

Pooja, who lives near New Delhi, was suffering from drug-resistant tuberculosis, a more aggressive strain of the disease that does not respond to first-line medication. After being diagnosed and treated by a community-based health program, Pooja was cured, and today leads a healthy and normal life.

The Global Fund/Atul Loke/Panos

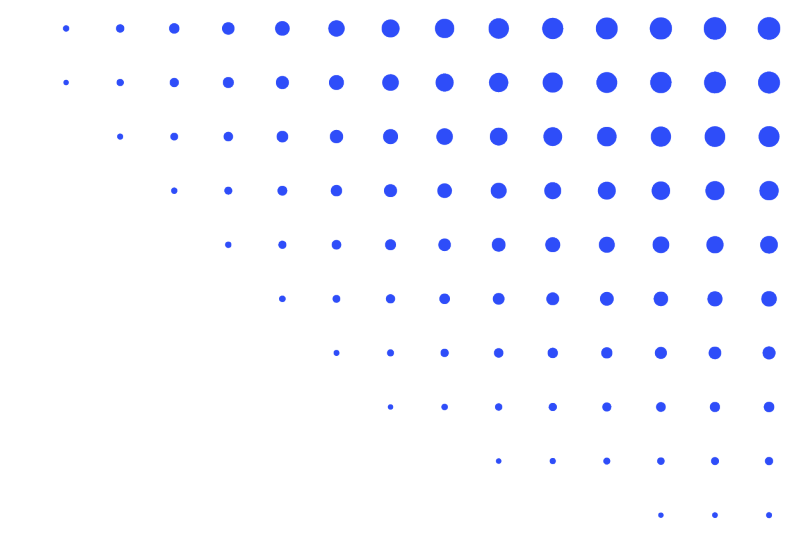
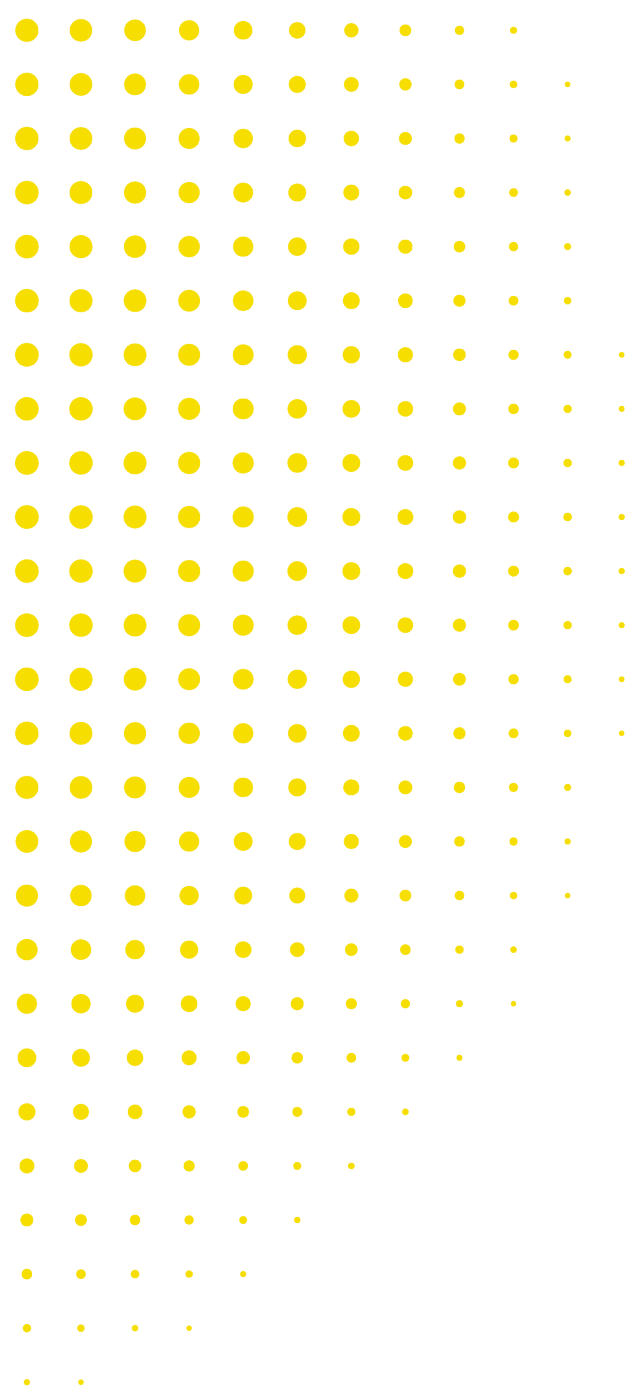


# The TB Quarterly Update

**Innovative Approaches to Finding and Treating Missing People with TB**

JANUARY 2023

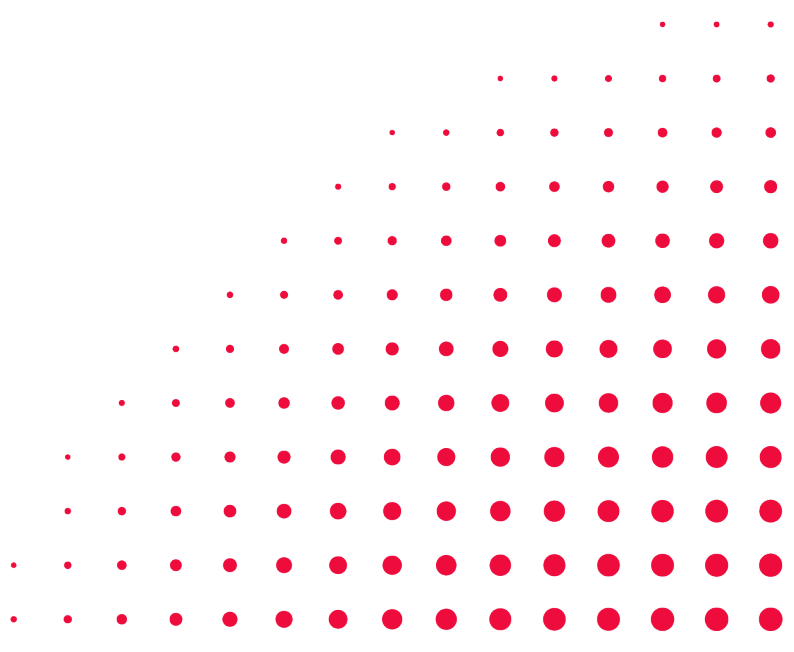




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# 1. What's New

## Global Fund 2023-2025 Country Allocation for TB

Every three years, the Global Fund allocates funding to countries to support HIV, TB and malaria programs and build resilient and sustainable systems for health. The allocation amount made available to countries is based on the funding raised during the Global Fund's corresponding three-year Replenishment cycle. Country allocations are calculated using a formula based on the country's disease burden and economic capacity. Adjustments are then applied through a transparent and accountable qualitative process. To learn more about the 2023-2025 country allocation process, visit the [Global Fund website](#).

## Documenting Community Engagement Best Practices During COVID-19 in Four Countries

Community cadres have played a crucial role in mitigating COVID-19-related effects on TB service delivery—including detecting missing people with TB, supporting medication adherence and providing psychosocial support to improve TB outcomes. In order to better understand how innovative community service delivery models sustained TB responses during the pandemic, the Global Coalition of TB Advocates (GCTA) docu-

mented community service delivery mechanisms in four high-burden countries—**Cambodia, India, Indonesia and Kenya**. Through the documentation process, which included peer-to-peer dialogue, in-depth interviews and focus group discussions with community health workers, national TB program coordinators and technical partners, a number of key lessons and recommendations were gleaned. Key insights on human rights, gender-related and other barriers were also compiled.

Findings from all four countries underscored how community-led innovations—such as home delivery of medication, nighttime home visits and provision of food to secure adherence—were fundamental to sustaining the engagement of TB communities during the COVID-19 pandemic. They also demonstrated how TB detection may have stopped altogether without them, as health systems prioritized the COVID-19 response. With many countries now transitioning out of the acute phase of the pandemic, community-led innovations remain critically important to reverse lost gains and to expedite progress on TB elimination. Furthermore, future pandemic responses must incorporate rights-based, gender-sensitive and patient-centric approaches for TB communities and other vulnerable groups. To read more about the report's findings, visit the [GCTA website](#).



**Amplifying Voices During Stop TB Community Summit**

In November 2022, the Stop TB Partnership (STP) mobilized more than 160 platform partners from over 35 countries, including Challenge Facility for Civil Society (CFCS) and country-level Stop TB Partnership partners, to join forces and strategize on how to amplify their voice and ensure TB is placed high on the international political agenda. The Community Summit, the first of its kind, was also an opportunity to strengthen the position of CFCS as an important mechanism for capacity building in sustainable community-led approaches in TB.

With the aim to inform, mobilize and coordinate TB communities for strategic engagement ahead of the United Nations High-Level Meeting (UNHLM) in 2023, a series of panel discussions and group exercises were

conducted. Over the course of the week, participants reflected on the outcomes of the previous UNHLM 2018, came up with innovative ideas for community advocacy in the run-up to next year’s UNHLM 2023 and engaged in the consultations for an important advocacy tool to set out key priorities for this meeting. The Summit also aimed to train grassroots organizations and partners in effective grant management and implementation—including grant support to build the capacity of handling grants, narrative and financial reporting and communications and advocacy skills.

At the end of the meeting, over 130 community and civil-society organizations endorsed the Bangkok TB Community-led Monitoring (CLM) statement, which calls on national TB programs, technical partners, technical assistance providers and donors to align, mainstream, scale up and resource OnelImpact CLM for all.



**Early Engagement of Uganda for Successful Implementation of TB Program Essentials**

For the next Global Fund cycle (2023-2025), the Global Fund has introduced Program Essentials. These are key evidence-based interventions and approaches that are critical to enable the three disease programs to achieve outcomes and impact against global targets. Program Essentials are expected to facilitate and support coun-

tries to develop and implement high-quality, equitable and impactful programs based on the country’s context and priorities. Actions targeted at the Program Essentials could also be directly funded by the country’s national disease programs or by other partners/entities.

To support the operationalization of recommendations for TB Program Essentials, an early engagement exercise was conducted in Uganda. Consultants were



Group photo from the 2-day workshop on TB Program Essentials with key stakeholders

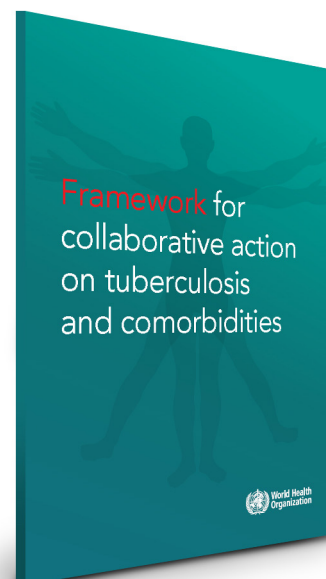
engaged to conduct a baseline assessment of TB Program Essentials, along with key informant interviews with the National TB Program and other stakeholders. The findings of the interviews and baseline assessment were presented in a stakeholders’ workshop, whose objective was to share perspectives from TB partners and stakeholders on how to catalyze action on the Program Essentials. At the end of the two-day workshop, the country had filled its Essential Data Table (a new requirement for the next cycle) ahead of the country dialogue process and identified gaps and technical assistance needs. Three-year targets were also developed to measure the country’s progress on each of the Program Essentials.

Following this pilot, a toolkit for “Successful implementation of TB Program Essentials at country level” has been developed by the Global Fund.

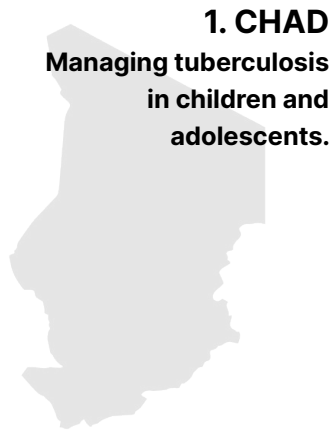
**New WHO Framework on Collaborative Action on TB and Comorbidities**

WHO recently released a new framework on integrated patient-centered care and prevention, including action on TB and comorbidities. The Framework for collaborative action on TB and comorbidities aims to support countries to scale-up people-centered services for TB, comorbidities and health-related risk factors that

are holistic and evidence based, with the goal of comprehensively addressing TB and other co-existing health conditions. It should be used in conjunction with other relevant WHO guidelines by people working in ministries of health, other relevant line-ministries, policymakers, international technical and funding organizations, researchers, nongovernmental and civil society organizations, as well as primary care workers, specialist health practitioners and community health workers. The framework is available [here](#).



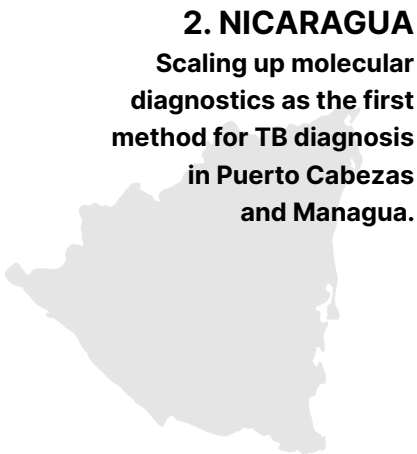
## Country-level Technical Assistance



### 1. CHAD

#### Managing tuberculosis in children and adolescents.

In Chad, children under 15 represent 6.4% out of all TB cases (National TB Program Annual Report), which is far below WHO estimates indicating that children represent approximately 10 to 15% of all people with TB. The under-notification of TB in children is largely linked to challenges with diagnosis and limited diagnostic capacities. With this context in mind, the Ministry of Public Health, with the support of its partners, developed its first specific guide for the management of tuberculosis in children in 2017. Since then, innovations in diagnosis and treatment of TB in children have emerged and new recommendations in these areas were addressed by WHO in 2022. To strengthen the management of pediatric TB, technical assistance from the TB Strategic Initiative will be aimed at updating the pediatric guide, developing training modules and supporting training of trainers.



### 2. NICARAGUA

#### Scaling up molecular diagnostics as the first method for TB diagnosis in Puerto Cabezas and Managua.

By the end of 2020, according to WHO, Nicaragua reported 90% of new bacteriologically confirmed TB cases were tested for rifampicin resistance. However, only 70% had this test done at the time of diagnosis. The proportion of presumptive people with TB with a rapid molecular test for TB diagnosis has not been reported. Additionally, more information is needed to understand the operational requirements and costs to move towards national expansion of rapid molecular testing as the first diagnostic method for TB in Nicaragua, as well as to monitor and ensure its potential to contribute to increase TB detection rates. In light of this, technical assistance will be used to support the end-to-end process of the demonstrative project in the municipality of Puerto Cabezas and three health centers in Managua. This process includes the design, monitoring of implementation, evaluation and generation of operational data. This will inform the planning of the national scale-up of universal access to molecular diagnostics as the first method for TB diagnosis in Nicaragua by the end of 2026.

## 2. Knowledge Sharing and Learning Resources

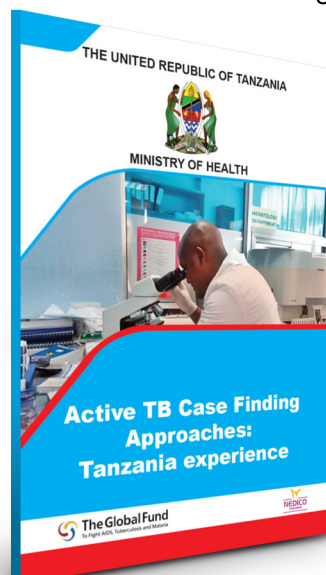
### BEST PRACTICES: Documenting Active Case Finding in Tanzania

According to the WHO Global TB Report (2021), Tanzania is among six high TB burden countries estimated to have achieved the End TB Strategy 2020 milestone of a 20% reduction in the TB incidence rate between 2015 and 2020. From 2015 to 2019, TB incidence and mortality fell 15% and 43%, respectively. While this reduction reflects significant progress, Tanzania still misses 36% of people with TB. Poverty, undernutrition, HIV infection and diabetes are among the challenges in combating the TB disease. Furthermore, low health-seeking behavior, distance to health facilities, low suspicion index among health care workers and shortage of staff in most health facilities are factors that negatively impact the success of TB notification interventions.

In order to support evidence-based scale-up of best practices that improve quality and efficiency in finding missing people with TB, Tanzania documented TB active case finding (ACF) approaches and lessons learned through the following two assessments:

#### 1. Active TB case finding approaches

Through a cross-sectional survey and key informant interviews with a range of TB stakeholders, the first exercise documented the various approaches used in TB active case finding in four regions of Tanzania: Dar es Salaam, Mtwara, Arusha and



Dodoma. The study further provided information on case-finding challenges, lessons learned and best practices. According to the findings, each region has at least one partner implementing TB-related interventions that focus on health facilities, and/or communities, with a number of

supported health facilities varying from 10 to 30. Funding for TB activities is contributed mainly by the Global Fund, USAID, PEPFAR, the German Leprosy and Relief Association (GLRA) and the Government of Tanzania.

#### Results

The following active case finding approaches and best practices were identified at facility and community-level during the assessment:

1. **The Quality Improvement (QI) TB model.**
2. **Special Saturday** clinics that offer TB screenings and referrals to children and/or individuals who were unable to attend the TB unit during weekdays.
3. **Contact investigation** using community health workers (CHWs).
4. **Mass TB education and screening** events and campaigns.
5. **Engagement of a community network of agents** to reach people who inject drugs (PWID) and collect plastic garbage for TB services.
6. **Engagement of transport agents** (e.g., motorcyclists and Tanzania Postal Corporation) for sputum referral and transportation to diagnostic facilities offering molecular tests.
7. **Engagement of Accredited Drug Dispensing outlets and traditional healers.**
8. **TAMBUA TB**, a mobile phone application that uses the MOH mHealth platform to send messages through basic mobile phones with information about TB and how to check for symptoms.
9. **Targeted screening in communities** using mobile TB vans.
10. **Targeted TB screening in prisons.**

#### Recommendations

1. Rolling out the QI TB model to include all facilities that provide TB services and supporting full implementation of the QI package to reduce variations across implementing partners.
2. Reviewing the TB screening tool in order to improve the TB suspicion rate.

3. Intensifying advocacy to the President’s Office, Regional Administration and Local Government (P-ORALG) and Councils so that they can allocate funds to support recruitment, training and the work of community health workers, including stipends and other incentives.
4. Considering exemption for X-ray services for TB diagnosis.
5. Improving coordination among TB implementing partners and stakeholders by strengthening the functionality of technical working groups and information exchange forums.

**2. Assessment of active case finding using mobile clinic vans**

The National TB and Leprosy Programme (NTLP) commissioned an assessment to evaluate uptake and impact of mobile clinics, using vans as an approach for active TB case finding among risk populations. The assessment adopted a mixed methods design that integrated an analysis of secondary routine TB service data with primary qualitative data generated during fieldwork. The assessment was undertaken in July 2022 in eight regions of Tanzania where mobile clinic vans have been used in delivering health-related services. Through mobile clinic vans, all clients are provided TB care services at one point, including free TB services across the entire treatment cascade, starting from TB screening to initiation of DOT. Presumptive TB cases are provided access to digital

X-ray and with bacteriological confirmation test. All confirmed people with TB are started on anti-TB medication in line with the guidelines and linked to a nearby facility for follow-up.

**Results**

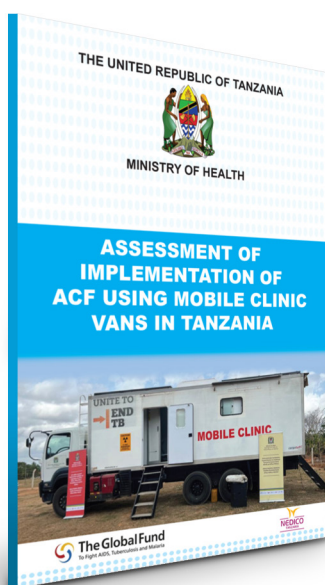
The number of clients receiving TB screening and testing services in the 14 districts visited by the evaluation team had increased from an average of 100+ per month in August 2021

to 300+ per month in September 2021, when mobile clinic vans visited a particular district council. This is largely attributable to the presence of the mobile vans, which invested in timely community awareness creation activities and proper site selection, especially in hard-to-reach areas. Increasing the number of clients receiving TB screening services precipitated a substantial increase in the number of people accessing TB testing services. The increase in numbers accessing services suggests that, previously, communities in the vicinity of mobile clinic van service sites were severely under-served.

The assessment also found that mobile clinic vans have improved turnaround time for GeneXpert, as well as the time it takes patients to be screened and start anti-TB medications. Overall, the approach has increased TB notifications in all implementation districts. The direct benefit of this outreach approach, as compared to health facility service delivery, is a dramatic shift with TB services now going to the people. The mobile clinic vans have been vital in reaching out to communities with quality health services for TB diagnosis and treatment.

**Recommendations**

1. Zonal or regional referral hospitals should dedicate a team of healthcare staff to the mobile van so that even when the support for the current mobile van service project phases out, the team can still deliver the service, provided the van is available.
2. All partners supporting TB and TB/HIV interventions should be encouraged to support the mobile van outreach services.
3. The NTLP, working with partners, should define and implement a maintenance plan for the vans and their equipment and accessories, including the digital X-ray and GeneXpert machines, AC, solar panels, etc.
4. The hosting institution should keep a quarterly calendar defining van movements and monitoring coverage and programmatic results for each region.
5. The Ministry of Health and PORALG should sensitize implementing partners and local government





authorities on the availability of mobile vans and advocate for budget allocation for implementation of mobile clinics.

6. To enable adequate patient follow-up and reduction of early loss to follow-up, the mobile clinic team should have a DOT nurse/clinician from a nearby facility and involve CHWs to support in treatment follow-up.
7. To ensure smooth running of mobile clinic services, the NTLP should plan for CAD4TB subscription and ensure adequate quantification,

forecast and allocation of GeneXpert cartridges and HIV test kits for mobile van operations.

8. A cost analysis should be conducted to identify the cost of notifying one TB patient through the mobile van clinic approach.

To read more about the ACF assessment, please visit [here](#).

To read more about the mobile van assessment, please visit [here](#).

## **CASE STUDY: Program Quality and Efficiency in the Democratic Republic of the Congo (DRC)**

### **Background**

The Democratic Republic of the Congo (DRC) is ranked among the thirty high burden countries (HBC) for TB, TB/HIV and MDR-TB. An estimated 305,000 (range 197K-436K) people fell ill with TB in DRC in 2021, with an estimated 42,000 deaths (range 25K-63K) among HIV-negative people and an additional 7,200 (range 4.7K-10K) among HIV-positive people (WHO Global TB Report, 2022). In 2020, the National TB Program (NTP) notified 200,955 new and relapse TB cases, with a TB treatment coverage of 70%. In 2021, the number of new and relapse TB cases increased by 6.7%, with a total

of 214,408 new and relapse TB cases. The number of TB cases among children 0-14 years old increased from 22,342 to 26,919 (+ 20.5%), while the number of notified MDR-TB cases increased from 1,115 in 2020 to 1,261 in 2021 (+ 13.1%). The treatment success rate for the 2020 cohort was 94% for drug-sensitive TB and 84% for drug-resistant TB (DRC National Tuberculosis Program Data, 2022). Moreover, based on a recent analysis, 56% of the people with TB face catastrophic costs.

### **Implementation**

In 2020, the Ministry of Health, supported by the Global Fund, conducted a situational analysis and developed a strategic plan to implement the program quality and efficiency (PQE) approach in the DRC.



National TB Program

Meeting to validate the pilot phase data with the 30 health facilities, September 2022

The three-phase process has included:

- 1. Pilot phase.** During this phase, implemented in 30 health facilities of Kinshasa starting in October 2021, the NTP developed a PQE toolkit, training materials and job aids for improving quality and efficiency of TB case detection practices at the health facility level. They also organized a training of trainers for health workers.
- 2. Extension phase.** This phase was planned to cover 100 health facilities in Kinshasa in Q4 of 2022.
- 3. Third phase.** This phase is expected to cover at least 3 health provinces and is planned for 2023.

During Q4 of 2022, a situational analysis of the pilot phase was conducted by the NTP and the provincial TB coordination (CPLT) of Kinshasa, with the support of a national consultant. A supervision guide was elaborated and used during the field visits and a meeting was organized with all 30 health facilities to discuss and validate the results.

This report presents the results obtained in the 30 pilot health facilities in Kinshasa from January to September 2022.

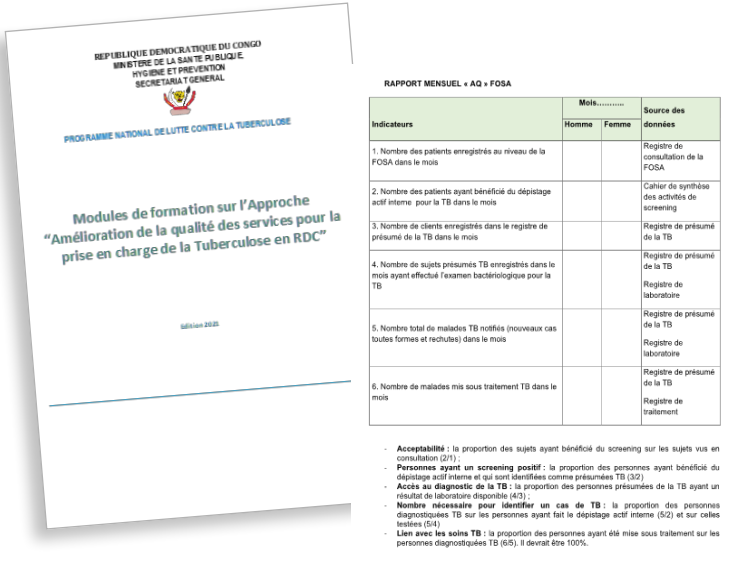
**Results**

In October and November 2021, the NTP organized a training of 60 trainers (2 for each health centre of the pilot phase) and 600 health workers (20 for each health centre). The training included 10 modules. Using the consultation registers in each entry point of health facilities, health workers were trained to note if the TB screening was done and if it was positive. The PQE focal point in each health facility is responsible for the month-ly report with the support of the provincial coordination and the NTP.

During the pilot phase, 56% of the people registered (78,072 out of 138,626) were screened for TB. Among the screened people, 26% (20,133) were declared TB presumptive. Among the 20,133 presumptive people with TB referred to the laboratory, 76% (15,318) carried out the TB diagnostic test (microscopy or GeneXpert), while the remaining 24% of them didn't, even though the test was free. One explanation for this is that because health workers did not only ask them about taking a TB

**Figure 1:** PQE validated training materials and the monthly report template

Source: National TB Program



test, but also asked about other exams that were not free, patients may have become discouraged given that they could not afford the total bill. To mitigate this, ca-shiers would have had to explain to the patient that they could take the TB test even if they did not have money to pay for the others exams.

The total number of people with TB notified among the 15,318 people who tested for TB was 5,552 (36%) in the 30 pilot health facilities. This result should be considered by the NTP to improve TB screening among people at- tending the entry points of the health centers. A total of 259 patients (5%) did not start on TB treatment in the health facilities where the diagnosis was done, but were referred in another TB center near the patient's domicile. Unfortunately, with the system in place, it is not possible to know how many of these referred people started TB treatment. However, supervisors advised TB focal points to note all the referred persons in a separate book, in-cluding if they were on treatment.

When the data was disaggregated by sex, it confirmed the predominance of TB in men. Although men were less numerous among the people registered at the health facilities, men with TB represented 57% of all TB cases, with a male-to-female ratio of 1.5.

**Figure 2:** Results obtained in the 30 pilot health facilities implementing the PQE approach from January to September 2022

Source: National TB Program

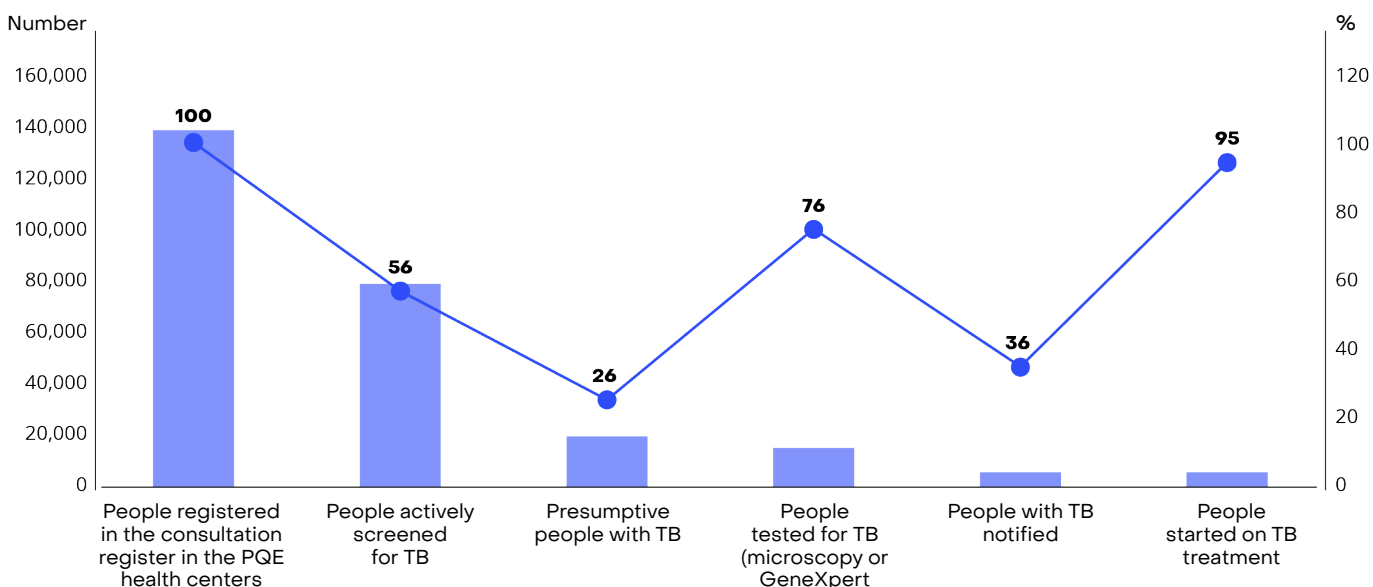


Table 1 below presents the TB cascade by entry point: general, antenatal and pre-school, nutrition, HIV, urgency, internal medicine and pediatric. Of note, 59.5% of the patients were registered in the general consultation

while internal medicine, pediatric and urgency notified 4.6%, 3.4% and 2.7% people with TB out of the total TB cases in the health facilities, respectively.

**Table 1:** Results obtained in the PQE 30 pilot health facilities by entry point

Source: National TB Program

Entry points	People registered in the consultation register n (%)	People actively screened for TB n (%)	Presumptive people with TB n (%)	People tested for TB (microscopy or GeneXpert) n (%)	People with TB notified n (%)	People with TB started on TB treatment n (%)	Contribution to TB notification by entry point (%)
General consultation	82,635 (59.5)	51,222 (62.0)	16,176 (31.6)	12,544 (78)	4,822 (38.4)	4,590 (95.2)	86.9
Antenatal consultation	13,508 (9.7)	5,627 (41.7)	512 (9.1)	269 (53)	25 (9.3)	25 (100)	0.5
Pre-school consultation	25,598 (18.5)	10,341 (40.4)	540 (5.2)	346 (64)	18 (5.2)	18 (100)	0.3
Nutrition	1,640 (1.2)	1,305 (79.6)	111 (8.5)	92 (83)	21 (22.8)	17 (81.0)	0.4
HIV	528 (0.4)	502 (95.1)	284 (56.6)	202 (71)	71 (35.1)	64 (90.1)	1.3
Urgency	2,860 (2.1)	2,457 (85.9)	678 (27.6)	500 (74)	151 (30.2)	149 (98.7)	2.7
Internal medicine	3,432 (2.5)	2,443 (71.2)	1,039 (42.5)	869 (84)	256 (29.5)	252 (98.4)	4.6
Pediatric	8,425 (6.1)	4,175 (49.6)	793 (19.0)	496 (63)	188 (37.9)	178 (94.7)	3.4
<b>Total</b>	<b>138,626</b>	<b>78,072</b>	<b>20,133</b>	<b>15,318</b>	<b>5,552</b>	<b>5,293</b>	<b>100.0</b>



National TB Program

Mentorship and supervision visit at the CDT Kimia

When the NTP compared the number of TB cases notified in the 30 health facilities from January to September, 2021 (before the intervention) with January to September, 2022 (during the intervention), the number of notified TB cases increased from 3,696 to 5,552, or 1,856 additional cases (50.2%) were attributable to the PQE intervention.

**Lessons learned and next steps**

In this pilot phase, the PQE approach implemented in 30 health facilities in Kinshasa has demonstrated measurable successes, resulting in consistent data availability and improvements in active case finding indicators. The positive results generated during the pilot motivated efforts to roll-out the PQE approach in Q4 2022 and in 2023. Key lessons have included the following:

- Screening of TB in the other departments/entry points in the health facilities has improved detection of additional cases of bacteriologically confirmed tuberculosis.
- Monthly meetings for data analysis and self-assessment of TB performance in the health facilities, with

the participation of the managers of the various entry points, is a path towards adoption of the PQE approach in the health centers.

- TB training of the health staff of the other services/entry points (e.g., general consultation, prenatal consultations, nutrition, emergencies, pediatrics and internal medicine) has contributed to the increase in performance of the health centers.
- Monthly TB reporting templates by the health facilities showed the contributions of each service/entry point in TB notification and are useful tools to analyze the performance during supervision and mentoring visits.
- The identification of presumed TB among people who consulted for other reasons in the health facilities can contribute to finding missing people with TB.

Although implementation challenges remain, the strategies and approaches applied have proven to be effective. Current plans include scaling-up in 100 health facilities in Kinshasa in 2022 and two other provinces in 2023 for more impactful results on a larger scale.

## CASE STUDY: Conducting a Community, Rights and Gender (CRG) Assessment in Mali

### Background

Since 2012, Mali has faced political instability and a security crisis that has negatively impacted access to quality health care services. The poverty rate has increased from 42.5% in 2019 to 44.4% in 2021, with 375,000 additional people living in extreme poverty (World Bank). The density of health workers is one of the lowest in the world: 0.52 per 1,000 inhabitants against the 2.3 per 1,000 inhabitants recommended by WHO. The TB incidence rate was estimated at 50 [32-72] cases per 100,000 inhabitants, with a mortality of 7.5 [4.4-11] deaths per 100,000 inhabitants among HIV-negative people. The TB treatment coverage in 2021 was estimated at 66% (46-100), with about 3,700 missing TB people every year (WHO Global TB Report, 2022). The national TB response is centered on integrating TB control into primary health care, and in community health centers (CSCOM), in particular. In Mali, 82 TB diagnostic and treatment centers (CDT) and 1,394 CSCOM, in theory, offer TB treatment follow-up, but the main obstacles and barriers for access to TB care are not well understood. Further data is needed to develop interventions aimed at increasing the effectiveness of the TB response in Mali.

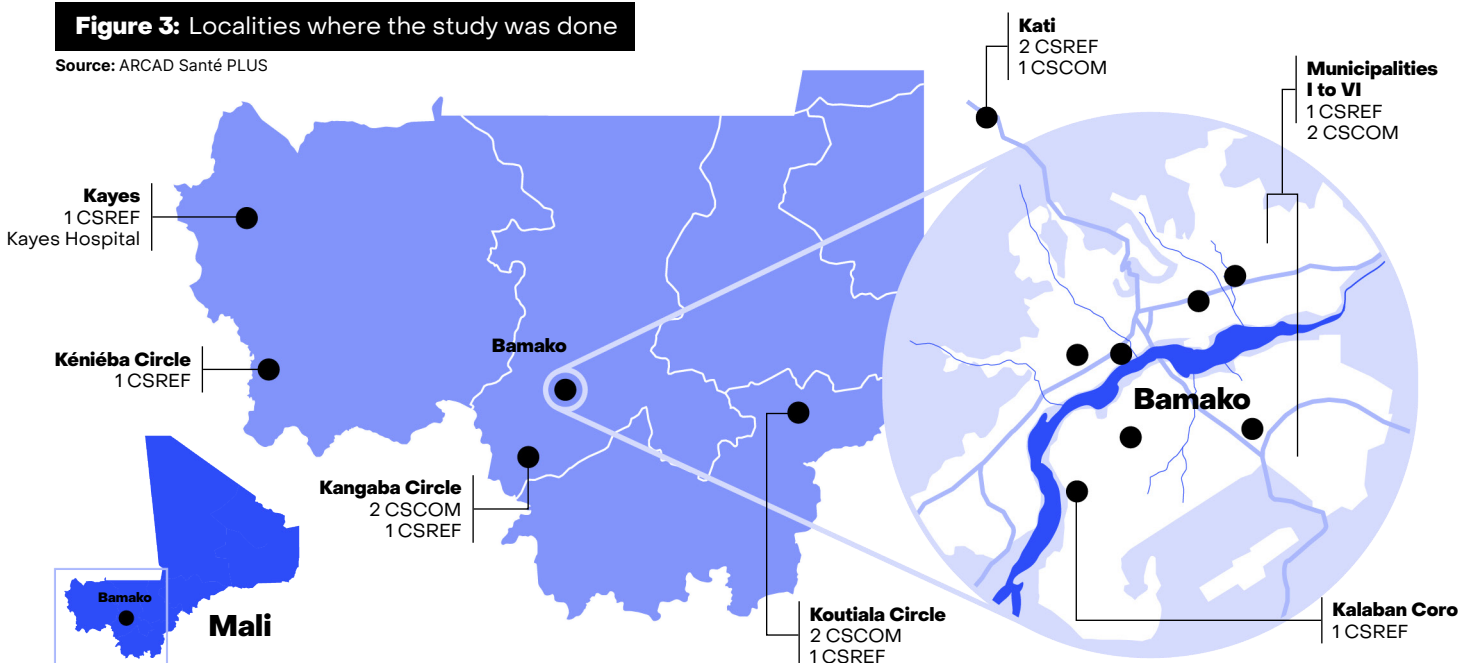
### Implementation

The Community Research Department of ARCAD Santé PLUS in partnership with the Institute of Research for Development (IRD/UMR1252 SESSTIM) carried out a community, rights and gender (CRG) assessment to identify the structural and individual factors that hinder or promote access and retention in care. The study was conducted in the District of Bamako and in the regions of Koulikoro, Sikasso and Kayes between April and July 2022 (Figure 3). A mixed approach using qualitative and quantitative techniques was used. Data was collected at three levels:

1. **Governmental and institutional:** 32 individual interviews
2. **Health facilities:** 18 CSCOM, 12 referral health centers (CSREF), 1 regional hospital and 1 university hospital
3. **Vulnerable and key populations, people with TB and their contacts:** 20 focus groups with drug users, men who have sex with men (MSM), sex workers, displaced, refugees and migrants people, people with diabetes, people with TB, people living with HIV (PLWHIV), parents of children with TB, family or relatives of people with TB, incarcerated persons, mine workers; a quantitative survey of 408 persons with TB (in TB centers and in prison) and 20 individual interviews with persons with TB who declared situations of stigmatization and/or discrimination during the quantitative survey.

**Figure 3:** Localities where the study was done

Source: ARCAD Santé PLUS



**Results**

**1. Governmental and institutional level:**

Stakeholders highlighted the progress in the reduction of vertical programs regarding the evolution of the TB programme in Mali. The creation of a single institution for HIV, hepatitis and TB (i.e., institutionalization) supports integrated policies that should enable optimization of resources (human and financial) and program effectiveness. However, they highlighted important needs that are required to ensure program effectiveness. These included strengthening health systems by improving infrastructure and technical platforms, particularly at the lowest level of the health pyramid and improving financial sustainability mechanisms aimed at

gradually reducing dependence on donors. There is also a need for evidence-based adaptation of health programs. For example, that TB diagnosis and care is free is perceived as a sufficient element to guarantee access to TB care. However, these programs fail to account for financial difficulties of patients and needs that might modify their behaviour with a potential negative impact on the management of their disease. The adoption of new recommendations on TB diagnosis and treatment and the development of communication messages focused on symptom identification (e.g., there is very little information on prevention) were also cited as critical. Finally, it was noted that poor planning resulted in a shortage of drugs at the health facility level.

*"To offer TB diagnosis, a technical platform is required. You need well-equipped laboratories."*  
(Community actor)

*"The fact of integrating TB, HIV and Hepatitis programs was a notorious decision. Because usually things go hand in hand. When you see a person with HIV you must necessarily look for TB. When you see a TB patient, you have to look for HIV."* (Caregiver)

*"The design of the program often does not take into account the real concerns. We do not do an in-depth community diagnosis to develop an action plan. When you design, you certainly come with your plan, your financing, your execution plan, but does that take into account the real needs? ..."* (Caregiver)

*"The drying up of certain sources of funding means that some activities are a little on hold with the difficulty of being able to organize missions, studies."* (Decision-maker)

From a legislative point of view, aside from the document produced in 2018 about the normative framework for TB care, there are few texts directly related to TB. Existing laws refer to human rights, general healthcare services delivery and other operational aspects such as border control or norms for the management of specific populations (e.g., refugees, miners). However, these laws are rarely concerned

with TB-specific aspects. Indeed, the legal dimension is misunderstood by decision-makers, caregivers and community actors. Patients' recourse to justice is perceived as something rare in the Malian context. In addition, there are opposing views on the importance of gender. This highlights a potential source of gender inequality, in particular through the lack of knowledge on this subject.

*"... the right to health is a common right... Based on this, I believe that the gender issue is a good thing... these laws make it possible to facilitate the conditions of access to care for everyone."* (Caregiver)

*"But I don't need to go through the texts, ... the notion of gender frankly I don't know what it's for."* (Decision-maker)

*"In relation to the laws [protecting patients] it seems to me that there is a charter, the patient's charter [with guidelines for care delivery to patients]. [In general] I have no information on the laws. We can pass."* (Decision-maker)

*"Yes, even if they exist, I don't know them..."* (Community Actor)

*"Yes, the laws, the measures, I heard about that during our training..."* (Caregiver)

*"Anything that relates to the legal, I will not be able to answer these questions."* (Decision-maker)

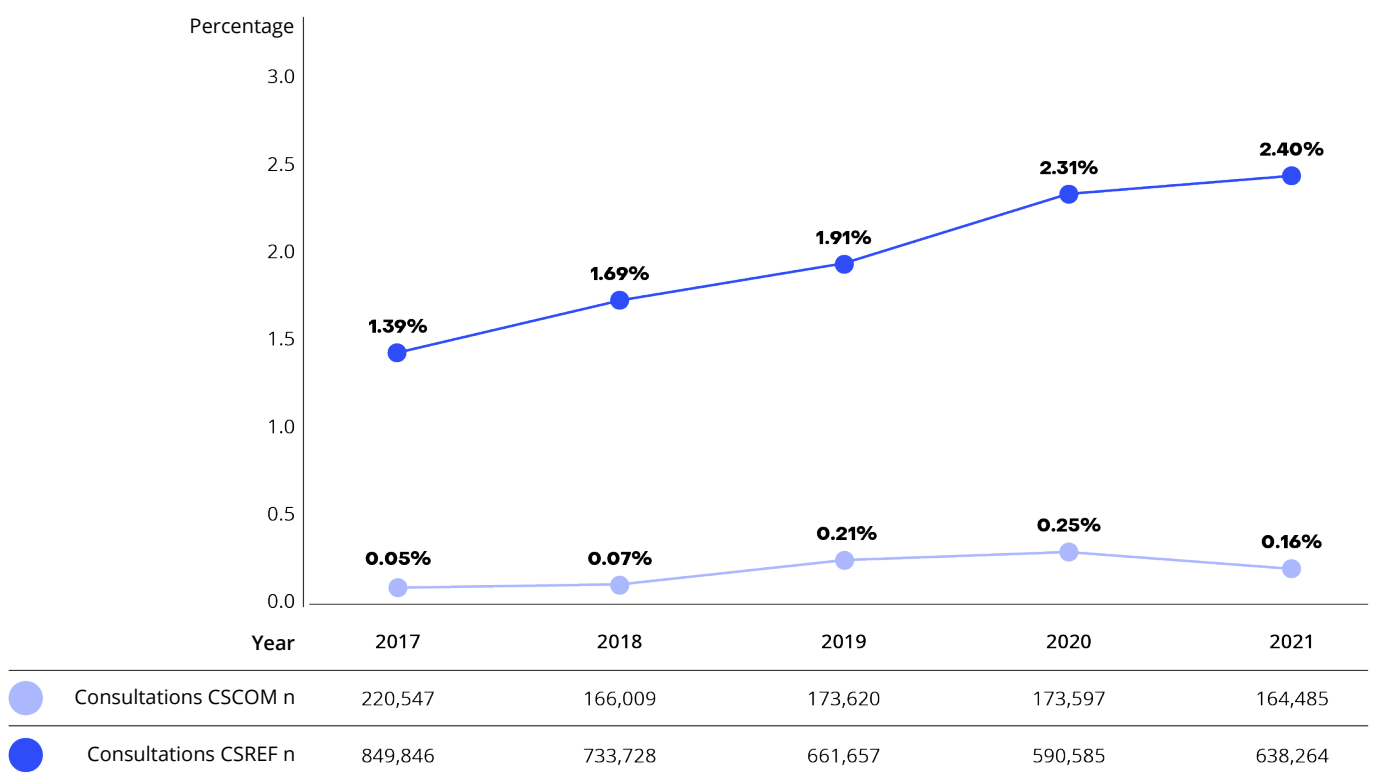
**2. Health facility level:**

TB care is not fully integrated into the community health centers. In the referral health centers, TB screening activities are also limited compared to the curative consultations. This is mainly due to the lack of an adequate technical platform, limited basic

equipment as well as a lack of infrastructure and human resources. Figure 4 shows TB screening as a proportion of the total curative consultations in the CSCOM (0.16% in 2021) and in the CSREF (2.4% in 2021).

**Figure 4:** TB screening as a proportion of the total curative consultations in the CSCOM and in the CSREF (aggregated data)

Source: ARCAD Santé PLUS



Although most of the centers selected for the study indicate that they provide HIV services, only half offer HIV counselling and testing and ARV treatment among TB-HIV patients. The majority of community health centers offer inadequate services to TB patients. In addition, community-based and psychosocial support services are often lacking

at all levels of the health pyramid. Figures 5 and 6 present the TB services offered to the population in the 32 health facilities included in this assessment. Community health workers (CHWs) play a very limited role in TB care activities. Finally, TB drug shortages were declared by most structures during the April 2021 – March 2022 period.





**3. Vulnerable and key populations, TB patients and their entourage:**

While the vulnerable and key populations interviewed had heard of TB, few of them knew the main causes and symptoms. In addition, they highlighted: 1) a lack of information guiding them to TB services; 2) insufficient organization of health facilities; 3) a lack of adaptability to the needs of HIV key populations; 4) the notion of free service, which should include psychosocial and other support.

The quantitative survey involved 408 TB patients, 390 adults and 18 children. Half of the adults were between 18 and 35 years, while 44% had no instruction level. Mental health, self-esteem and quality of life, including sexual health, had deteriorated since TB diagnosis for most patients interviewed. Half of them faced expenses associated with TB care that led to a “catastrophic” financial situation. Ignorance

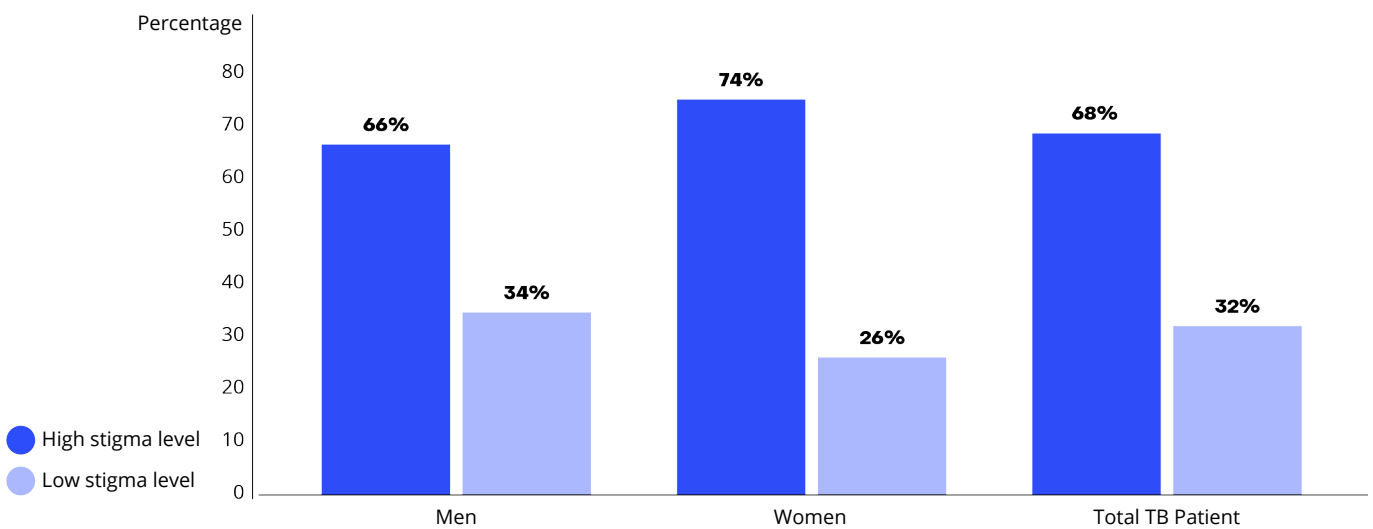
*“Some of us are not well considered in some health facilities, so we want to be tested where we are considered.” (Sex worker at the focus group)*

*“There are great difficulties in accessing these services. The first difficulty is to be aware of the existence of the TB service in order to be able to search for it.” (Injecting drug user at the focus group)*

of patient protection laws and human rights concerned 90% of TB patients. Figure 7 shows that 68% of the TB patients in the study perceived strong stigma associated with TB (66% for men and 74% for women). Most TB patients raised concerns about confidentiality when talking with caregivers. TB is perceived as a disease that has many consequences on the patient’s relationship with their family, social and professional environment, including with caregivers.

**Figure 7:** Stigma level declared by the patients disaggregated by sex (n 390)

Source: ARCAD Santé PLUS



Most of the participants in the quantitative survey were not aware of any laws or human rights protecting them. In addition, most of participants in the qualitative survey did not seem in favour of denouncing practices of stigmatization and discrimination. This lack of both awareness of and

interest in laws/human rights could be explained by a perceived difficulty in finding a viable solution in the case of litigation related to healthcare services. Indeed, participants in the qualitative survey often noted that complaints addressed to the authorities were not considered and no action was taken.

**Family**

*"It was very hard for me with the family of my husband.... I slept alone with my children and when I felt bad I called only my sister-in-law... As she is a health worker, she gave my injections and told me the medication to take. My husband did not come into my room or look at me or ask me about my health..."*  
(Woman with TB)

**Community**

*"I was coughing, I was vomiting, my whole body had changed color. So all my friends abandoned me, even if I fell, some did not touch me."*  
(TB patient)

**Health Facility**

*"But what the health worker did to me, that's what really hurt me. Otherwise, some may be stigmatized in the family, others in the workplace or in the community, but for me it was at the health center. And it was my caregiver who did this to me...He tried to say that I was badly brought up...he doesn't know me, why he can say that I am badly brought up."*  
(TB patient)

**Lessons learned and next steps**

This study highlights important barriers to accessing quality TB prevention and treatment services in Mali. They mainly include the availability of TB services and their capacity to offer quality care; weaknesses in people-centred care approaches; limited health staff with adequate training; high levels of stigma; limited knowledge about laws and patients' rights and low interest in gender considerations by institutions. To improve the number and quality of TB services at the health facilities, it will be critical to work with the civil society to:

1. Upgrade laboratory facilities at the CSCOM level to improve the decentralization of TB services;
2. Promote task-shifting at the community level (e.g.,

in HIV programs) to optimize human resources for health;

3. Improve knowledge about gender and human rights among program staff, health workers, community health workers and communities;
4. Adopt a specific text to fight against discrimination/stigmatization related to gender in the response to TB;
5. Develop support from human rights associations, as well as justice institutions.

These results were presented during a national workshop and will be considered during the intervention prioritization in 2023 and during the next Global Fund grant cycle.

# 3. Other Updates

## Upcoming Meetings

### Peer-review workshops for Global Fund proposals, Thailand and Kenya

In order to support countries to apply for funding for the Global Fund 2023-2035 cycle GC7, two workshops are being organised from 13-15 February and 21-23 February in Bangkok, Thailand and Nairobi, Kenya, respectively. Specifically, the interactive workshops are designed to support countries to review and strengthen their draft funding request proposals before final submission to the Global Fund. Through peer-to-peer and expert review, self-assessment and country dialogue, participants will be able to identify bottlenecks, prioritize cross cutting investments and develop more coherent, robust requests that address urgent country needs.

### Stop TB Board Meeting

Stop TB Partnership will hold its board meeting from 25-26 March, in Varanasi, India.

# 4. Voices

“*ARCAD Santé plus is Mali’s Prime Recipient for the integrated TB/HIV community activities. The organization is responsible for setting up mobile intervention strategies to reach communities that do not have easy access to health centers. Regular screening campaigns in prisons, as well as among internally displaced populations linked to the security situation in Mali, facilitate the identification of people with TB. For each TB patient diagnosed, a contact investigation is carried out by community actors in the household to identify relatives with symptoms or eligible for TPT. This year, we performed an assessment of the obstacles and limitations to vulnerable people’s rights in the TB response and we will develop an intervention plan. The community approach is an essential component to identify missing TB people and we must work to maximize the complementarity between national programs and community-based organizations.*”

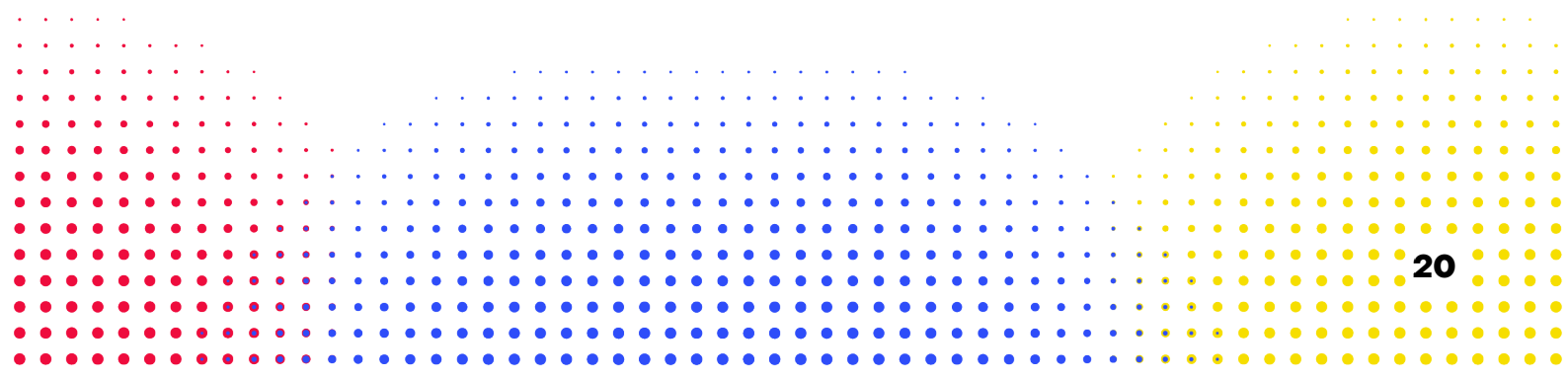


**Dr Dembele Bintou Keita, MD, MPH ,**  
**General Director,**  
**ARCAD Santé plus, Mali**

“*Civil society organizations and communities are now even more organized and capacitated in the fight to end TB if provided the necessary financial resources. And for the UNHLM 2023, I urge UN Member States to be bold and very ambitious in the key ask if we are to end TB by 2030.*”



**Austin Arinze Obiefuna,**  
**Vice Chair,**  
**Stop TB Partnership**





The Global Fund/Vincent Becker

### About the TB Strategic Initiative

The **TB Strategic Initiative**, funded by the Global Fund and implemented by the Stop TB Partnership (Stop TB) and the World Health Organization (WHO), has been working with national TB programs and partners since 2018 to stop the spread of TB and reach the global goal adopted by world leaders to end TB by 2030. This ambitious joint effort, initially launched in 13 countries, aims to address specific barriers to finding missing people with TB, especially among key vulnerable populations, through a combination of innovative approaches, knowledge-sharing and best practices. Now in its second phase (2021-2023), the TB Strategic Initiative will catalyze further efforts to find and successfully treat people with TB facing barriers and that are currently missed at different points in the TB care cascade in 20 priority countries.

