioeconomic status, gender, ethnicity or other social circumstances, are able to access effective TB prevention, diagnosis and treatment.

"Integrated, people-centred, community-based and gender-responsive health services based on human rights" is a key commitment by Heads of States, outlined in the Political Declaration of the UNHLM on TB. It is also the focus of a recently released community report on progress towards UNHLM targets, entitled A deadly divide: TB commitments vs. TB realities[8].

Gender inclusion at all levels can positively shape TB programmes and improve access to care for all. NTPs should scale up interventions to reduce health inequities, including disparities related to gender and age; remove human rights barriers for accessing TB services; integrate human rights considerations into policies and policy-making processes; and support meaningful engagement of key and vulnerable populations and networks. Ensuring equality and equity is an important benchmark for being considered an inclusive programme.

National TB responses with good governance promote and encourage active participation of nongovernmental organizations (NGOs), the private sector, TB-affected communities, key population groups and civil society in the planning, implementation and monitoring of activities. This theme of social inclusiveness examines the extent and manner in which the entire community, within and outside the government, collaborates to set a high standard.

Scores for Individual Components

1. Social Contracting with Government Funds (NGOs/private sector)

Benchmark: A well-functioning TB programme should develop a mechanism for using government funds to procure services from nongovernmental entities for interventions that are better implemented outside of government for quality, cost or other reasons. The mechanism should ensure clear and transparent policies and guidelines for applying for these contracts, as well as a transparent tender process that meets international standards. Contracting at subnational level is also encouraged to successfully meet TB programme objectives.

Note: There were numerous examples of countries engaging NGOs, TB-affected community networks and the private sector through grants with the Global Fund and other donors. Though important, these were not the focus of this component. Grants to NGOs or the private sector to purchase only commodities, such as equipment, medicines, etc., were also not scored. This component of the survey assessed whether there was a mechanism in place in the country for engaging these entities for service provision with government funds and whether such engagement had already been implemented.

Government outsourcing can be an important way to create cost efficiencies and procure highly specialised services. Established mechanisms for the government to contract nongovernmental entities to provide key services denote the maturity and sustainability of the NTP. Therefore, this survey did not check the nature of services for which engagement was sought (e.g., service delivery, advocacy, monitoring, law and policy reform, etc.), but focused on the existence of a mechanism and its implementation. Countries were specifically asked about the availability of a mechanism, even if it was not put into practice for TB.

The engagement of NGOs, TB-affected community networks and the private sector was assessed separately, and the average score was considered for this component. Therefore, if a country achieved an average of 4 for both engagement of NGOs and TB-affected community networks and engagement of the private sector, then it would be considered to have achieved the benchmark.

NGO Engagement:

- **Eight (44%) of the 18 countries had no policy, guidelines or examples of contracting NGOs with government funds (score 0),** although they may have engaged such organisations using donor funds. These were Cambodia, Ethiopia, Kenya, Mozambique, Nigeria, Uganda, the United Republic of Tanzania and Zimbabwe.
- **India had both a policy and guidelines and had engaged NGOs at the national and subnational levels in more than 50% of its provinces (score 4).**
- **Seven (39%) countries had a policy and guidelines in place but had not engaged NGOs using government funds (score 2).** These were Bangladesh, the Democratic Republic of the Congo, Indonesia, Kyrgyzstan, Pakistan, Uzbekistan and Zambia. Of these, the Democratic Republic of the Congo and Pakistan had scored 0 in the first survey. In this survey, there was better documentation of the 2011 and 2009 guidelines, respectively, by these countries.
- **The Philippines and Tajikistan had a policy and guidelines in place and had engaged NGOs at the national level (score 3).** The Philippines had new guidelines dated May 2020 for contracting province-wide and city-wide health systems by the Department of Health for the delivery of population-based services. Tajikistan, too, had new guidelines from 2021 for a "standardized package of support services" (non-medical services), developed as part of the project TB-REP 2.0. According to the guidelines, NGOs and the private sector can be engaged and government funds can be released to them for the services delivered.

Private Sector Engagement:

- **Nine (50%) countries had no policy, guidelines or examples of contracting the private sector with government funds, although they might have done so with donor funds (score 0).** These were Cambodia, Ethiopia, Indonesia, Kenya, Kyrgyzstan, Mozambique, Nigeria, Tajikistan and the United Republic of Tanzania. Ethiopia had national guidelines for public–private mix (2017) for the provision of medicines, training, forms and laboratory consumables to the private sector, but there was no mechanism for channelling domestic funding to these services.

- **Zimbabwe had only a policy but no guidelines or implementation (score 1).**
- **Six (33%) countries had a policy and guidelines but had not yet engaged the private sector using government funds (score 2).** These were Bangladesh, the Democratic Republic of the Congo, the Philippines, Uganda, Uzbekistan and Zambia.
- **Pakistan had a policy and guidelines and had engaged the private sector at the national level (score 3).**
- **Only one country, India, had both a policy and guidelines, and had engaged the private sector at the national and subnational levels in more than 50% of its provinces (score 4).** However, there was no separate documented proof of the engagement of NGOs and the private sector in the various states/provinces because these groups are engaged through common policy, implementation guidelines and monitoring framework.

Engagement of both NGOs and Private Sector:

- **Six (33%) countries (Cambodia, Ethiopia, Kenya, Mozambique, Nigeria and United Republic of Tanzania) scored 0 for both NGO and private sector engagement.** Only India achieved the benchmark for social contracting with government funds.

2. Inclusion of Key Populations in the NSP:

Benchmark: The NSP includes prioritisation of KPs using the STP Key Populations Data for Action Framework[9], appropriate activities, adequate budget and monitoring indicators for all KPs identified through a data-based prioritisation exercise.

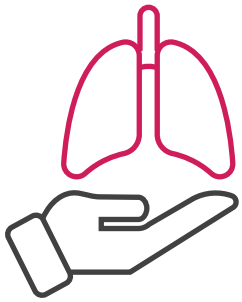
Note: Almost all countries' NSPs included monitoring indicators and budget for children and people living with HIV, but the other identified KPs were largely left out. Therefore, in this survey, a higher score was given to countries that included four other KPs in their NSP.

- **A total of 12 (66%) countries had undertaken a formal data assessment (score 1).** The six countries where formal data assessment had not been done were Ethiopia, Mozambique, Uganda, Uzbekistan, Zambia and Zimbabwe (score 0).
- **Fourteen (78%) countries listed four or more KPs (besides children and people living with HIV) in their NSP (score 1).** These were Bangladesh, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Kyrgyzstan, Mozambique, Nigeria, Pakistan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. In Mozambique, Uganda and Zimbabwe, formal data assessment had not been done. Bangladesh had an improved score in this survey. Four (22%) countries listed fewer than four KPs (score 0). These were Cambodia, the Philippines, Tajikistan and Uzbekistan. Only in Uzbekistan had formal data assessment not been done.
- **Monitoring indicators and budget for KPs in the NSP:**
  - Six (33%) countries included no indicator or budget for KPs others than children and people living with HIV (score 0). These were Bangladesh, Mozambique, Pakistan, the Philippines, Uganda and Zambia.
  - Five (28%) countries included both an indicator and a budget (score 1). These were the Democratic Republic of the Congo, Ethiopia, Kenya, Nigeria and the United Republic of Tanzania.
  - Seven (39%) countries included either an indicator or a budget line (score 0.5). These were Cambodia, India, Indonesia, Kyrgyzstan, Tajikistan, Uzbekistan and Zimbabwe.
- **Only the Democratic Republic of the Congo had developed an action plan (score 0.5).** (However, because it had a combined budget for all KPs, it did not score 1). In India, an action plan had been developed by one of the states. Zimbabwe had included strategic activities with yearly budgets in the NSP, but had not included detailed activities, responsible agencies or indicators (score 0). Bangladesh had included activities for two of the four KPs (score 0).

None of the countries achieved the benchmark for this component.

Scores for Individual Components (Cont'd)

3. Inclusion of Civil Society/TB Survivors



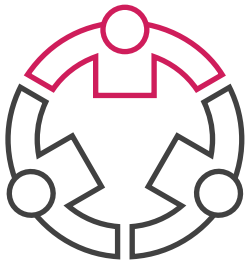
Benchmark: The NTP includes civil society, TB survivors, KPs and minority groups in a meaningful way in (i) programme reviews at national and subnational levels, (ii) joint monitoring missions/external programme reviews, (iii) development of the NSP or proposals for major donors (Global Fund and USAID), and (iv) as members of the core team for research planning and implementation, as well as in the dissemination of research findings.

Note: The measurement of the fourth element of this component was made less stringent for this survey, considering research activity from the last two to three years instead of just the last year. In addition, the measurement of this component relied only on NTP interviews. The CS partners were not asked about their perception, and the nature and extent of their involvement was not explored (for instance, did they only do field visits or did they participate in the discussion or provide inputs to and feedback on the JEPR report).

- **Inclusion in the quarterly/semi-annual/annual progress reviews of the programme:**
  - In four (22%) countries, the NTP did not consult with CS partners to review progress in 2021 (score 0). These were Kyrgyzstan, Mozambique, Tajikistan and Uzbekistan. This observation was made by all four NTPs, except for Tajikistan where CS partners confirmed this.
  - In five (28%) countries, the NTP consulted with CS partners either at the national or subnational level (score 0.5). These were the Democratic Republic of the Congo, Kenya, the Philippines, the United Republic of Tanzania and Zimbabwe.
  - In nine (50%) countries, the NTP consulted with CS partners at both the national and subnational levels (score 1). These were Bangladesh, Cambodia, Ethiopia, India, Indonesia, Nigeria, Pakistan, Uganda and Zambia.
- **Inclusion in the most recent JEPR: In 13 (72%) countries, the NTP invited civil society/TB survivors to participate in the last JEPR (score 1).** The five countries where civil society/TB survivors were not included in the JEPR (as reported by NTPs) were Cambodia, Kyrgyzstan, Mozambique, Pakistan and Uzbekistan (score 0).
- **Inclusion in proposal or NSP development: Civil society/TB survivors were included in all countries for NSP development (score 1).**
- **Inclusion in research activities in 2020 or 2021: In 11 (61%) countries, civil society/TB survivors were involved in the research activities (planning or implementation of research or dissemination of findings) (score 1).** These were Bangladesh, Cambodia, the Democratic Republic of the Congo, Ethiopia, Indonesia, Nigeria, the Philippines, Uganda, the United Republic of Tanzania, Uzbekistan and Zimbabwe.

Five (28%) countries achieved the benchmark for this component of including civil society/TB survivors. These were Bangladesh, Ethiopia, Indonesia, Nigeria and Uganda.

4. Inclusion of TB Community and Subnational Entities



Benchmark: NTPs solicit 360-degree feedback from all stakeholders of the NTP, i.e., systematically and regularly collecting inputs from all stakeholders – the communities, civil society and governmental implementers at all levels. Feedback from the community can be either through digital platforms, for example, the OneImpact app or WhatsApp groups, or through non-digital/traditional platforms, for example, regular feedback surveys collected on paper from people receiving TB treatment. Subnational entities (provincial and district) provide inputs for planning and budgeting, for example, for the NSP, as well as for implementation and monitoring, for example, during quarterly/annual programme reviews conducted by the NTP and the JEPR. Countries might have other additional platforms to gauge the inputs of subnational entities.

Note: The survey did not assess the quality of the feedback, i.e., if it was meaningful, inclusive and comprehensive, nor did the survey assess the NTP's response to the feedback.

The measurement of participation of subnational entities was less stringent and only a yes/no response was considered, with no consideration for the extent of involvement (for instance, no distinction was made in scoring if the NTP reported that (i) the subnational entities were visited by the JEPR team, (ii) the subnational entities were part of the JEPR team, or (iii) the subnational staff only participated in the discussions and provided inputs and feedback to the JEPR report). In this survey, the frequency of programme review and opportunities for feedback were not considered in the response. Data collection is expected to be more comprehensive in future surveys for this benchmark.

"Subnational entities" refers to provinces or states and not districts.

Feedback from the Community:

- **Sixteen (89%) countries had at least one platform to obtain feedback from the communities in 2021 (score 1).** Some common platforms were the OneImpact app or its variation and the national Stop TB forum. Participation of civil society in technical working groups was also seen in many countries. The other platforms for feedback were regular patient satisfaction surveys (Ethiopia) and a call-centre (India) where the community could call and ask questions.
- **The United Republic of Tanzania and Uzbekistan were the only countries where a platform for feedback by communities could not be documented for the year 2021.** The NTP of the United Republic of Tanzania was planning to implement the OneImpact app in 2023.
- **Representation in the Country Coordinating Mechanism (CCM) did not count for this component, as the focus was on assessing community-level feedback.** One-off meetings or messages through Facebook accounts, Twitter or websites that did not provide a regular or frequently used platform were also not scored.

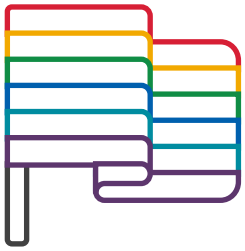
Feedback from subnational entities (provinces/states) in 2021:

- **In 17 (94%) countries, the subnational entities participated in NSP development or stakeholder engagement.** There was no participation in Uzbekistan.
- **In 16 (89%) countries, subnational entities participated in the quarterly/semi-annual/annual programme review.** There was no participation in Kyrgyzstan and Uzbekistan.
- **In 15 (83%) countries, subnational entities also participated in the JEPR or supervision visits of the NTP.** There was no participation in Kyrgyzstan, Pakistan and Uzbekistan.

Fourteen (78%) countries achieved the benchmark for NTPs taking feedback from the communities and subnational entities. These were Bangladesh, Cambodia, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, Tajikistan, Uganda, Zambia and Zimbabwe.

Scores for Individual Components (Cont'd)

5. Gender Inclusiveness



Benchmark: This benchmark has six components:

1. Service providers (and staff at all levels) have received training on TB and gender in the past two years.
2. Data are available (gender-disaggregated treatment outcome data in addition to case notification), and monitoring indicators and evaluation criteria adequately measure the programme's response to gender inequalities in TB care.
3. At least 50% of TB programme managers at the national and provincial level combined are women.
4. The NTP has developed a national TB gender strategy and action plan based on a gender assessment for TB.
5. The NSP highlights gender inclusiveness in TB services and programmes, which is assessed based on five elements: (i) the NSP mentions gender; (ii) the NSP provides data or commits to conducting a gap analysis or assessment on gender; (iii) gender-specific activities are described; (iv) indicators with targets for gender are included; and (v) a defined budget is allocated for gender-specific activities.
6. Women TB survivors are included in NTP events.

Note: In this survey, inclusion of gender in NTP activities was assessed on the basis of six components, each with a score of 1. A "yes" for all six subcomponents meant achievement of a score of 4 (please see scoring guidance).

The component on inclusion of women TB survivors in NTP events was meant to give an indication of the leadership role of women. Currently, all six elements carry equal weight, although inclusion in the NSP is a more complex subcomponent.

a. **Gender sensitization/training:** This indicator was scored as 1 if at least 50% of staff had taken the gender sensitization/training. Two countries responded with "yes", but there was no documentation coupled with the lack of CS partners' concurrence (India) and fewer than 50% of staff trained (Philippines). Therefore, in all 18 countries, none of the staff or fewer than 50% of the staff were considered to have had gender sensitization/training in the past 24 months.

b. **Male–female ratio of NTP and provincial managers:** The ratio of women TB programme managers at provincial/state and national levels was 50% or more in two (11%) countries. Indonesia (32 of 62 subnational units and one national unit) and the Philippines (16 of 17 regions and one national unit) had women TB programme managers.

c. **Availability of TB gender assessment report for the country:** A TB gender assessment report led by civil society, as per the tool developed by STP, was available for 14 (78%) countries (Bangladesh, Cambodia, Democratic Republic of the Congo, India, Indonesia, Kenya, Kyrgyzstan, Mozambique, Nigeria, Pakistan, Philippines, Tajikistan, United Republic of Tanzania and Uzbekistan). A community, rights and gender (CRG) assessment report was not available for Ethiopia, Uganda, Zambia and Zimbabwe. An assessment is under way in Zimbabwe.

d. **NSP highlights gender inclusiveness in TB services and programmes:**
   - Two (11%) countries (Democratic Republic of the Congo and Ethiopia) had included all five elements (please see the benchmark) in their NSP. The Democratic Republic of the Congo had none of the elements during the first survey but was successful in incorporating all of them for this survey (score 1).
   - Eight (44%) countries had included three or four elements. These were Bangladesh, Cambodia, India, Indonesia, Kenya, Nigeria, the United Republic of Tanzania and Zimbabwe.

- Six (33%) countries had included one or two elements. These were Mozambique, the Philippines, Tajikistan, Uganda, Uzbekistan and Zambia.
- Pakistan and Kyrgyzstan did not include any of the five elements for gender inclusiveness in the NSP (score 0).

e. **Women TB survivors included in any NTP event in 2021:** In 15 (83%) countries, women participated in at least one NTP event. Mostly this was limited to participation in World TB Day activities. In Kyrgyzstan, Mozambique and Tajikistan, there was no participation of women. In Ethiopia, the CS partners said "no" to women's participation, but according to the NTP, women gave testimony and were available at the annual research council meeting.

f. **Gender-disaggregated data for treatment outcomes:** It was possible to get gender-disaggregated data for treatment outcomes for the 2020 cohort in 14 (78%) countries. These were Bangladesh, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Kyrgyzstan, Mozambique, Nigeria, Tajikistan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. In four (22%) countries, gender-disaggregated data were not available: Cambodia, Pakistan, the Philippines and Uzbekistan.

Mozambique shared a format to say that it could disaggregate data by gender, although a report was not available. Similarly, in Kenya, it was possible to get gender-disaggregated data, but the report for 2020 was not available.

None of the countries achieved the benchmark for gender inclusiveness.

Scores for Individual Components (Cont'd)

Table 2. Inclusiveness Benchmarks Achieved by 18 Countries

Country Name	Achievement of Transparency Benchmarks (Yes/No)				
	Benchmark 1: Social Contracting with Govt. Funds	**Benchmark 2:** Inclusion of Key Populations in NSP	**Benchmark 3:** Inclusion of Civil society/TB Survivors	**Benchmark 4:** Inclusion of TB Community and Subnational Entities	**Benchmark 5:** Gender Inclusiveness
Bangladesh			■	■	
Cambodia				■	
Democratic Republic of the Congo				■	
Ethiopia			■	■	
India	■			■	
Indonesia			■	■	
Kenya				■	
Kyrgyzstan					
Mozambique				■	
Nigeria			■	■	
Pakistan					
Philippines				■	
Tajikistan				■	
Uganda			■	■	
United Republic of Tanzania					
Uzbekistan					
Zambia				■	
Zimbabwe				■	
Number of countries that achieved the benchmarks	**1**	**0**	**5**	**14**	**0**

Inclusive Index

31%-80%

Range of the index for transparency

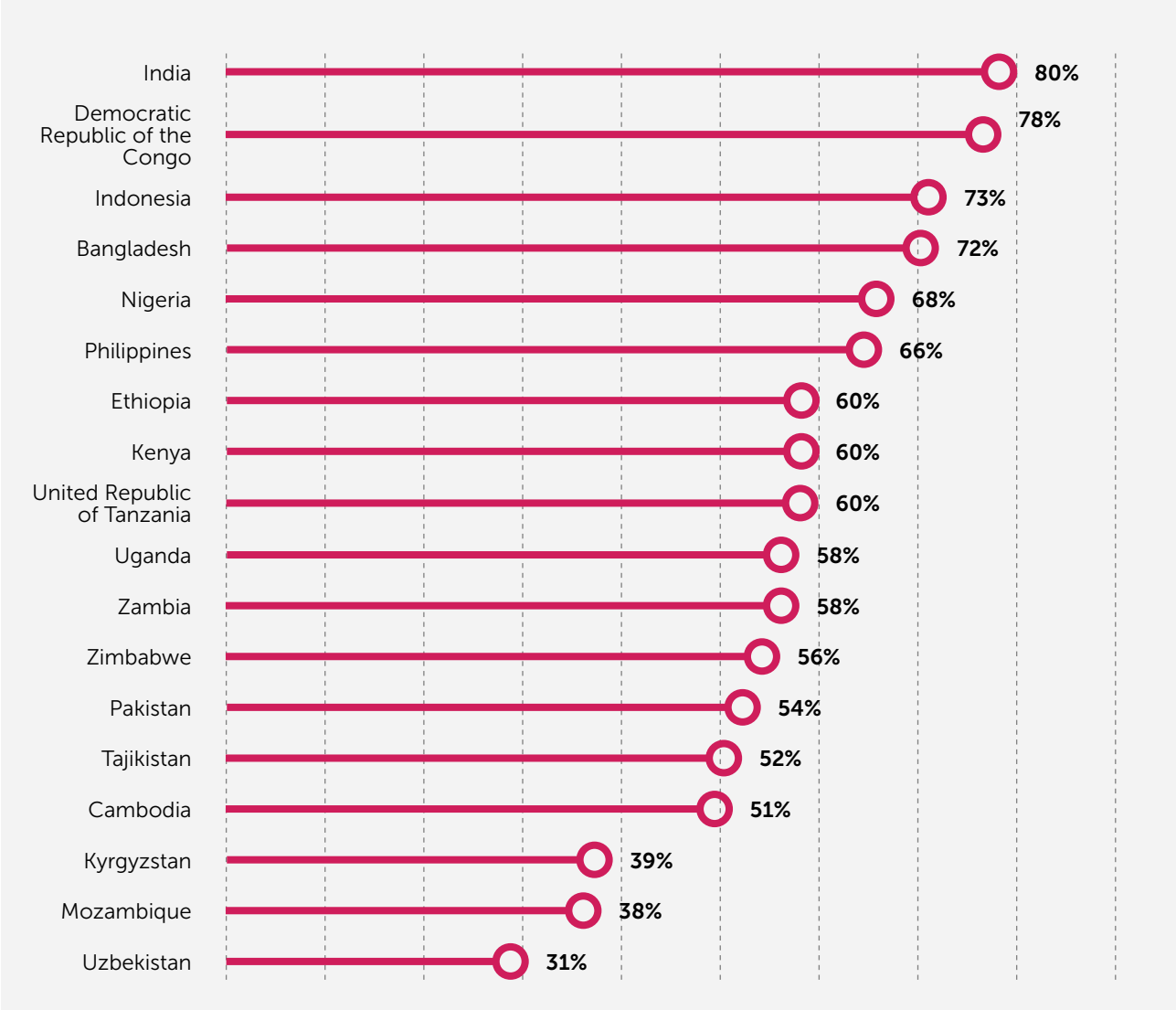
83% (15/18)

countries had an index of 50% or more in the social inclusiveness theme. These were Bangladesh, Cambodia, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Nigeria, Pakistan, the Philippines, Tajikistan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

2 of these 15

countries had an index of 75% or more: the Democratic Republic of the Congo (78%) and India (80%).

Figure 2: Inclusiveness Index in the Second Survey



THEME

3

Legal Framework

Theme 3: Legal framework

Key Findings

72% **13 of the 18 countries achieved the benchmark for mandatory TB notification.** The five countries that did not achieve this benchmark were Cambodia, the Democratic Republic of the Congo, Ethiopia, Mozambique and Pakistan.

61% **11 of the 18 countries achieved the benchmark for including DR-TB medicines in the nEML and making them available for free to people receiving TB treatment.** The seven countries that did not achieve this benchmark were Bangladesh, India, Kenya, Mozambique, Tajikistan, Uganda and Zambia.

0% **None of the countries achieved the benchmark for the availability of social protection schemes and social health insurance for all people with TB.**

6% **1 of the 18 countries achieved the benchmark for inclusion of human rights issues in TB training modules or guidance documents:** the Philippines.

0% **None (0%) of the countries achieved the benchmark for TB stigma reduction being featured and measured in the NSP.**

Theme Index

27%-74% Range of the index for social legal framework.

83% (15/18) countries had an index of 50% or more for the legal framework theme, of which none had an index of 75% or more.

The goal to end TB should be approached from an epidemiological, legal and social policy perspective.

The Political Declaration of the UNHLM on TB commits to removing legal and social barriers in order to eliminate stigma and discrimination and promote TB responses guided by human rights principles.

Good governance requires a robust legal framework with strong laws and policies to be in place to enable implementation and monitoring of appropriate TB care and prevention services, and to protect the rights of people affected by TB. While the NTP may have the intention to promote good governance through its NSP, the legal and policy framework may not enable the NTP to reach its objectives in reality. Legislation on notification of TB and inclusion of TB commodities in the nEML facilitate increased access to care. In addition, social protection measures and stigma reduction policies help to protect the people affected by TB and achieve NSP goals.

Overcoming the legal and policy barriers that exacerbate the stigma associated with TB and the people affected by it will enable access to quality, affordable and timely TB care, as well as a return to normal life. This rights-based approach to TB is articulated in both the *Declaration of the rights of people affected by TB*[10] and *Activating a human rights-based tuberculosis response*[11]. The need to scale up work that promotes enabling legal environments, identifies and overcomes legal barriers to TB services, and builds comprehensive social protection systems was identified as a priority in the communities' report The deadly divide: *TB commitments vs. TB realities*[8] and in the United Nations Secretary-General's progress report on the UNHLM on TB commitments[12].

Scores for Individual Components

1. Mandatory TB Notification

Benchmark: TB notification is mandated by a public health act or law and is implemented in the entire country (public and private sector), including monitoring of its implementation while ensuring protection of privacy and confidentiality.

- **In 13 (72%) countries, TB notification was mandated (score 4).** These were Bangladesh, India, Indonesia, Kenya, Kyrgyzstan, Nigeria, the Philippines, Tajikistan, Uganda, the United Republic of Tanzania, Uzbekistan, Zambia and Zimbabwe. In Tajikistan, notification was mandated by an MoH prikaz (order). In Nigeria, it was mandated through an "action memorandum" of the national council of health. Nigeria was the only country where TB notification increased during the pandemic.
- **In Pakistan, mandatory notification was partially implemented (score 2).** It was mandated at the provincial level. National-level mandatory notification was stated to be in an advanced stage.
- **Notification was not mandated in four (22%) countries: Cambodia, the Democratic Republic of the Congo, Ethiopia and Mozambique.** In the Democratic Republic of the Congo, Ethiopia and Mozambique, TB notification was not shown to be supported by a public health act or law (score 0).

The 13 countries where TB notification was mandatory were considered to have achieved the benchmark.

2. Drug-resistant (DR-) TB Medicines are on the nEML and Available for Free

Benchmark: All WHO Group A and B DR-TB medicines are included in the nEML and available free of charge to people receiving treatment for TB (public and private sector), including monitoring of the implementation of the law/policy.

This survey checked the availability of bedaquiline and linezolid on the nEML and whether they were available for free to people receiving treatment.

- Twelve (67%) countries had bedaquiline on the nEML. These were all countries except Bangladesh, India, Kenya, Mozambique, Tajikistan and Uganda.
- Fourteen (78%) countries had linezolid on the nEML. These were all countries except Kenya, Mozambique, Uganda and Zambia.
- Neither medicine was included in the nEML of Kenya, Mozambique and Uganda.
- In all 18 countries, these two medicines were available free of charge to people receiving treatment.

Eleven (61%) countries had both bedaquiline and linezolid on the nEML and had them available free of charge to people receiving treatment, thus achieving the benchmark. These were Cambodia, the Democratic Republic of the Congo, Ethiopia, Indonesia, Kyrgyzstan, Nigeria, Pakistan, the Philippines, the United Republic of Tanzania, Uzbekistan and Zimbabwe.

3. Social Protection

The CRG commitments of the Political Declaration include psychosocial, nutrition and socioeconomic support for all people affected by TB.

Benchmark: This benchmark has two components measuring the provision of social protection schemes and social health insurance for all people with TB, including those from ethnic minorities, migrants and other vulnerable populations. Systems for social protection include legal, financial, mental health, and nutrition support, among others[12]. The social health insurance system in the country, under Universal Health Coverage or otherwise, should include diagnosis, treatment and prevention of all forms of TB, including MDR-TB, for all populations of the country.

Note: For this survey, social protection schemes included employment protection, nutrition support and financial support in the form of cash transfer/reimbursement. Scoring was done for partial and complete coverage.

The extent to which the laws provide employment protection to people with TB: Every person with TB should have the right to accommodations at work, including leaves of absence and breaks to allow them to maintain their employment at the same status after their diagnosis and to accommodate them while they are infectious and receiving treatment. If long-term hospitalisation and/or partial or permanent disability makes it impossible for a person with TB to maintain their employment due to restrictions imposed by law or the terms of their employment contract, they should have the right to social security.

Employment Protection for People Affected by TB

- **Five (28%) countries had employment protection for all people with TB.** These were Indonesia, Kyrgyzstan, the Philippines, Uganda and the United Republic of Tanzania.
  - In Kyrgyzstan, people are protected by the Law of the Kyrgyz Republic dated 18 May 1998 No. 65 "On the protection of the population from tuberculosis" http://cbd.minjust.gov.kg/act/view/ru-ru/73?cl=ru-ru.
  - In Indonesia, it is legally mandated to pay employees who are sick. Legal provisions exist in the Philippines through the Department of Labor and Employment Department Order 73-05 "Guidelines for the implementation of policy and program for TB prevention and control in the workplace". Uganda has a general labour protection law that includes TB.
- **Nine (50%) countries had partial protection.** These were Bangladesh, Cambodia, India, Kenya, Mozambique, Pakistan, Tajikistan, Uzbekistan and Zambia.
  - In India, employment protection was available to those in government service or in certain formal sectors but not to all. In Kenya, too, employment protection was not available to casual labourers. In Mozambique, there was no legislation, but people with TB could get a certificate from a hospital to stay away from work for two months or more. In Zambia, the legislative process was under way. These four (18%) countries, thus, got a partial score for employment protection.
  - In Tajikistan, in 2021, the MoH approved the "Standardized package of community-based supportive services to improve TB outcomes", which contains all three elements of social protection assessed in this survey.
  - In Pakistan, as per the CS partners' field observation, miners are known to have employment protection.
- **Four (22%) countries had no employment protection (score 0).** These were the Democratic Republic of the Congo, Ethiopia, Nigeria and Zimbabwe.

Cash Transfer / Reimbursement Scheme

- Cash transfer/reimbursement was not available in three (17%) countries: Cambodia, Ethiopia and Kyrgyzstan.
- Cash transfer/reimbursement was available to all people receiving TB treatment in India.
- In the remaining 14 (78%) countries, cash transfer/reimbursement was partially available. In several of these countries, such as the Democratic Republic of the Congo, Indonesia, Kenya, Kyrgyzstan, Mozambique, Nigeria, Uganda, Zambia and Zimbabwe, cash transfer/reimbursement was available for people receiving treatment for MDR-TB, for example.

Scores for Individual Components (Cont'd)

3. Social Protection (Cont'd)

Nutrition Support

- Nutrition support was not available in three (17%) countries: Kenya, Pakistan and Zambia.
- Nutrition support was available to all people receiving TB treatment in India, where nutrition support was provided through direct cash transfers to the bank accounts of people receiving treatment. In addition, a new initiative (Nikshay Mitra) was launched, enabling individuals, corporations and NGOs to "adopt" people receiving treatment for TB by providing them with nutrition, support for diagnostics and vocational training for their family members. This initiative was widely publicised [13].
- In the remaining 14 (78%) countries, nutrition support was partially available. In several of these countries, nutrition support was only for people receiving treatment for MDR-TB.

None of the countries surveyed offered all three social protection measures to people receiving treatment for TB. No country achieved the benchmark.

Social Health Insurance

- **In 14 (78%) countries, social health insurance was not available, or if it was available, it did not cover TB or covered it only partially (score 0).** The first group of countries included Cambodia, the Democratic Republic of the Congo, Mozambique, Tajikistan, Uganda, the United Republic of Tanzania, Uzbekistan and Zimbabwe. The second group included Indonesia, Kenya, Nigeria, Pakistan and the Philippines. In Bangladesh, social health insurance was in its pilot stage in three subdistrict units (score 0).
- **Social health insurance was available for all people in three (17%) countries, but it was not sufficient** to avert catastrophic costs for people receiving treatment for TB. These were Ethiopia, Kyrgyzstan and Zambia (score 1).
- **In India, through the Health Benefit Package 1.0 (Pradhan Mantri Rashtriya Swasthya Suraksha Mission), social health insurance was available,** including provisions for TB and MDR-TB for all people in the country. It was mentioned that the proportion of total costs covered by the insurance would avert catastrophic costs for people receiving treatment for TB. However, there was no demonstrated evidence to support this. Hence, a score of 1.5 was considered.

None of the countries achieved the benchmark for social protection and social health insurance.

4. Law or Policy that Defines and Protects the Human Rights of People with TB

Benchmark: a) Human rights to privacy and confidentiality for people affected by TB and freedom from discrimination are three elements included in TB training modules/technical guidelines; and b) all those engaged in TB service delivery are trained on these issues.

Note: In the first survey, the second element of the benchmark was not considered. In this second survey, the second element was considered for scoring, but the extent of training was not assessed.

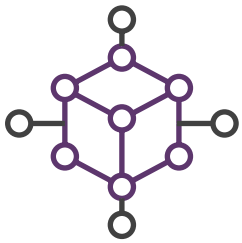
- **Nine (50%) countries had included *all three elements* in their training modules.** These were the Democratic Republic of the Congo, Ethiopia, India, Kenya, Nigeria, Pakistan, the Philippines, the United Republic of Tanzania and Uzbekistan.

Of these nine countries, the Philippines had conducted training on these elements.

- **Five (28%) countries** – Indonesia, Kyrgyzstan, Mozambique, Uganda and Zambia – had included all three elements but *not in the training modules.*
- **Two (11%) countries** – Tajikistan and Zimbabwe – had included two elements in the training modules.
- **Two (11%) countries** had *not included* any element in their TB guidance/training documents. These were Bangladesh and Cambodia.

The Philippines achieved the benchmark for training on human rights by including all three elements in the training modules/TB guidance and conducting the training.

5. Policy Framework to Reduce TB Stigma



The right to be free from discrimination should be the universal norm. The Universal Declaration of Human Rights and seven international treaties prohibit discrimination. Six regional treaties establish the right to be free from discrimination, and 147 national constitutions protect against discrimination, such as the constitutions of India and Kenya[11].

Benchmark: includes four elements:

a. The NSP makes it clear that it is illegal to stigmatise anyone with TB, including limiting or preventing access to TB services: (i) the NSP mentions activities to reduce stigma, including stigma against women and other vulnerable populations; (ii) the NSP provides data from a stigma assessment; (iii) appropriate context-specific activities are described to respond to stigma; (iv) indicators with targets are included to reduce stigma; and (v) a defined budget is allocated for stigma-reduction activities.

b. A baseline stigma assessment has been done.

c. Service providers (and staff at all levels) are trained on TB and stigma.

d. A communication strategy has been developed that includes advocacy to reduce stigma.

- **Sixteen (89%) countries, except Kyrgyzstan and the Philippines, included interventions for stigma in their NSP.** The NTP of Kyrgyzstan did not share the NSP and the CS partners responded with a "no" (score 1).
- **Six (33%) countries had included an indicator for TB stigma in the NSP.** These were the Democratic Republic of the Congo, Ethiopia, India, Nigeria, Uganda and the United Republic of Tanzania. In the Democratic Republic of the Congo and India, indicators were included in the CRG action plan and the End Stigma Strategy, respectively (score 1).
- **Two (11%) countries had included a budget line for TB stigma in the NSP.** These were the Democratic Republic of the Congo and Zimbabwe (score 1). For the Democratic Republic of the Congo, the NSP had a budget line on gender and human rights, and the CRG action plan included a budget for the right to health or dignity without mention of stigma.
  - Kenya had a budget allocation in the Global Fund New Funding Model 3 grant, but because of a lack of documentation, it was not considered for scoring. Bangladesh had only a one-year budget in a separate attachment "CRG activity" as part of a Global Fund grant, which was not scored.
  - The NTP of Kyrgyzstan did not share the NSP and the CS partners' response was "no".
- **Stigma assessment:** Only two (11%) countries – Nigeria and the Philippines – had already done some analysis of stigma and mentioned it in the NSP. In Nigeria, this was part of the patient catastrophic survey (2017); in the Philippines, it was a part of an analysis (2019) by Actions for Health Initiatives, Inc., supported by STP and USAID- 'Situation analysis of TB elimination program in Greater Manila using CRG tools'.
  - Several countries had planned for a stigma assessment in their NSP. These were Bangladesh, the Democratic Republic of the Congo, Ethiopia, Mozambique, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. (Nigeria had also proposed it). However, since the stigma assessment was a proposed activity, it was considered to be an intervention and not scored for this element. Kyrgyzstan was not scored because the NTP did not submit the NSP and the CS partners' response was "no".

A new national-level stigma assessment was under way in Nigeria. Indonesia completed its assessment in 2022/ early 2023. Assessments in the Democratic Republic of the Congo and Mozambique were in the preparatory phase.

None of the countries achieved the benchmark for TB stigma reduction.

Scores for Individual Components (Cont'd)

Table 3. Legal Framework Benchmarks Achieved by 18 Countries

Country Name	Achievement of Legal Framework Benchmarks (Yes/No)				
	Benchmark 1: Mandatory TB Notification	**Benchmark 2:** DR-TB Medicines in nEML and Free	**Benchmark 3:** Social Protection	**Benchmark 4:** Law/Policy on Human Rights for TB	**Benchmark 5:** Policy Framework to Reduce TB Stigma
Bangladesh	■				
Cambodia		■			
Democratic Republic of the Congo		■			
Ethiopia		■			
India	■				
Indonesia	■	■			
Kenya	■				
Kyrgyzstan	■	■			
Mozambique					
Nigeria	■	■			
Pakistan		■			
Philippines	■	■		■	
Tajikistan	■				
Uganda	■				
United Republic of Tanzania	■	■			
Uzbekistan	■	■			
Zambia	■				
Zimbabwe	■	■			
Number of countries that achieved the benchmarks	**13**	**11**	**0**	**1**	**0**

Legal Framework Index

27%-74%

Range of the index for legal framework.

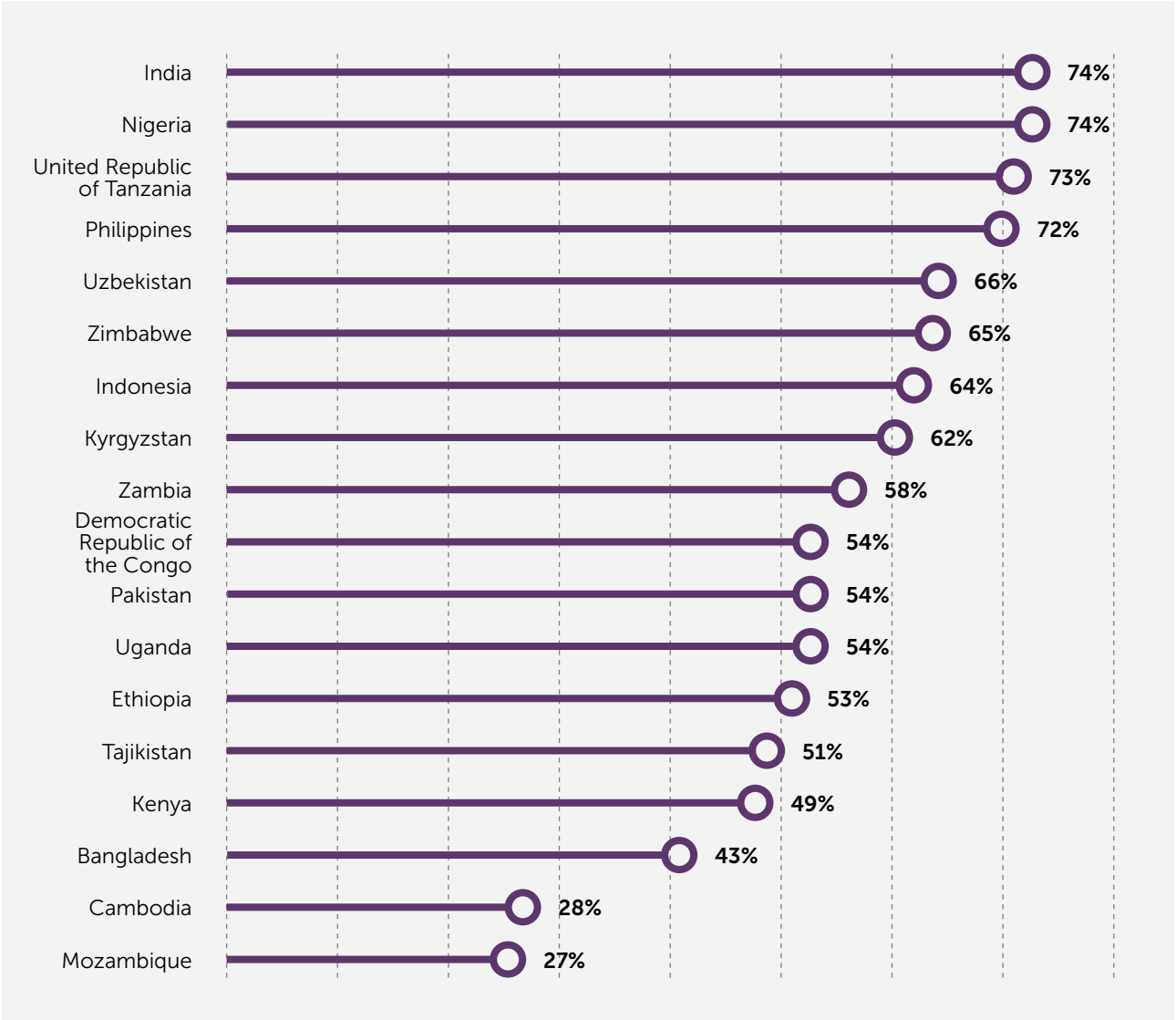
78% (14/18)

of the countries had an index of 50% or more for the legal framework theme. These were the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kyrgyzstan, Nigeria, Pakistan, the Philippines, Tajikistan, Uganda, the United Republic of Tanzania, Uzbekistan, Zambia and Zimbabwe.

0 of these 14

achieved an index of 75% or more.

Figure 3: Legal Framework Index in the Second Survey



THEME

4

Process Efficiency and Effectiveness

Theme 4: Process Efficiency and Effectiveness

Key Findings

32% **3 of the 18 countries achieved the benchmark for approval efficiency,** based on the last GDF quote approved in the country: India, Nigeria and Tajikistan.

6% **1 of the 18 countries achieved the benchmark for NTP manager empowerment:** Uzbekistan.

6% **1 of the 18 countries achieved the benchmark for NTP capacity:** Bangladesh.

22% **4 of the 18 countries achieved the benchmark for the ability to rapidly adopt/adapt international guidelines as national policies:** the Democratic Republic of the Congo, Nigeria, the Philippines and Tajikistan.

6% **1 of the 18 countries achieved the benchmark for the NTP's capacity to absorb funds from different sources:** India.

Theme Index

36%-78% Range of the index for process efficiency and effectiveness

83% (15/18) countries had an index of 50% or more for the process efficiency and effectiveness theme, of which only one (6%) had an index of more than 75% - Nigeria.

Efficient and effective governance is essential for ensuring TB programmes' success in utilizing resources and delivering timely results. To achieve this, NTPs must be empowered, adequately staffed and capable of functioning efficiently within existing governance processes.

In addition, the NTP should optimise resource utilisation, enhance access to affordable, quality-assured key medicines, foster innovation, and facilitate the rapid introduction and scale-up of cost-effective health technologies and implementation models.

To assess the NTP's ability to operate efficiently and effectively within the government system, this survey collected information on several key benchmarks.

Scores for Individual Components

1. Approval Process Efficiency

Benchmark: The final approved NSP, annual budget or other such document with prior approval (for example, at the beginning of the financial year) enables the NTP to move forward and implement without requiring additional approvals from other ministry officials. If approvals are required, the process takes less than a week, as TB activities have already been prioritised.

Note: In the first survey, this benchmark was assessed by reviewing the approval efficiency of the implementation of the last training organised by the NTP. The NTP managers were asked about (i) the number of authorisation signatures required to implement the training, and (ii) the number of weeks required for the approval of the last training. Countries follow different administrative pathways for utilizing donor funds and utilizing government funds. In the first survey, the focus was on the approval efficiency for training using government funds. In the second survey, this benchmark was measured based on approval of the last GDF quote.

Of the 18 countries, Indonesia had not procured from GDF since 2019 and Zimbabwe did not respond to this question. The following analysis is based on responses from the remaining 16 NTPs. The theme index score for these two countries was adjusted.

Limitation: Most of the NTPs gave a range, i.e., no one specifically answered the question about the number of days required for approval of the quote for the last procurement through GDF. Therefore, the STP team considered the upper limit of the range mentioned by the NTP.

- **Three (19%) of the 16 countries took 2–3 days to respond to the last GDF quote (score 4). These were India (2 days), Nigeria (1 day) and Tajikistan (2 days).**
- **Four (25%) countries took 7 days to respond. These were Bangladesh, Mozambique, Uzbekistan and Zambia (score 3).**
- **Four (25%) countries took 14 days to respond. These were Cambodia, Kenya, Kyrgyzstan and Uganda (score 2).**
- **Three (19%) countries took longer to respond: Pakistan took 30 days (score 1), while the Democratic Republic of the Congo and Ethiopia took two months or longer (score 0).**

The benchmark for approval process efficiency was achieved by India, Nigeria and Tajikistan.

Note: The assessment of this benchmark was based on the reporting by the NTP without supporting documentation.

2. NTP Manager Empowerment

Benchmark: This benchmark was adjusted slightly from the first survey. The comparison between the ranking of TB programme manager and that of the HIV programme manager and head of the HIV/AIDS commission seemed less than satisfactory because of the different epidemiology of HIV in different countries. In addition, the perception of national partners, i.e., of CS partners, was considered a better gauge than the perception of external partners. The four elements of this benchmark are given in annex 2.

Seniority of the NTP manager:

- **In eight (44%) countries, the NTP manager was one or two steps away from the health minister (score 1).** These were Cambodia, the Democratic Republic of the Congo, Ethiopia, Indonesia, Kyrgyzstan, Mozambique, Nigeria and Uzbekistan.
- **In 10 (56%) countries, the NTP manager was more than two steps away from the health minister (score 0).** These were Bangladesh, India, Kenya, Pakistan, the Philippines, Tajikistan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.
The NTP manager has access to relevant and recent NTP information (as assessed by the number of people with Xpert as the initial test in a district):
- The response to this was a "yes" by all countries. In some countries, information was reported to be accessible through GxAlert and in some through DHIS2.

Empowerment of the NTP managers to deliver the targets of the Global Fund TB grant – as perceived by the NTP managers:

Of the 18 countries, 14 had a government Principal Recipient, 13 had a nongovernment Principal Recipient, and nine had both[1].

- Eight (44%) NTP managers felt *fully* empowered to deliver the targets of the Global Fund TB grant (score 1). These were Bangladesh, Cambodia, India, Indonesia, Kyrgyzstan, Mozambique, the United Republic of Tanzania and Uzbekistan.
- Ten (56%) NTP managers felt that they were partially empowered (score 0.5). These were the Democratic Republic of the Congo, Ethiopia, Kenya, Nigeria, Pakistan, the Philippines, Tajikistan, Uganda, Zambia and Zimbabwe.
- None of the NTP managers felt a total lack of empowerment.

1. **Government Principal Recipients:** Bangladesh* (Economic Relations Division), Cambodia (Ministry of Economy and Finance), Democratic Republic of the Congo* (MoH), Ethiopia (NTP), India* (MoH), Indonesia* (MoH), Kenya* (National Treasury), Mozambique* (MoH), Nigeria (NTP), Pakistan* (NTP), Uganda* (Ministry of Finance), United Republic of Tanzania* (Ministry of Finance and Planning), Uzbekistan (National AIDS Centre) and Zimbabwe (Ministry of Health and Child Care)
Nongovernment Principal Recipients: Bangladesh* (BRAC), Democratic Republic of the Congo* (Catholic Organization for Relief and Development Aid), India* (Foundation for Innovative New Diagnostics, International Union Against Tuberculosis and Lung Disease, William J. Clinton Foundation, Plan India), Indonesia* (Konsorsium Komunitas Penabulu-STPI), Kenya* (AMREF Health Africa), Kyrgyzstan (United Nations Development Programme), Mozambique* (Centro de Colaboração em Saúde), Pakistan* (Mercy Corps), Philippines (Philippines Business for Social Progress), Tajikistan (United Nations Development Programme), Uganda* (The AIDS Support Organisation (TASO) (U) Limited), United Republic of Tanzania* (AMREF Health Africa) and Zambia (Churches Health Association of Zambia)

*Countries with both government and nongovernment Principal Recipients

Scores for Individual Components (Cont'd)

2. NTP Manager Empowerment (cont'd)

A few NTP managers gave the following reasons for their responses:

- Reasons given for feeling "partially empowered" were lack of adequate resource allocation, lack of adequate number of subrecipients, bureaucracy and restructuring.
- Reasons given for feeling "fully empowered" included having planning, execution and monitoring under the oversight of the programme manager.

Empowerment of the NTP managers to deliver the targets of the Global Fund TB grant – as perceived by the in-country CS partners:

- **In seven (39%) countries, the CS partners felt that NTP managers were *fully* empowered to deliver the targets of the Global Fund TB grant (score 1).** These were Bangladesh, the Democratic Republic of the Congo, Kenya, Tajikistan, Uganda, Uzbekistan and Zambia. (The perceptions of the NTP and CS partners matched only in two countries: Bangladesh and Uzbekistan).
- **In nine (50%) countries, the CS partners felt that the NTP managers were *partially* empowered (score 0.5).** These were Ethiopia, India, Indonesia, Mozambique, Nigeria, Pakistan, the Philippines, the United Republic of Tanzania and Zimbabwe. (The perceptions of the NTP and CS partners matched in five countries: Ethiopia, Nigeria, Pakistan, the Philippines and Zimbabwe).
- **In two (11%) countries, the CS partners felt that the NTP managers were *not empowered* at all (score 0).** These were Cambodia and Kyrgyzstan. However, in both countries, the NTP managers felt fully empowered.

Reasons given for full empowerment were the qualifications and experience of the NTP manager.

- Reasons given for partial empowerment were the lack of adequate resources, lack of adequate authority given to the NTP manager and minimal engagement of CS partners (by the NTP).
- A reason given for no empowerment was the frequent turnover of managers.

The benchmark for NTP manager's empowerment was achieved by Uzbekistan.

3. Capacity of the NTP (number of staff in relation to population/burden/provinces)

Benchmark: The NTP has sufficient capacity at the national level. The required strength of the technical/management staff at the national level will vary with the size of the country, burden of TB and status of the programme. Applying a uniform criterion can be challenging. It is expected that countries will carry out an assessment to determine the staffing needs in the NTP, which will serve as the benchmark for that country. Until that happens, four subcomponents have been considered as given below, which take into account (i) the total population of the country, since this affects the diagnostic effort, (ii) the TB burden, since this determines the effort required for treatment support, (iii) the number of provinces/states in the country, since this determines the number of administrative interactions by the NTP's office (noting that provincial and district-level staff were not considered for this component), and (iv) CS partners' perception of the NTP's capacity (staff strength in relation to the work or responsibilities). This fourth subcomponent was added in this survey.

- Population in millions divided by the number of technical staff (staff and long-term consultants of more than a year) is 1 or less in small countries (50 million or less – eight such countries in the survey) and 10 or less in bigger countries.

Note: Division into big and small countries: Based on population size, for this survey, eight countries with population of 50 million or less were considered to be 'smaller'. These were Cambodia, Kyrgyzstan, Mozambique, Tajikistan, Uganda, Uzbekistan, Zambia and Zimbabwe. The others were regarded as bigger countries.

3. Capacity of the NTP (number of staff in relation to population/burden/provinces (cont'd))

(Box cont'd)

- Number of people developing TB in the last year divided by the number of technical staff (staff and long-term consultants of more than a year) is 10,000 or less in countries with a population of 50 million or less, and 50,000 or less in bigger countries.
- Number of provinces/oblasts/states in the country divided by the number of technical staff (staff and long-term consultants of more than a year) at the NTP is 0.5 or less.
- In this survey, instead of external partners' perception of the NTP's capacity, the CS partners were asked "What is your perception of the NTP's capacity (staff strength in relation to its work/responsibilities)". The scoring was 1, 0.75, 0.5, 0.25 for the response "NTP has 100%, 75%, 50%, 25% capacity", respectively. This was the fourth element for scoring this component.

Population in millions by number of technical/ management staff:

The assumption was that there was one NTP staff for every 1 million population in smaller countries and one for every 10 million population in bigger countries.

- **This criterion was met in 13 (72%) countries (score 1).** These were Bangladesh, Cambodia, the Democratic Republic of the Congo, Ethiopia, Indonesia, Kenya, Kyrgyzstan, Nigeria, Pakistan, the Philippines, Tajikistan, the United Republic of Tanzania and Zimbabwe.
- **This criterion was not met in five (28%) countries (score 0).** These were India, Mozambique, Uganda, Uzbekistan and Zambia.

Estimated number of people developing TB by the number of technical/management staff:

The assumption was that there was one NTP staff for every 10,000 people with TB in smaller countries and one for every 50,000 people in bigger countries.

- **This criterion was met in all countries (score 1).**

Number of provinces by number of technical/ management staff:

The assumption was that there were two NTP staff per province/state.

- **This criterion was met in nine (50%) countries (score 1).** These were Bangladesh, the Democratic Republic of the Congo, Indonesia, Kyrgyzstan, Nigeria, Pakistan, Tajikistan, Uganda and the United Republic of Tanzania.
- **Nine (50%) countries did not meet this criterion (score 0).** These were Cambodia, Ethiopia, India, Kenya, Mozambique, the Philippines, Uzbekistan, Zambia and Zimbabwe.

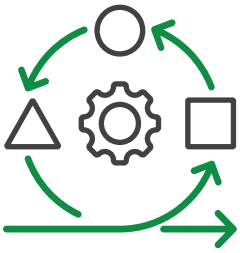
CS partners' perception of their NTP's capacity (staff strength in relation to the work or responsibilities):

- **Only in one (6%) country (Bangladesh) did the CS partners feel that the NTP had sufficient staff strength to fulfil its responsibilities (score 1).**
- **In nine (50%) countries, the CS partners felt that the NTP had 75% capacity to fulfil its responsibilities (score 0.75).** These countries were Cambodia, the Democratic Republic of the Congo, Ethiopia, Indonesia, Kenya, Nigeria, Tajikistan, Uzbekistan and Zimbabwe.
- **In eight (44%) countries, the CS partners felt that the NTP had 25% capacity to fulfil its responsibilities (score 0.25).** These countries were India, Kyrgyzstan, Mozambique, Pakistan, the Philippines, Uganda, the United Republic of Tanzania and Zambia.

Only Bangladesh achieved the benchmark for NTP capacity.

Scores for Individual Components (Cont'd)

4. Ability of the NTP to Rapidly adopt/adapt International Guidelines as National Policies



Benchmark: a) Adoption of new international guidelines by the NTP within a year (this benchmark refers to the most recent international guidelines each year), and b) roll-out of the policies to the provincial/district level within six months of national policy adoption.

Three new international guidelines were considered: (i) Chest X-ray has been included for the systematic screening of individuals under 15 years of age who are close contacts of a person with TB. (ii) Among individuals aged 15 years or older in populations in which TB screening is recommended, computer-aided detection (CAD) software may be used in place of human readers for interpreting digital chest X-rays for screening and triage for TB disease. (iii) Testing for fluoroquinolone resistance by automated nucleic acid amplification testing (NAAT) has been included in the TB diagnostic algorithm.

Note: In this survey, only the first part of the benchmark (adoption) was considered for scoring and not the roll-out to districts.

Chest X-ray has been included for the systematic screening of individuals under 15 years of age who are close contacts of a person with TB:

- **Eleven (61%) countries had included chest X-ray for systematic screening of individuals under 15 years of age who are close contacts of a person with TB (score 1).** These were Bangladesh, Cambodia, the Democratic Republic of the Congo, Ethiopia, India, Kyrgyzstan, Nigeria, the Philippines, Tajikistan, Uzbekistan and Zambia.
- **Seven (39%) countries had not included chest X-ray for systematic screening of individuals under 15 years of age who are close contacts of a person with TB (score 0).** These were Indonesia, Kenya, Mozambique, Pakistan, Uganda, the United Republic of Tanzania and Zimbabwe.

Among individuals aged 15 years or older in populations in which TB screening is recommended, CAD software may be used in place of human readers for interpreting digital chest X-rays for screening and triage for TB disease:

- **Nine (50%) countries had adopted CAD software in place of human readers for interpreting digital chest X-rays for screening and triage for TB disease among individuals who are 15 years or older (score 1).** These were the Democratic Republic of the Congo, Ethiopia, Indonesia, Nigeria, the Philippines, Tajikistan, Uganda, the United Republic of Tanzania and Zambia.
- **Nine (50%) countries had not adopted CAD software in place of human readers for interpreting digital chest X-rays for screening and triage for TB disease among individuals who are 15 years or older (score 0).** These were Bangladesh, Cambodia, India, Kenya, Kyrgyzstan, Mozambique, Pakistan, Uzbekistan and Zimbabwe.

Testing for fluoroquinolone resistance by automated NAAT has been included in the TB diagnostic algorithm:

- **Nine (50%) countries had adopted automated NAAT for testing for fluoroquinolone resistance in the TB diagnostic algorithm (score 1).** These were Cambodia, the Democratic Republic of the Congo, Indonesia, Kyrgyzstan, Nigeria, the Philippines, Tajikistan, Uganda and Zimbabwe.
- **Nine (50%) countries had not adopted automated NAAT for testing for fluoroquinolone resistance in the TB diagnostic algorithm (score 0).** These were Bangladesh, Ethiopia, India, Kenya, Mozambique, Pakistan, the United Republic of Tanzania, Uzbekistan and Zambia.

Four countries had included all three guidelines in the TB diagnostic algorithm and were considered to have achieved the benchmark. These were the Democratic Republic of the Congo, Nigeria, the Philippines and Tajikistan.

5. Capacity of the NTP for Fund Absorption

Benchmark: This benchmark includes two components:

a. The NTP absorbs 95% or more funds from all domestic and external sources in the designated time period.

b. The NTP absorbs 95% or more funds from the Global Fund in the designated time period.

Note: Ideally, component "a" of this benchmark should cover domestic funds, while "b" should cover Global Fund funds. However, there is a limitation with the datasets currently available. Consequently, under component "a", this survey considered the proportion of total expenditure/total funding received from all sources in the most recent year (2021), as per the information available in the WHO dataset (https://www.who.int/teams/global-tuberculosis-programme/data); results for component "b" were based on the data shared by the Global Fund and did not consider whether the NTP was the Principal Recipient.

Absorption of funds from all sources in 2021 (WHO):

Data were not available for Nigeria and Uzbekistan, which were excluded from the analysis.

- **In 2021, eight of 16 (50%) countries had expended 95% or more of their funds from all sources (score 2).** These were the Democratic Republic of the Congo, Ethiopia, India, Kenya, Mozambique, Uganda, the United Republic of Tanzania and Zambia.
- **Five (31%) countries expended 85% or more but less than 95% (score 1).** These were Bangladesh, Cambodia, Pakistan, the Philippines and Zimbabwe.
- **Three (19%) countries expended less than 85% of the funds from all sources.** These were Indonesia, Kyrgyzstan and Tajikistan.

Utilisation of domestic funds:

NTP managers were asked during the interviews about what domestic funds cover. The amount of funding was not asked. Based on their responses:

- Fifteen (83%) countries spent domestic funds on human resources;
- Thirteen (72%) on first-line drugs and five (28%) on second-line drugs;
- Six (33%) on rapid molecular diagnostics and 13 (72%) on other diagnostics;
- All 18 on infrastructure and health system services for TB; and
- Eleven (61%) on programmatic activities such as travel, supervision, meetings and training.

Absorption of funds available through Global Fund grants:

The scoring for this component was based on data shared by the Global Fund for "in-country absorption". There were some limitations: (i) The first limitation was related to differences in the time periods for which data were available: For the majority of countries, the expenditure data were available as of June 2022 for the first half (50%) of the implementation phase of New Funding Model 3, covering the full calendar year of 2021 and the first half of 2022. However Kyrgyzstan, Tajikistan and Ukraine only had expenditure data as of December 2021. This is because the GF requires them to report annually. In addition, for these three countries, the exact period of implementation of the grants was not shared. India had four grants, two of which had expenditure data as of March 2022 and two of which had data as of September 2022. The analysis could not adjust for these variations. (ii) The second limitation was related to the different types of grants: Eight countries had only TB grants, five had only TB/HIV grants and five had a mix of both.

Scoring of absorption in GF grants - Scoring followed the established Global Fund benchmark and categorisation of countries for this indicator. Countries with an in-country absorption rate of 85% or more received the maximum possible score of 2, those with 65–84% received a score of 1, and those with less than 65% received a score of 0. If the countries had a mix of both TB and TB/HIV grants and the absorption rate of the TB grant was very low compared to that of the TB/HIV grant, then the scoring was downgraded by 1.

- Two (11%) of the 18 countries – India and Zimbabwe – scored 2.
- Seven (39%) countries scored 1. These were the Democratic Republic of the Congo, Ethiopia, Kyrgyzstan, Nigeria, the Philippines, the United Republic of Tanzania and Zambia.
- Nine (50%) countries scored 0. These were Bangladesh, Cambodia, Indonesia, Kenya, Mozambique, Pakistan, Tajikistan, Uganda and Uzbekistan.

India achieved the benchmark for capacity for fund absorption.

Scores for Individual Components (Cont'd)

Table 4. Process Efficiency and Effectiveness Benchmarks Achieved by 18 Countries

Country Name	Benchmark 1: Approval Process Efficiency	Benchmark 2: NTP Manager Empowerment	Benchmark 3: Capacity of NTP	Benchmark 4: Ability to Adopt/Adapt International Guidelines	Benchmark 5: NTP's Capacity for Fund Absorption
Bangladesh			■		
Cambodia					
Democratic Republic of the Congo				■	
Ethiopia					
India	■				■
Indonesia	Data NA				
Kenya					
Kyrgyzstan					
Mozambique					
Nigeria	■			■	
Pakistan					
Philippines				■	
Tajikistan	■			■	
Uganda					
United Republic of Tanzania					
Uzbekistan		■			
Zambia					
Zimbabwe	Data NA				
Number of countries that achieved the benchmarks	**3**	**1**	**1**	**4**	**1**

Note: Indonesia did not procure in the last 2 years and Zimbabwe did not respond to this question.

Process Efficiency and Effectiveness Index

36%-78%

Range of the index for Process Efficiency and Effectiveness

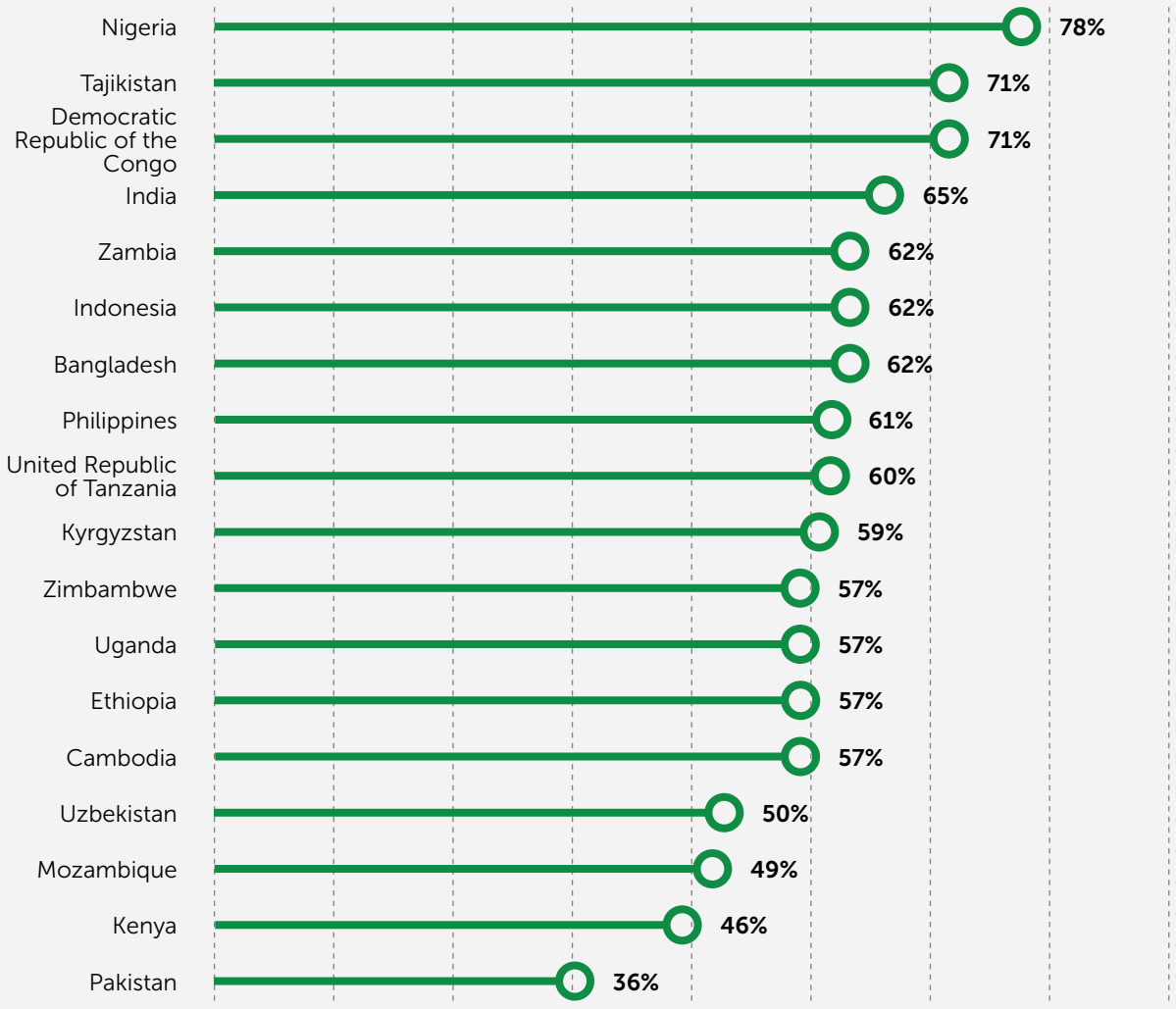
83% (15/18)

of the countries (Bangladesh, Cambodia, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kyrgyzstan, Nigeria, Philippines, Tajikistan, Uganda, United Republic of Tanzania, Uzbekistan, Zambia and Zambia) achieved 50% or more for the process efficiency and effectiveness index.

1 of these 15

achieved a score greater than 75%: Nigeria (78%)

Figure 4: Process Efficiency and Effectiveness Index in the Second Survey



Annexures

Annex 1: Terms of Reference for the Regional Civil Society and Community Participation in 2021 STP Governance Report

Background

A second survey of NTP governance is planned. As part of continuing to improve and enhance the process, this iteration of the report will also include more focused and structured civil society and affected community engagement and participation in each of the focus countries. Regional civil society networks will be engaged to facilitate the selection and participation of TB-affected community and civil society representatives in each of the assessment countries.

Objective

Utilizing regional TB civil society organisations and networks, enhance the participation of TB civil society and affected communities in the 2022 STP Governance Report through the engagement of three (3) TB-affected community or civil society respondents in each of the focus countries.

Activities

Activities will be undertaken working closely with the STP Secretariat and the lead consultant.

1. Review the 2021 STP Governance Report.
2. Develop and implement the terms of reference and selection process to identify three national civil society/ affected community partners in each country who can participate in the Governance Report process. Ideally respondents should have:
   i. a reasonable level of engagement with the NTP
   ii. an understanding of the fundamentals of governance (and/or principles of transparency, inclusiveness, legal frameworks and process efficiency)
   iii. familiarity with key TB programmes and funding arrangements (e.g., Global Fund) in the country
   iv. a working knowledge of the implementation of the national TB response (possibly including NTP planning, implementation, monitoring, review)
   v. experience engaging with the CCM; and,
   vi. a working level of English (or access to translation services).
3. The relevant countries in each region are:
   - Africa: the Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe (11 countries)
   - Asia: Bangladesh, Cambodia, India, Indonesia, Pakistan, the Philippines and Viet Nam (seven countries)
   - Eastern Europe and Central Asia: Kyrgyzstan, Tajikistan, Ukraine and Uzbekistan (four countries).
4. Undertake a briefing of the country civil society/ affected community participants/respondents (three in each country) that introduces them to their role and expectations and detailed timelines noting that the three participants in each country should develop a shared position with regard to the various components of the governance assessment.
5. Follow up to ensure that country participants/ respondents compile and develop inputs to the STP Governance Report, participate in relevant interviews and provide any clarifications needed on their submissions.
6. Ensure coordination as well as timely and effective information sharing between country participants/ respondents and STP (including lead consultant).

Deliverables

1. Three (3) TB-affected community and civil society participants/respondents in each selected country in your region: 33 participants/respondents from African countries (three in each of the 11 countries), 21 from Asian countries (three in each of the seven countries), and 12 from countries in Eastern Europe and Central Asia (three in each of the four countries).
2. A briefing event with country participants/respondents.
3. Country level inputs and feedback to the relevant governance assessment questions in each country.

Annex 2: 20 Benchmarks

Benchmarks for Transparency

1. **A working NTP website –** A working NTP website, owned by the NTP/MoH, with the latest relevant information, including the latest organogram of NTP with the contact details (phone number and email) of individual officials and their functions to enable the public to give feedback or ask a question to the NTP.
2. **Case notification data on the website –** Publicly available real-time TB case notification data are available on the website (real-time means at least daily updates for national- and provincial-level data).
3. **Latest TB technical guidelines on the website –** Within three months of release of global technical guidelines, national guidelines are updated, and within six months, national guidelines are available on the NTP website and easily accessible. (Note – Easily accessible means that the relevant information on the website is categorised appropriately and easy to find. The element of timing in this benchmark was assessed less stringently for this survey.)
4. **NSP and annual budget on the website –** Final and approved three- to five-year budgeted NSP is on the NTP website and is easily available at least a quarter before the NSP comes into effect. This document is supplemented with a detailed approved annual budget for the NTP for the year, which is available on the NTP website in the first quarter of the financial year and is easily accessible.
5. **External programme review –** The NTP provides an opportunity for all stakeholders for organised and systematic feedback through a Joint External Programme Review (JEPR) at least every three years and has the final review reports available on the website within three months of the review. (Note – JEPR has various names, e.g., Joint Monitoring Mission or External Programme Review. In this report, JEPR denotes a process whereby national and international stakeholders jointly review the programme and make recommendations to the government. Country missions by the Green Light Committee are not considered JEPRs.)

Benchmarks for Inclusiveness

1. **Social contracting with government funds (NGOs/ private sector) –** A well-functioning TB programme should develop a mechanism for using government funds to procure services from nongovernmental entities for interventions that are better implemented outside of government for quality, cost or other reasons. The mechanism should ensure clear and transparent policies and guidelines for applying for these contracts, as well as a tender process that meets international standards. Contracting at subnational level is also encouraged to successfully implement the programme. (Note – There were numerous examples of countries engaging NGOs, TB-affected community networks and the private sector through grants with the Global Fund and other donors. This component of the survey assessed whether there was a mechanism in place in the country for engaging these entities with government funds and whether such engagement had already been implemented.)
2. **Inclusion of key populations (KPs) in the NSP –** The NSP includes prioritisation of KPs using the STP Key Populations Data for Action Framework, appropriate activities, adequate budget and monitoring indicators for all KPs identified through a data-based prioritisation exercise.
3. **Inclusion of civil society/TB survivors –** The NTP includes civil society, TB survivors, KPs and minority groups in a meaningful way in a) programme reviews at national and subnational levels, b) joint monitoring missions/external programme reviews, c) development of the NSP or proposals for major donors (Global Fund and USAID), and d) as members of the core team for research planning and implementation, as well as in the dissemination of research findings.

4. **Inclusion of TB community and subnational entities –** NTPs collect 360-degree feedback from all stakeholders of the NTP, i.e., systematically and regularly collecting inputs from all stakeholders – the communities, civil society, and governmental implementers at all levels. Feedback from the community can be either through digital platforms, for example, the "OneImpact" app or WhatsApp groups, or through non-digital/traditional platforms, for example, regular feedback surveys collected on paper from people receiving TB treatment. Subnational entities (provincial and district) provide inputs for planning and budgeting, for example, for the NSP, as well as for implementation and monitoring, for example, during quarterly/annual programme reviews conducted by the NTP and the JEPR. Countries might have other additional platforms to gauge the inputs of subnational entities.
5. **Gender inclusiveness –** This benchmark has six components:
   a. Service providers (and staff at all levels) have received training on TB and gender in the past two years.
   b. Data are available (gender-disaggregated treatment outcome data in addition to case notification), and monitoring indicators and evaluation criteria adequately measure the programme's response to gender inequalities in TB care.
   c. At least 50% of TB programme managers at the national and provincial level combined are women.
   d. The NTP has developed a national TB gender strategy and action plan based on a gender assessment for TB.
   e. The NSP highlights gender inclusiveness in TB services and programmes, which is assessed based on five elements: i) the NSP mentions gender; ii) the NSP provides data or commits to conducting a gap analysis or assessment on gender; iii) gender-specific activities are described; iv) indicators with targets for gender are included; and v) a defined budget is allocated for gender-specific activities.
   f. Women TB survivors are included in NTP events.

Benchmarks for Inclusiveness

1. **Mandatory TB notification –** TB notification is mandated by a public health act or law and is implemented in the entire country (public and private sector), including monitoring of the implementation of the law while ensuring protection of privacy and confidentiality.
2. **Drug-resistant (DR-) TB medicines are on the National Essential Medicines List (nEML) and available for free –** All WHO Group A and B DR-TB medicines are included in the nEML and available free of charge to people receiving treatment for TB (public and private sector), including monitoring of the implementation of the law/policy.
3. **Social protection –** This benchmark has two components measuring the provision of social protection schemes and social health insurance for all people with TB, including those from ethnic minorities, migrants and other vulnerable populations. Systems for social protection include legal, financial, mental health, and nutrition support, among others. Secondly, the social health insurance system in the country, under Universal Health Coverage or otherwise, should include diagnosis, treatment and prevention of all forms of TB, including MDR-TB, for all populations of the country.
4. **Law or policy that defines and protects the human rights of people with TB –** a) Human rights to privacy and confidentiality for people affected by TB and freedom from discrimination are three elements included in TB training modules/technical guidelines; and b) all those engaged in TB service delivery are trained on these issues.
5. **Policy framework to reduce stigma –**This benchmark includes four elements:
   a. The NSP makes it clear that it is illegal to stigmatise anyone with TB, including limiting or preventing access to TB services: i) the NSP mentions activities to reduce stigma, including stigma against women and other vulnerable populations; ii) the NSP provides data from a stigma assessment; iii) appropriate context-specific activities are described to respond to stigma; iv) indicators with targets are included to reduce stigma; and v) a defined budget is allocated for stigma-reduction activities.
   b. A baseline stigma assessment has been done.
   c. Service providers (and staff at all levels) are trained on TB and stigma.
   d. A communication strategy has been developed that includes advocacy to reduce stigma.

Benchmarks for Process Efficiency and Effectiveness

1. **Approval process efficiency –** The final approved NSP, annual budget or other such document with prior approval (for example, at the beginning of the financial year) enables the NTP to move forward and implement without requiring additional approvals from other ministry officials. If approvals are required, the process takes less than a week, as TB activities have already been prioritised.
2. **NTP manager empowerment –** This benchmark includes four elements:
    a. The NTP manager is senior staff and is no more than two steps from the health minister in the hierarchy.
    b. The NTP manager has access to relevant and recent programme information to be empowered for making decisions.
    c. The NTP manager perceives him/herself to be fully empowered to deliver the targets of the Global Fund TB grant.
    d. CS partners perceive the NTP manager to be fully empowered to deliver the targets of the Global Fund TB grant.
3. **Capacity of the NTP (number of staff in relation to population/burden/provinces) –** The NTP has sufficient capacity at the national level. The required strength of the technical/ management staff at the national level will vary with the size of the country, burden of TB and status of the programme. Applying a uniform criterion can be challenging. It is expected that countries will carry out an assessment to determine the staffing needs in the NTP, which will serve as the benchmark for that country. Until that happens, four sub-components have been considered as given below.
    a. Population in millions divided by the number of technical staff (staff and long-term consultants of more than a year) is 1 or less in small countries (50 million or less – eight such countries in the survey) and 10 or less in bigger countries.
    b. Number of people developing TB in the last year divided by the number of technical staff (staff and long-term consultants of more than a year) is 10,000 or less in countries with a population of 50 million or less, and 50,000 or less in bigger countries.
    c. Number of provinces/oblasts/states in the country divided by the number of technical staff (staff and long-term consultants of more than a year) at the NTP is 0.5 or less.
    d. The civil society's perception of NTP's capacity of staff strength in relation to the work or responsibilities.

Note - provincial and district level staff were not considered for this component.

4. **Ability of the NTP to rapidly adopt/adapt international guidelines as national policies –** Adoption of new international guidelines by the NTP within a year (this benchmark refers to the most recent international guidelines each year), and b) roll-out of the policies to the provincial/district level within six months of national policy adoption.
5. **Capacity of the NTP for fund absorption –** This benchmark includes two components: a. The NTP absorbs 95% or more funds from all domestic and external sources in the designated time period. b. The NTP absorbs 95% or more funds from the Global Fund in the designated time period.

Annex 3: Scoring Guidance

Scoring guidance for the survey

Bench-mark No.	Themes and Bench-mark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Transparency										
Trans-parency Bench-mark 1	**A working NTP website**	T1a. Does NTP have a web page/website T1b. Is NTP organogram (or the names and designations of all NTP officials) available on the website T1c. Are contact details (email or phone num-ber) available for any one NTP official on the NTP/MoH website T1d. Name, designation and contact details (email or phone num-ber) of all officers of NTP is available on the website	T1a can be scored as 0, 0.5 & 1 but T1b, c & d are scored as 0 or 1; Score for each sub-component is added to get the total score. A final review of the websites is done before finalizing the survey.	no NTP website/ webpage on MoH website & no organogram & contact details of NTP	0.5 if no NTP website and no webpage on MoH but search for TB on MoH site gives results; 0.5 if no NTP website but contact details are available on WHO website; if website was working ear-lier but now not working for less than 6 months	Information for the sub-com-ponent is current and readily avail-able on the NTP website or on a dedicated page of MoH website.	website/ webpage available and information is buried inside a document and thus, not easily accessible	2 of 4 sub-com-ponents are present	3 of 4 sub-com-ponents are present	A working NTP website with latest organogram + current contact de-tails of NTP + current contact details of in-dividual NTP officials
Trans-parency Bench-mark 2	**Case notifica-tion data on the website**	T2. Is Case Notification data available publicly on NTP website/MoH?	The NTP websites were reviewed in November 2022 and the scores were adjusted accord-ing to the latest data available on the NTP website. The adjusted scoring criteria are given here.	No data or latest data is till 2020 or earlier/ more than four quarters earlier		Latest available data is till 2021/older than last two quarters but not older than four quarters		Latest data available is till Q1 of 2022/two quarters prior and for national level only	Updated provincial level data available till at least Q1 of 2022/ two quarters prior	Provincial level data available which is updated daily on the national website
Trans-parency Bench-mark 3	**Latest TB technical guidelines on the website**	T3a. Are National MDR-TB guideline available? (give date of the guidelines)	Two guidelines are used as markers, more recent guidelines are scored higher. If a sin-gle technical guideline covers both topics, both are scored.	Not pub-lished on the website	0.5 if national TB technical guidelines are available on WHO website	Guidelines published on the website but updated in 2019 or earlier (more than two years ago)		Guidelines published on the website and updated in 2020 or 2021 (within the last two years)		
		T3b. Are National TB Preventive Treatment (TPT) guidelines avail-able? (give date of the guidelines)		Not pub-lished on the website	0.5 if national TB technical guidelines are available on WHO website	Guidelines published on the website but updated in 2019 or earlier (more than two years ago)		Guidelines published on the website and updated in 2020 or 2021 (within the last two years)		
Trans-parency Bench-mark 4	**NSP and Annual budget on the website**	T4a. Is TB National Strategic Plan available on the website? (most recent)		NSP not available on the website		Draft NSP available on website		Approved NSP without budget on website	Approved NSP with budget on the website	
		T4b. Is Annual budget of NTP available?			0.5 if annual budget is old by one year (not of current year) (or if the current an-nual budget is given as just a figure i.e. not in detail)	Head-wise annual budget either on the NTP/MoH website				
Trans-parency Bench-mark 5	**External program review**	T5a. When was JEPR done? (JEPR is Review with inclusion of external partners) (JEPR done in recent years will get higher score)		0 if JEPR done before 2017 (more than 4 years ago) (NOTE - if JEPR done before 2017/ more than 4 years ago and report available, total score stays 0)		if JEPR done in 2017 and 2018 (not within 2 years but within 4 years of the governance survey)		if JEPR done in 2019, 2020 & 2021 (in the year of the governance survey or two preced-ing years)		
		T5b. Is the final JEPR report available (please share a copy)	Availability of the final report on the website is not scored though it is the ideal practice.	if no JEPR or no report		if draft report available (debriefing PPT consid-ered as draft)		final report of JEPR available either on website or with NTP		

Benchmark No.	Themes and Benchmark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Inclusiveness										
Inclusiveness Benchmark 1	**Social Contracting with Govt funds (NGOs/ Private Sector)**	Social Contracting **NGO**: social contracting mechanism (tendering/guidelines/ policy) available to contract NGOs with the government funds (not donor funds) I1ai. A policy for contracting NGOs using government funds (not donor funds) is available. I1aii. Guidelines for contracting NGOs using government funds (not donor funds) is available. I1aiii. Contracting of NGOs has been done in the national TB program at the national level only I1aiv. Contracting of NGOs has been done under the TB program at the sub-national level- in more than 50% of the sub-national entities	Questions pertained to social contracting mechanisms for NGOs and private sector using government funds. Scoring was done for mechanisms and practice to direct domestic funds from government to NGOs and private sector. Contracts using donor funds are not scored. The policy could be for health programs in general and not specifically for TB program. Each of the four sub-components carries a score of 0 or 1. Engagement of NGOs and private sector by in-kind grants is also not scored. Average score of I1a and I1b is considered	no policy or guidelines and no tendering has been done using govt. funds		One of four elements is present.		2 of 4 elements are present (policy, guidelines and tendering at the national or sub-N level) or if tendering has been done at the national and sub-N levels without policy or guidance	3 of 4 elements are present	All 4 elements are present - policy, guidelines are present and tendering has been done at national and more than 50% of the sub-national levels
		Social Contracting **Private sector**: social contracting mechanism (tendering/guidelines/ policy) available to contract Private Sector with the government funds (not donor funds) I1bi. A policy for contracting the private sector using government funds (not donor funds) is available. I1bii. Guidelines for contracting the private sector using government funds (not donor funds) is available. I1biii. Contracting of private sector has been done in the national TB program at the national level only I1biv. Contracting of private sector has been done under the TB program at the sub-national level- in more than 50% of the sub-national entities	Questions pertained to social contracting mechanisms for NGOs and private sector using government funds. Scoring was done for mechanisms and practice to direct domestic funds from government to NGOs and private sector. Contracts using donor funds are not scored. The policy could be for health programs in general and not specifically for TB program. Each of the four sub-components carries a score of 0 or 1. Engagement of NGOs and private sector by in-kind grants is also not scored. Average score of I1a and I1b is considered	no policy or guidelines and no tendering has been done using govt. funds		One of four elements is present.		2 of 4 elements are present (policy, guidelines and tendering at the national or sub-N level) or if tendering has been done at the national and sub-N levels without policy or guidance	3 of 4 elements are present	All 4 elements are present - policy, guidelines are present and tendering has been done at national and more than 50% of the sub-national levels

Benchmark No.	Themes and Benchmark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Inclusiveness Benchmark 2	Inclusion of Key Populations in NSP	I2a. NSP highlights and identifies/lists 4 or more Key Populations (other than children and PLHIVs) I2b. STP assessment has been done or based on data, key populations have been prioritised I2c. NSP includes monitoring indicator and/or budget for any KPs other than children & PLHIVs I2d. Action plan has been formulated for KPs	12a&b are scored as 0 & 1, 12c & d are scored as 0, 0.5 & 1. Thus, max score for each sub-component is 1. I2a-Score 1 if NSP lists 4 KPs other than children and PLHIVs, otherwise 0 I2b-if no STP assessment or if KPs have been listed without a data-based exercise then scored zero I2c-score of 0.5 for monitoring indicator and 0.5 for budget for any KP other than children and PLHIVs I2d-score of 0.5 if indicator and budget line given for individual KPs and 0.5 if action plan given. Action plan should be with timeline and responsible entity	if KPs not mentioned at all, or only children & PLHIVs are listed or if less than 4 KPs other than children and PLHIVs are listed; and no activity done for identification of KPs	NSP includes monitoring components (0.5 point) and budget (0.5 point) for any KPs other than children & PLHIVs. However, budget and components are not individually given for all listed KPs.	1 of 4 elements are given in the NSP;	2 of 4 elements are given in the NSP but not fully.	2 of 4 elements are given;	3 of 4 elements are present	If 4 or more KPs for TB are listed in NSP, formal prioritisation for TB key population has been done, and components and budget are given individually for all KPs and action plan has been formulated
Inclusiveness Benchmark 3	Inclusion of civil society/TB survivors	I3a. NTP consulted with TB civil society/ TB survivors to review progress in 2021	I3a scored as 0,0.5,1 and the other three subcomponents scored as 0,1. 13a - Based on minutes of the meeting shared by NTP or CS, if NTP consulted with the CS/TB survivors for progress review at the quarterly/semi annual/ annual meetings at the national level (0.5) or at the sub-national level (0.5)	0 if NTP did not consult with TB civil society/TB survivors to review progress in 2019	0.5 if CS consulted at national or sub-national level only;	if consulted at both national & sub-national levels				
		I3b. NTP invited TB Civil Society/TB Survivors to participate in the most recent JEPR^/external reviews	This was based on acknowledgment or list of participants or methodology sections of the JEPR report or if answered as yes by the CS respondents. Because of the pandemic a modified version of JEPR was also considered.	if CS did not participate in JEPR		if CS participated in JEPR				
		I3c. NTP consulted with civil society and TB survivors to develop the NSP and donor proposals	This was based on acknowledgment or list of participants or methodology sections of the NSP or if answered as yes by the CS respondents	if NTP did not consult CS in development of NSP or donor proposal		if NTP consulted CS				
Inclusiveness Benchmark 4	Inclusion of TB community and sub-national entities	I4a. Does a platform(s) exist for obtaining feedback from the community– e.g. standing bodies, meetings, apps, etc.?	Total score of I4a, b, c and d is considered. All four subcomponents scored as 0,1.	if no platform for feedback from community		if platform for community feedback exists (one-impact app, member of TWG, patient feedback survey etc.)				
		I4b. Does a platform exist for obtaining feedback from sub-national entities?	This was based on documented information or confirmation by CS	if no platform for feedback from sub-national entities (e.g., JEPR or NSP consultation)		if platform for feedback from sub-national entities exists or if sub-national entities participated in JEPR or NSP consultation				
		I4c. Did sub-national entities participate in the quarterly or annual program review	This was based on documented information or confirmation by CS	if sub-national entities did not participate in quarterly or annual program review		if sub-national entities participated in quarterly or annual program review				
		I4d. Did sub-national entities participate in the Joint External Program Review or in the supervision visits conducted by the NTP	This was based on documented information or confirmation by CS	if sub-national entities did not participate in JEPR or supervisory visits		if sub-national entities participated in JEPR or supervisory visits				

Benchmark No.	Themes and Benchmark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Inclusiveness Benchmark 5	Gender inclusiveness	I5a. NTP staff undertaken TB & gender sensitization /training in the past 24 months.	Scoring for IBM5 for gender inclusiveness is based on six sub-components each with a maximum score of 1 (sum of score of I5 a to f)*4/6 I5a-scored as 0,1; and based on supporting documentation	if NTP staff have no training		if at least 50% of the staff have taken training				
		I5b. Male-female ratio of NTP and provincial managers	Based on list of provincial TB managers. NTP manager also included.	if less than 50% of provincial managers are women		if 50% or more of provincial TB managers are women				
		I5c. TB Gender assessment report available for the country		TB Gender assessment report NOT available for the country		TB Gender assessment report available for the country				
		I5d. NSP highlights gender inclusiveness in TB services and programs.	Based on five elements mentioned in the NSP, (each carried a score of 0.2)- Gender mentioned in the NSP; NSP provides data or mentions conducting a gap analysis/assessment on gender; gender specific activities for implementation are described in the NSP; NSP has indicators or targets for gender; a defined budget of funds is allocated specifically for gender activities.	NSP does NOT highlight gender inclusiveness in TB services and programs.		NSP highlights gender inclusiveness in TB services and programs.				
		I5e. Women TB survivors included in any NTP event in 2021/in the previous year	This was based on documented information or confirmation by CS	Women TB survivors NOT included in any NTP event in the previous year		Women TB survivors included in any NTP event in the previous year				
		I5f. Gender disaggregated data for treatment outcome available for 2020 cohort/for the most recent treatment outcome report		Gender disaggregated data for treatment outcome NOT available for 2020 cohort.		Gender disaggregated data for treatment outcome available for 2020 cohort.				
Legal Framework										
Legal Framework Benchmark 1	Mandatory notification	L1. TB notificaiton is mandated by the govt.	This was based on documented information like an Act or legislation	Not mandatory				Mandatory in some provinces or in the process of being made mandatory (partial)		Mandatory
Legal Framework Benchmark 2	DR-TB drugs in nEML and free	L2a. i) Country has Bedaquiline listed on their National Essential Medical List in 2021/ in the previous year		Not listed			It is listed			
		L2a. ii) Country has Linezolid listed on their National Essential Medical List in 2021/in the previous year		Not listed			It is listed			
		L2b. Are the above drugs available for free to the patients	As confirmed by both NTP and CS	These drugs are not available for free to the patients		available for free to the patients				

Benchmark No.	Themes and Benchmark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Legal Framework Benchmark 3	Social protection	Social protection schemes available	"L3a and L3b had a maximum score of 2 each; L3a had three elements, each with a maximum score of 1. Scoring of L3a =(L3ai+ii+iii)* 2/3 Scoring of benchmark =(L3a+L3b)"							
		L3ai. employment protection		if not available	if available partially	if available for all people on treatment for TB				
		L3aii. Cash transfer/ reimbursement		if not available	if available partially	if available for all people on treatment for TB				
		L3aiii. Nutrition support		if not available	if available partially	if available for all people on treatment for TB				
		L3b. Is there a social health insurance system in the country, under Universal Health Care or otherwise?		if no social health insurance or if social health insurance available but TB & MDR-TB are excluded from it or if these are available only partially		if social health insurance is available and TB & MDR-TB are included in it for all people in the country		if social health insurance is available and TB & MDR-TB are included in it for all the people in the country; and the proportion of total costs covered by the insurance averts catastrophic costs for patients.		
Legal Framework Benchmark 4	Law/ policy on human rights for TB	L4a. TB training module/guidance or any other document like patient charter contains information on 'Confidentiality'?	Scoring for LBM4 for law/policy on human rights for TB is based on scoring of five sub-components each scored as 0,1. The score of the benchmark is (sum of score of L4 a to e)*4/5	if none of the documents mention human rights (HR) or if given in NSP only		If given in patient charter or any TB guidelines/ training module				
		L4b. TB training module/guidance or any other document like patient charter contains information on 'Privacy'?		if none of the documents mention human rights or if given in NSP only		If given in patient charter or any TB guidelines/ training module				
		L4c. TB training module/guidance or any other document like patient charter contains information on 'Freedom from discrimination'?		if none of the documents mention human rights (HR) or if given in NSP only		If given in patient charter or any TB guidelines/ training module				
		L4d. The human rights issues (L4a,b,c) are given in the TB training module?		if none of the documents mention human rights or if given in NSP or patient charter		If given in TB guidelines/ training module				
		L4e. Training of NTP staff has been conducted on human rights issues in 2021 or 2020?		Training of NTP staff has not been conducted		Training of at least 50% of the staff has been conducted in human rights issues				

Benchmark No.	Themes and Benchmark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Legal Framework Benchmark 5	Policy framework to reduce TB stigma	L5a. NSP includes Intervention(s) to reduce stigma due to TB	Total of score of L5a, b, c and d is considered; Information in NSP was considered.	no mention in NSP		NSP includes intervention(s) to reduce TB stigma				
		L5b. NSP includes Indicator(s) for TB stigma		no mention in NSP		NSP includes Indicator(s) for TB stigma				
		L5c. NSP includes budget line(s) for reducing TB stigma		no mention in NSP		NSP includes budget line(s) for reducing TB stigma				
		L5d. NSP provides data or mentions conducting a gap analysis/assessment on stigma		no mention in NSP		NSP provides data or mentions conducting a gap analysis/ assessment on stigma				
Process Efficiency & Effectiveness										
Process Efficiency & Effectiveness Benchmark 1	Approval process efficiency	P1. Time taken by the country to approve the GDF quote for the last procurement.	The GDF quote for last procurement was considered. Number of days taken for approval were scored. If the country had not procured from GDF in the last two years then the survey response was considered as 'not procured' and theme score was adjusted.	more than a month		up to 1 month		up to 2 weeks	up to 1 week	up to 3 days
Process Efficiency & Effectiveness Benchmark 2	NTP Manager empowerment	P2a. Number of officials in the hierarchy between the NTP Manager and Health Minister	Total of score of P2a, b, c and d is considered for the score of this benchmark	if more than 2 officials in the hierarchy between the NTP manager and the health minister		if 2 or fewer officials in the hierarchy between the NTP manager and the health minister				
		P2b. NTP manager has a way of knowing how many people were tested with Xpert as an initial test in a particular district	The method of knowing is mentioned by the NTP manager.	NTP manager has no way of knowing		NTP manager has a way of knowing (method to be mentioned)				
		P2ci. Perception of NTP manager (not the civil society) – if s/he feels adequately empowered to deliver targets of Global Fund TB grant (P2cii. Who is/are the PR(s) for the current TB grants in the country?)	This is based on NTP Manager's perception and they had the option of elaborating on their response.	NTP manager feels not empowered at all	NTP manager feels the need for more empowerment	NTP manager feels fully empowered				
		P2d. Perception of civil society – if the NTP manager is adequately empowered to deliver targets of Global Fund TB grant	This is based on Civil Society's perception and they had the option of elaborating on their response.	CS feels NTP manager is not empowered at all	CS feels NTP manager needs more empowerment	CS feels NTP manager is fully empowered				

Benchmark No.	Themes and Benchmark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Process Efficiency & Effectiveness Benchmark 3	Capacity of NTP (number of staff in relation to population/ burden/ provinces)	Total number of staff and consultants (working for at least one year duration) at the national level	Total of score of P3a, b, c and d is considered for the score of this benchmark; EBM3 a, b &c are calculated from the information given by NTP on number of staff and number of provinces. Population and number of TB patients is taken from the last Global TB Report							
		P3a. Relation to total population:	pop in million/# staff	if >1		"if 1 or less in small countries (if 10 or less in big countries) (small countries are with pop of 50m or less)"				
		P3b. Relation to TB burden:	# of all TB patients in GTR 2022/# staff	if more than 10,000		if 10,000 or less (if 50k or less in big countries)				
		P3c. Provinces and districts:	# of provinces/# staff	if more than 0.5		if 0.5 or less				
		P3d. Civil society's perception of the NTP's capacity (staff strength in relation to its work/ responsibilities)	This is based on Civil Society's perception	0 if civil society's perception is that NTP has no capacity	0.25 if CS's perception is that NTP has 25% capacity and needs 75% more	1 if civil society's perception is full capacity or adequately staffed with no need for additional staffing	0.75 if CS's perception is NTP has 75% capacity and needs 25% more			
Process Efficiency & Effectiveness Benchmark 4	Ability of NTP to rapidly adopt/ adapt international policies	NTP should be able to rapidly adapt international policies into national policies.	"Total of score of P4 d, e and f is considered for scoring the benchmark (P4a,b&c were not included in the questionnaire) ; If a country said yes to all three questions, the total score was rounded to 4 NTP's ability to adopt international policies within a year of their publication is assessed as evidenced by the inclusion in the national guidelines of the policies which were released by WHO in 2021. If the answer is yes to any of the questions, then NTP is requested for the date of enacting the policy. (P4a,b,c were questions in the previous survey which were not included this time as they were not recent)"							
		P4d. Chest X-ray has been included for the systematic screening of individuals younger than 15 years who are close contacts of someone with TB		0 if no		1.3 if yes				
		P4e. Among individuals aged 15 years and older in populations in which TB screening is recommended, computer-aided detection software programmes may be used in place of human readers for interpreting digital chest X-rays for screening and triage for TB disease.		0 if no		1.3 if yes				
		P4f. Testing for FQ resistance by automated NAAT has been included in the TB diagnostic algorithm		0 if no		1.3 if yes				

Benchmark No.	Themes and Benchmark	Components	Notes on Scoring	Score 0	Score 0.5	Score 1	Score 1.5	Score 2	Score 3	Score 4
Process Efficiency & Effectiveness Benchmark 5	Capacity of NTP for absorption of funds	P5a. What is the % of expenditure/funding from all sources in the (most recent) year (2021) (WHO database)	Total of score of P5a and b is considered	<85%		85% or more		95% or more		
		P5b. Capacity of NTP for GF fund absorption	"This was based on information provided by GF. The scoring did not consider if NTP was the Principal Recipient. Scoring followed the established GF benchmark and categorisation of countries for this indicator. If the countries had a mix of both TB and TB/HIV grants and the absorption rate of the TB grant was very low as compared to the TB/HIV grant, then the scoring was downgraded by one. "	<65%		65% to 84%		85% or more		
		P6. What does the domestic budget funds cover. Options are given below	This component is not scored but is described in the narrative.							
		P6a. Human Resources								
		P6b. First line drugs								
		P6c.Second line drugs								
		P6d. Rapid molecular diagnostics (e.g. Xpert)								
		P6e. Other diagnostics (e.g. microscopy)								
		P6f. Infrastructure and services of health system for TB								
		P6g. Programmatic activities (travel, supervision, meetings, trainings etc)								
		P6h. Others								

LEGEND

^JEPR is Joint External Program Review and includes Joint Monitoring Mission, Joint Program Review etc. where review is jointly done by internal and external partners

Annex 4: Civil society partner responses for the four countries where the NTP did not respond (Malawi, South Africa, Ukraine and Viet Nam)

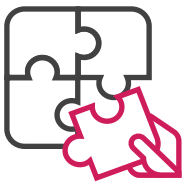
The following is a summary of the CS partner responses from the four countries – Malawi, South Africa, Ukraine and Viet Nam – where the NTP did not respond.

Transparency

Ukraine had a page on the MoH website with an email and phone number for contacting the NTP, TB case notification data up to 2021, WHO guidelines and official orders/laws, and a draft national TB strategy up to 2030. The JEPR (2010) report was available on the WHO website. A JEPR was planned for 2021 but could not be conducted because of the conflict. However, in the last quarter of 2022, a remote review was held with CS partner and WHO participation.

Viet Nam also had a website with contact details and TB guidelines, but no other information. A JEPR was done in 2020 or 2021, but the report was not available.

Malawi and South Africa did not have a website.



Inclusiveness

Social contracting – Ukraine had a policy (decree by cabinet of ministers) for contracting NGOs and the private sector using government funds. Multiple guidelines covering different aspects of the contracting process were available on the Internet. NGOs had not been contracted, but contracting of the private sector had been done at the national level.

Viet Nam had no policy or guidelines for contracting NGOs, but had contracted the private sector for insurance at the national level, supported by policy and guidelines.

For Malawi and South Africa, this information was uncertain.

KPs – This response was based on the NSP, which was the same as in the first survey for Malawi, Ukraine and Viet Nam (refer to first survey). The response to the first governance survey from South Africa was based on an NSP that covered the period 2017–2022. The subsequent NSP was not available.

Civil Society Participation –

Malawi – CS partners did not participate in the progress review in 2021 or in research activities. They did participate in proposal/NSP development and in the JEPR in 2019.

South Africa – CS partners did not participate in the progress review in 2021. They did participate in proposal/NSP development, research activities and the JEPR in 2019.

Ukraine – CS partners participated in the NSP/proposal development. They regularly participated in the annual programme reviews. They did not participate in research activities in 2021. The last JEPR was done in 2010, more than a decade ago. Therefore, their participation in that JEPR was not considered for this governance survey.

Viet Nam – CS partners did not participate in the progress review in 2021, research activities and the latest JEPR. They did participate in proposal/NSP development.

There was a platform to receive feedback from the CS partners in all countries, except for Viet Nam where only a Facebook page was available.

The response on feedback from subnational entities is not presented here.

In all countries, except for South Africa, less than 50% of provincial and national-level leadership for TB was provided by women. Women TB survivors were not included in NTP events. Gender-disaggregated data were available for treatment outcomes in all countries. Gender inclusion in the NSP is expected to be the same as in the first survey, except for South Africa.

Legal Framework

TB notification was mandated in all four countries.

As per the CS partners, bedaquiline and linezolid were included in the nEML in all countries except for South Africa.

Employment protection, cash transfer and nutrition support were available to a varying degree in all countries.

The CS partner responses to inclusion of human rights issues in training documents could not be verified.

Inclusion of elements related to stigma in the NSP is expected to be the same as in the first survey, except for South Africa where the NSP is not the same as in the first survey.

Process Efficiency and Effectiveness

The CS partners could not answer on the time taken for approval of the last GDF quote. The response to the hierarchical position of the NTP manager is expected to be the same as in the first survey. In all four countries, the NTP manager had a way of knowing how many people were tested with Xpert as the initial test in a particular district.

The NTP manager was considered to be fully empowered by the CS partners, except in Viet Nam where no response was received to this question. In Malawi and Viet Nam, the NTP was considered to have 75% capacity, but in South Africa and Ukraine, only 25%.

Capacity of the NTP in terms of staff per million population, burden of disease or number of provinces is not presented here because of the inability of CS partners to know the exact staffing situation. The first survey should give an approximation.

In Malawi and Ukraine, chest X-ray had been included for the systematic screening of individuals under 15 years of age who are close contacts of a person with TB.

The following policy had been adopted in all four countries: Among individuals aged 15 years or older in populations in which TB screening is recommended, CAD software may be used in place of human readers for interpreting digital chest X-rays for screening and triage for TB disease.

Testing for fluoroquinolone resistance by automated NAAT had been included in the TB diagnostic algorithm in Ukraine and Viet Nam.

Capacity of NTP for Fund Absorption

Data were not available for South Africa. Ukraine expended more than 95% of the funds from all sources, while Malawi and Viet Nam expended less than 85% (WHO database 2021). For the absorption rate of the Global Fund TB grant (New Funding Model 3), Malawi scored 2, Ukraine 1, and South Africa and Viet Nam 0.

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