

Guidance Note

Matching Funds TB 2020-2022 Funding Cycle

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GENEVA, SWITZERLAND

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1. Introduction

1.1 Purpose of this document

This document provides strategic guidance to applicants who are eligible for additional catalytic **Matching Funds** beyond the allocation amount for the 2020-2022 allocation period.

The purpose of this document is also to:

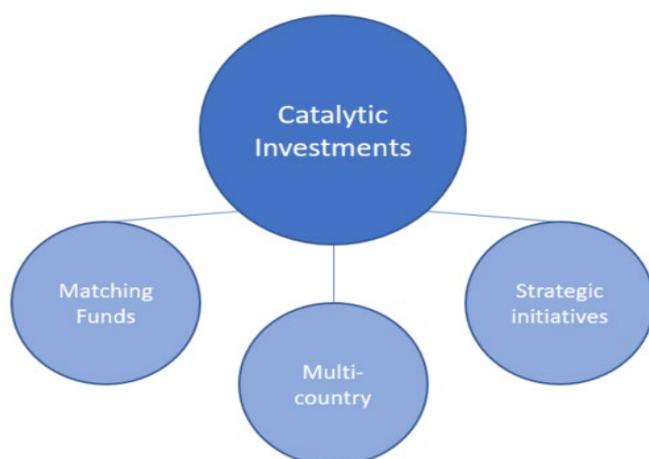
- Provide further operationalization details to the operational policy note on [design and review of funding requests \(for the 2020-2022 allocation period\)](#);
- Outline the various conditions for accessing Matching Funds in each “strategic priority area”;
- Make recommendations for the programming of Matching Funds and the focus of the investments which the Technical Review Panel (TRP) and Grant Approvals Committee (GAC) will consider in their review; and
- Provide lessons learned related to Matching Funds from the 2017-2019 funding cycle.

1.2 Background

For each funding cycle, the Global Fund sets aside a portion of resources additional to country allocations referred to as catalytic investments in order to address issues which cannot be adequately addressed by the country allocations alone. In the 2020-2022 funding cycle, the Global Fund has set aside US\$890 million, comprised of three categories:

- **Matching Funds:** these funds are available to selected countries to incentivize the programming of the country allocation towards key strategic priorities, in line with the Global Fund Strategy 2017-2019: Investing to End the Epidemics (the “Strategy”) and partner disease strategies;
- **Multi-country approaches:** these funds are available to target a limited number of critical, pre-defined areas to meet the aims of the Strategy and are best addressed through a multi-country approach; and
- **Strategic Initiatives:** these limited funds are available for centrally managed approaches for strategic areas that cannot be addressed through country allocations due to their innovative, cross-cutting or off-cycle nature, but are critical to ensure country allocations deliver against the Strategy.

Diagram 1: The three categories of catalytic investments



Matching Funds are designed to inspire innovation and ambitious evidence-based programming approaches. The **strategic priority areas** for Matching Funds are:

- HIV prevention: Adolescent girls and young women in high prevalence settings
- HIV prevention: Scaling up community-led key population programs
- HIV prevention: Condom programming
- HIV: TB preventive treatment for people living with HIV, with a family approach
- TB: Finding missing people with TB
- TB: Strategic engagement in Western and Central Africa
- Cross cutting: Programs to remove human rights-related barriers to health services

Subject to funding confirmation, there are two possible additional priority areas:

- HIV prevention: Differentiated HIV service delivery - Self-testing
- Resilient and sustainable systems for health: Data science in community health

Table 1: Summary of Matching Funds strategic priority areas

HIV Prevention	Adolescent girls and young women in high prevalence settings
	Scaling up community-led key population programs
	Condom programming
	Differentiated HIV service delivery - Self-testing (subject to funding confirmation)
HIV	TB preventive treatment for people living with HIV, with a family approach
TB	Finding missing people with TB
Cross-cutting	Programs to remove human rights-related barriers to health services
RSSH	Data science in community health (subject to funding confirmation)

1.3 How to Access Matching Funds

Matching Funds may be available for countries based on the following considerations:

- (i) critical gaps with respect to the strategic priority areas in line with epidemiological context and evidence; and
- (ii) potential for catalytic impact (i.e. potential to achieve results beyond a proportional increment to the country allocation).

Countries eligible for Matching Funds were notified in their **allocation letter**. In order to apply and access Matching Funds, applicants will need to integrate interventions for their country allocation and the Matching Funds in their funding request to the Global Fund (see [application materials](#) for funding request as well as the [operational policy note on design and review of funding requests](#)).

In order to operationalize Matching Funds, countries are eligible to receive **technical assistance through Strategic Initiatives**. The details on how to access this support will be communicated at a later stage.

1.4 Matching Funds: Lessons Learned from the 2017-2019 Funding Cycle

Based on lessons learned from the 2017-2019 funding cycle and given the significant scale up in the 2020-2022 allocation, the GAC with input from Partners provided strategic direction to ensure approaches leverage the increase in allocations to push for stronger results, maximize impact and avoid complacency. To improve efficiency and underpin impact, **applicants are strongly encouraged to submit their Matching Funds application together with their allocation funding requests**.

1.5 Technical Review Panel's (TRP) Lessons Learned from the 2017-2019 Funding Cycle

In their [2017-2019 observation report](#), the TRP made the following recommendations for applicants with respect to matching funds applications:

- Applications should avoid presenting non-prioritized lists of programs and interventions in Matching Funds requests and should rather present a coherent investment approach with a limited number of interventions intended to achieve high impact.
- Applicants should use an evidence-based approach for Matching Funds requests or present a pilot for an innovative approach designed to be scaled-up based on findings.
- When substantial amounts are invested, or innovative ideas proposed, indicators to measure the additional program effect resulting from the matching funding should be identified.
- **Matching Funds requests should be submitted with allocation funding request** to maximize the opportunity for impact during the implementation period and support efficiency in the application and review processes.

2. TB Preventive Treatment (TPT) for People Living with HIV, with a Family Approach

2.1 Background

TB remains the leading cause of death among people living with HIV (PLHIV). Ending TB transmission in institutional, community and household settings are critical to achieving the goal of reducing by 90 percent the TB incidence rate by 2030. Achieving this rate will require substantial reductions in the progression from latent TB infection (LTBI) to active TB disease among approximately 1.7 billion people already infected worldwide. Currently, TB preventive treatment is one of the three major categories of health care interventions available for TB prevention, the other two being prevention of transmission of Mycobacterium tuberculosis through infection prevention and control, and vaccination of children with the bacille Calmette-Guérin (BCG) vaccine.

TB preventive treatment (TPT) is a high-impact intervention critical to reducing the burden of TB and achievement of the global targets. WHO recommends systematic testing and TPT for PLHIV, household contacts of bacteriologically-confirmed pulmonary TB cases and clinical risk groups (in all countries). In most countries however, people eligible for TPT are not receiving care. The TPT coverage among people newly enrolled in HIV care and children aged under 5 years was 49 percent and 27 percent respectively in 2018.

The United Nations High Level Meeting (UN HLM) Political Declaration on TB contains several ambitious targets for TB prevention for those most at risk of falling ill. This includes rapid scale-up of access to testing and provision of TPT for at least 30 million people by 2022 of which 6 million are PLHIV and 4 million are children aged under 5 years who are household contacts of people affected by TB. In addition, target 3.3 of the sustainable development goal 3 (SDG 3) calls for ending the epidemic of TB (AIDS and malaria) by 2030. Such targets will not be met without scaled up comprehensive strategies to prevent, diagnose and treat people with TB.

2.2 Principles and rationale

The main objective of the TPT Matching Funds strategic priority area is to scale-up TB preventive therapy among PLHIV and children under 5 years who are in contact with PLHIV with TB. It was developed through extensive consultation with key partners including WHO, PEPFAR, Stop TB, UNAIDS and other stakeholders.

Countries were selected based on high TB/HIV burden, complementarity with other strategic initiatives and projects to maximize results and/or presence of particular epidemiological situations such as high resistance to isoniazid (INH) and where use of once-weekly isoniazid-rifapentine for 12 weeks (3HP) use could be an added value.

2.3 Access conditions

To access the additional funds indicated in the allocation letter for the TPT Matching Funds strategic priority area, eligible countries are to meet the following condition:

A country must invest a portion of its HIV allocation that is greater than or equal to the amount of available Matching Funds in programming for TB preventive treatment for People Living with HIV with a family approach.

2.4 Programmatic conditions

In addition to the standard conditions outlined above, applicants should program their Matching Funds for TPT in line with the focus of investments and programmatic considerations outlined below. Through their review, the TRP will confirm whether these programmatic priorities have been addressed and recommend accordingly to the GAC.

The Matching Funds should be operationalized consistently with the following principles:

- Funding earmarked to support innovative strategies/approaches to scale up TPT among PLHIV and children under 5 years that are contacts of a PLHIV with TB.
- A corresponding increase in programmatic targets for TPT among PLHIV and for children under 5 years anticipated through both the increased use of country allocations and use of Matching Funds for this strategic priority area.
- Foster collaboration with other partner's initiatives focusing on scaling up TPT such as IMPAACT4TB, TB REACH and PEPFAR supported initiatives.

2.5 Investment Focus

Illustrative interventions and activities are listed below (these are further elaborated in the [TB Information Note](#)), which can be adapted or expanded depending on the country contexts and TB epidemiology:

- **Dialogue and collaboration between the National AIDS program (NAP) and the National TB program (NTP) are encouraged:** HIV programs should take ownership of TPT provision among PLHIV as part of a routine package of care for PLHIV. This should be done in collaboration with TB programs. This shift of responsibilities to the HIV program should also include funding of commodities and overall oversight.
- **Priority interventions to high-risk groups:** Countries should also include treatment of TB infection in their list of priority interventions to high-risk groups such as PLHIV and household contacts of people with pulmonary TB (especially children under 5). National HIV and TB guidelines should be updated to include new regimens as well as updates on drug-drug interactions and innovative technologies.
- **Intensified TB screening and diagnosis at health facilities and community:** People living with HIV should be systematically and routinely screened for TB at health facilities. Screening for TB should be conducted at different departments/units of health facilities, including among attendants of out-patient departments, specialized clinics such as HIV, diabetes, mental health, maternal and child health clinics and patients admitted to in-patient wards. All health workers, and not only those who work in TB units, need to be sensitized and involved. Systematic screening of PLHIV should also take place through outreach and community-based approaches. If a PLHIV is diagnosed with TB, this needs to be recorded and the individual should be started on TB treatment immediately. Following WHO recommendation, lack of access to chest x-ray, tuberculin skin test (TST) and Interferon-Gamma Release Assay (IGRA) should not be a barrier for initiation of TPT. Patients with TB/HIV should also be started on ART and on cotrimoxazole prophylaxis if they are not already receiving it.

- **Prevention and treatment of TB Infection:** Screening of PLHIV should aim to both, diagnose additional people with TB and serve as an entry point to provision of TPT for PLHIV without active TB disease. Contacts of PLHIV diagnosed with TB (children under 5 years) should be routinely traced and evaluated to rule out active disease. Those contacts without active disease should be offered TPT.
- **TPT regimes:** Countries should use the TPT regime that best suits their needs and are encouraged to consider the resistance patterns of their TB epidemic to choose between available regimes. Other issues that countries should consider before choosing the regimes are their side effects, benefits in adherence, and cost. Countries are encouraged to use the additional funds to complement and expand on the work of other projects or initiatives such as IMPAACT4TB, PEPFAR, and others.
- **Approaches to accelerate the scale-up of TPT:** In the past, countries such as Kenya and Uganda have successfully rolled out 100-day plans to rapidly increase uptake of TPT with successful results. If applicable, countries can adapt these methods to their own settings. For further reference see Kenya’s experience in “Assessment and best practices of joint TB and HIV applications. Progress, challenges and way forward.”
- **Improving access to TPT:** The underserved and vulnerable will require extension of service delivery points beyond the traditional health facilities. Depending on the setting, this approach will require effective use of community systems, community-based health workers and mobile clinic approaches. Differentiated models of care should be considered in order to effectively deliver TPT, especially to key populations. Key population groups that are underserved or face specific barriers should be prioritized. Barriers may also include gender, stigma and legal issues that should be assessed and addressed.
- **Psychosocial support:** people taking TPT should receive appropriate counselling, follow-up and support (digital health technologies can also be used).
- **Supply chain:** Forecasting and procurement of TPT regimens for PLHIV should be completed via the HIV supply chain.
- **M&E:** Whereas a separate monitoring and evaluation framework for catalytic funding is not required, countries should have corresponding increase in programmatic targets and coverage. Results will be reported via the regular performance framework. The indicators to be monitored are set out in the table below.

Table 2: TB indicators to be monitored

Module	Indicator Code	Indicator	Disaggregation category
TB/HIV	TB/HIV-7	Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period.	Age (U5, 5-14, 15+); Gender (female, male), TPT regimen (3HP, 1HP, RIF, 3RH, INH)
TB, care and prevention	TCP-5.1	Number of people in contact with TB patients who began preventive therapy.	Age (U5)

2.6 Strategic Initiative for Technical Assistance for Matching Funds

In order to operationalize Matching Funds, countries may also be eligible to receive technical assistance through Strategic Initiatives. The details on how to access this support will be communicated at a later stage.

3. Finding Missing People with TB

3.1 Background

Finding and diagnosing all people with TB and putting them on treatment is one of the main challenges faced by TB programs. In 2018, 30 percent of all people with TB were “missed” – because they were either not diagnosed/treated or not reported to national programs. The proportion of missed cases is much higher among people with drug-resistant TB (DR-TB) (68 percent), people living with HIV (PLHIV) (44 percent), and children. The missing people with TB contributes to ongoing transmission and slow decline in TB burden.

The missing people with TB tends to concentrate in underserved communities and among key populations. Providing a comprehensive package of care in collaboration with affected communities in high-burden countries will ensure rapid progress in ending TB, by bringing innovative approaches to scale and covering programmatic gaps. The longer the delay in finding the missing people with TB, the longer it will take to reach the global targets.

3.2 Principles and rationale

During the 2020-2022 funding cycle, 20 countries with the largest number (and proportion) of missing people with TB were selected for Matching Funds; these countries contribute to 83% of all missing people globally (see table 3 below).

The main objective of the finding missing people with TB Matching Funds strategic priority area is to find missing people with TB among both drug susceptible (DS) TB and DR-TB. Applicants should scale up successful interventions to find and treat people with TB and implement new and innovative interventions, approaches and ideas beyond business as usual.

3.3 Access conditions

To access the additional funds indicated in the allocation letter for the missing people with TB Matching Funds strategic priority area, eligible countries are to meet the following conditions:

1. For countries allocated Matching Funds for this strategic priority area for the first time in the 2020-2022 funding cycle: Invest a portion of its TB allocation that is greater than or equal to the amount of available matching funds in programming for Finding Missing People with TB.
2. For countries with continuing Matching Funds for this strategic priority area: Satisfaction of condition (1) above and an increase in the allocation amount designated to find additional missing people with TB, compared to the budget levels in Global Fund grants from the 2017-2019 allocation period.

3.4 Programmatic conditions

In addition to the standard conditions outlined above, applicants should program their Matching Funds for missing people with TB in line with the focus of investments and programmatic considerations outlined below.

Countries should show:

- A clear demonstration in the funding request of the additionality to the number of cases notified and reducing the gap of missing cases both for drug susceptible and drug-resistant TB.
- Matching Funds earmarked for scale up of innovative approaches to find missing people with TB through targeted interventions based on the epidemiological profile, country context and lessons learned and not simply top up the allocation.
- Comprehensive approach to finding missing people with TB including improving quality of care and provision of TB preventive treatment for high risk groups.

3.5 Investment Focus

Applicants are strongly encouraged to use a comprehensive package approach that integrates finding missing people with TB, treatment and prevention.

Illustrative interventions and activities are listed below (these are further elaborated in the [TB Information Note](#)), which can be adapted or expanded depending on the country contexts and TB epidemiology:

- **Intensified TB screening and diagnosis at health facilities.** People visiting or already at health facilities are not systematically and routinely screened for TB and this is a missed opportunity to diagnose and treat TB. Screening for TB should be conducted at different departments/units of health facilities, including among attendants of out-patient departments, specialized clinics such as diabetes, mental health, maternal and child health clinics and in-patients. Effective screening and early diagnosis of DS-TB/DR-TB require use of more sensitive screening and more specific diagnostic tools such as X-rays (including digital X-rays with artificial intelligence) and rapid molecular tests.
- **Systematic screening of high-risk groups including through outreach and community-based approaches.** This includes all contacts of people with TB, PLHIV and workers exposed to silica dust, prisoners, migrants and people living in urban slums and remote rural areas. Contacts of people identified with TB should be screened and evaluated to rule out active disease. Those contacts considered not to have active disease should be offered TPT.
- **Eliminate barriers faced by children in accessing TB prevention, diagnostic and treatment services.** TB case detection and provision of TPT among children can be significantly improved by scaling up the implementation of comprehensive child contact management. Strengthening systematic screening of children at the pediatric outpatient and maternal; nutrition and child health departments in both public and private health facilities should be prioritized. Children with TB should receive the new child-friendly paediatric formulation that improves uptake and outcome.
- **Prevention and Treatment of TB Infection.** Ending TB transmission in institutional, community and household settings are critical. Applicants should include TPT in their list of priority interventions to high-risk groups such as PLHIV and household contacts of people with TB. This includes scale-up of the use of the new shorter and safer drugs (such as 3HP and 3RH) including through financial support from domestic sources, Global Fund and PEPFAR.

- **Scale up access and optimize utilization of rapid molecular diagnostic tests and X-rays.** Specimen transportation systems and digital health also need to be strengthened to improve diagnosis as well as communication of results.
- **Universal drug-susceptibility testing and DR-TB diagnosis.** Drug susceptibility testing (DST) needs to be scaled up for both retreatment and new patients, to reach universal coverage levels. In addition, treatment needs to be scaled up to ensure that all diagnosed patients are treated.
- **Address access barriers, including community-based and integrated services.** Scale-up programs to support integrated community and family-based approaches to TB and DR-TB care, and remove access barriers, reduce delays in diagnosis and improve management of TB in men, women, children and adolescents and the elderly.
- **TB/HIV Collaborative activities.** A significant reduction of TB incidence and elimination of HIV-associated TB deaths can be achieved by adopting and scaling up policies that ensure integrated, patient-centered delivery of effective prevention, early diagnosis, and prompt treatment of TB and HIV. This requires intensifying collaboration between TB and HIV programs, integration of TB/HIV services, joint programming, implementation, supervision and monitoring.
- **Engaging the Private Sector in providing TB diagnosis, treatment and prevention services.** In some countries, most of TB patients consult private providers for their TB-related symptoms. Engagement of these care providers in TB diagnosis, treatment and prevention is very critical. Innovative approaches to engage and collaborate with them including through mandatory notification, involvement of interface agents and by providing incentives should be explored and integrated into the effort in fighting TB.

3.6 Strategic Initiative for Technical Assistance for Matching Funds

In order to operationalize Matching Funds, countries may also be eligible to receive technical assistance through Strategic Initiatives. The details on how to access this support will be communicated at a later stage.

Table 3: Countries accounting for majority of missing people with TB/DR-TB globally (in 2018)

	Country	Drug-Susceptible (DS) TB				Drug-resistant (DR) TB			
		Estimated incidence (DS-TB)	Missing people with TB	% missed	Global share of missing cases %	Estimated incidence (DR-TB)	Missing DR-TB cases	% missed (DR-TB)	Global share of missing DR %
1	Bangladesh	357,000	89,857	25%	3.0%	5,900	4672	79	1.6%
2	Congo (DR)	270,000	100,252	37%	3.3%	6,000	5235	87	1.8%
3	India*	2,690,000	696,000	26%	23.2%	130,000	71653	55	24.1%
4	Indonesia	845,000	281,121	33%	9.4%	24,000	14962	62	5.0%
5	Kenya	150,000	55,466	37%	1.8%	2,300	1835	80	0.6%
6	Mozambique	162,000	69,619	43%	2.3%	8,300	7142	86	2.4%
7	Myanmar	181,000	43,028	24%	1.4%	11,000	7521	68	2.5%
8	Nigeria	429,000	325,079	76%	10.8%	21,000	18725	89	6.3%
9	Pakistan	562,000	201,528	36%	6.7%	28,000	24176	86	8.1%
10	Philippines	591,000	219,332	37%	7.3%	18,000	10724	60	3.6%
11	South Africa	301,000	73,001	24%	2.4%	11,000	-2199	-20	-0.7%
12	Tanzania	142,000	67,308	47%	2.2%	1,900	1451	76	0.5%
13	Ukraine	36,000	9,488	26%	0.3%	13,000	6453	50	2.2%
14	Cambodia	49,000	20,380	42%	0.7%	1,000	872	87	0.3%
15	Cameroon	47,000	23,597	50%	0.8%	890	714	80	0.2%
16	Ethiopia	165,000	51,387	31%	1.7%	1,600	859	54	0.3%
17	Ghana	44,000	30,126	68%	1.0%	870	639	73	0.2%
18	Uganda	86,000	30,165	35%	1.0%	1,500	984	66	0.3%
19	Viet Nam	174,000	74,342	43%	2.5%	8,600	5474	64	1.8%
20	Zambia	60,000	24,929	42%	0.8%	3,100	2473	80	0.8%
	All	7,341,000	2,486,005	33%	83%	297,960	184,365	62	62%

*Matching Funds were not allocated to India

4. Finding Missing People with TB: Strategic Engagement in West and Central Africa

4.1 Background

In West and Central Africa (WCA), critical gaps in TB case finding and treatment have contributed to a substantial burden of undiagnosed TB and unsatisfactory treatment outcomes — with regional estimates indicating that more than forty percent of people with TB are unreported or missing, and that 70 percent of countries have treatment success rates that are lower than the global average (see table 4 below).

According to the last [Global TB Report](#), treatment coverage is only 57 percent in WCA and only 20 percent of the 20 WCA countries (i.e. only four countries including Cabo Verde, Senegal, Sierra Leone and Togo) have TB treatment coverage higher than the global average (69 percent). The remaining 16 countries are below the global average, and none have achieved the global targets. In the same year (2018), there were 117,000 missing cases of TB, including 41,284 in Western Africa (WA) and 69,086 in Central Africa (CA). Case-finding in the region is mostly ‘passive’ with limited community engagement.

Despite a gradual expansion of GeneXpert availability and use in the region, access is limited, and sample transport systems remain challenging. The overall health system and the laboratory capacity remains weak in most of the countries. TB case finding among children is poor in the region, as approximately three quarters of children remain undiagnosed. Only 7.8 percent of the TB cases in 2018 were children (0 to 14 years old). Furthermore, rates of underdiagnosed and undertreated MDR/RR-TB are very high, with only 17 percent of patients with DR-TB diagnosed and treated in 2018.

The region has also some of the lowest indicators for treatment success. Compared to the global average (success rate of 85 percent) only Benin, Burundi, Cabo Verde, Guinea, Senegal and Sierra Leone have higher treatment success rates. The poorest treatment outcomes are in the cohort of patients co-infected with HIV (14 percent versus 5 percent of mortality compared to HIV negative).

4.2 Principles and rationale

The aim of this priority area is to implement and scale up innovative interventions to improve TB indicators in five countries: Burkina Faso, Chad, Congo, Mali and Niger. The proposed countries for this initiative were selected based on a combination of factors including:

- (i) epidemiological relevance in the region;
- (ii) number of missing people with TB;
- (iii) gaps and opportunities;
- (iv) programmatic aspects; and
- (v) potential for impact.

This initiative is also expected to benefit other countries in the region by generation of local evidence and the dissemination of lessons learned.

Although selected countries are not expected to ‘match’ the funding provided for this initiative through grants or other sources, countries are expected to have corresponding increase in investments in

the interventions supported through this initiative through country grants and other sources of funding. This initiative will be implemented as part of the country grant.

Countries are expected to come up with high impact prioritized interventions which will be supported through this initiative in their funding request, with clear justification and rationale. The interventions will be reviewed by the TRP and those found to be strategic and technically sound will be recommended to the GAC for funding. The final funding per country will depend on the quality of interventions proposed in each funding request. The main objectives are to:

1. Improve quality of TB diagnosis and treatment (e.g. innovative approaches for intensified TB case finding; lab strengthening; enhancing access to rapid diagnostic tools, including effective samples transportation; patient centered approaches, including decentralized and integrated care; etc.);
2. Find innovative approaches for community TB responses (including integrated care);
3. Focus on vulnerable groups, including children and people living with HIV/AIDS;
4. Seek local technical assistance (medium to long term) to support in country operationalization; and/or
5. Strengthen in-country and regional high-level engagement with relevant stakeholders and implementers.

Table 4: Important TB indicators for the selected countries

Indicators	Burkina Faso	Chad	Congo	Mali	Niger
Estimated Missing people with TB in 2018	3505	8922	9294	3111	8361
TB treatment coverage	63%	59%	54%	69%	56%
Global TB treatment coverage	69% global average				
TB treatment successful outcomes	80%	79%	66%	78%	82%
Global TB treatment successful outcomes	85% global average				
% of children notified with TB	3%	7%	8%	4%	4%
% of children notified with TB globally	11%				
MDR-TB treatment coverage	30%	7%	8%	9%	10%
Global MDR-TB treatment coverage	approximately 30% global average				
TB patients tested for HIV	84%	71%	19%	71%	81%
TB patients tested for HIV Globally	in AFRO region average is 87%				
TB/HIV patients on ARV	91%	NA	49%	95%	85%
TB/HIV on ART Globally	in the 30 high TB/HIV burden countries average is 87%				
TB/HIV co-infection rate	10%	17%	28%	10%	4%
Children <5 contact of TB in TPT	25%	NA	NA	3.90%	36%
Global average Children <5 contact of TB in TPT	27%				

4.3 Investment Focus

The list of proposed interventions is indicative, and countries can decide which ones to include depending on their epidemiological context and priorities.

- **Improve quality of TB diagnosis and treatment**

- ✓ **Strategies for intensified TB screening and diagnosis at health facilities level are required** to ensure that people visiting or already at health facilities are systematically and routinely screened for TB and that there are not missed opportunities to diagnose and treat TB and DR-TB.

Screening for TB should be conducted at different “entry points” within the health facilities, including among attendants of out-patient departments, specialized clinics such as diabetes, mental health, maternal and child health clinics and patients admitted to in-patient wards. Effective screening and early diagnosis of TB and DR-TB require the use of more sensitive screening and more specific diagnostic tools such as X-rays (including digital X-rays) and rapid molecular tests. In some countries private health providers may play an important role in TB detection. Engagement of these care providers in TB diagnosis, treatment and prevention is critical. Innovative approaches to engage them can be explored.

- ✓ **Laboratory network strengthening and strengthening access to rapid diagnostic tools** are essential to allow early and accurate diagnosis of TB and DR-TB.

It is necessary to scale up access and optimize utilization of rapid molecular diagnostic tests and X-rays in order to expand access to TB screening and TB diagnosis. Specimen transportation systems and digital health also need to be strengthened to improve diagnosis and prompt communication of results. Activities to be scaled up include drug susceptibility testing (DST) for both retreatment and new patients (to reach universal coverage levels), and access to prompt treatment initiation to ensure that all diagnosed patients are adequately treated. National capacities need to be strengthened to make optimal utilization of the existing diagnostic networks.

Expanding access to TB diagnostic services does not necessarily require massive deployment of diagnostic tools. Specimen referral systems play a critical role in ensuring access to laboratory services by allowing patients to receive care at one location, while their specimens are transferred to various levels of a tiered laboratory system for testing. In this sense, countries should optimize the use of available GeneXpert (place machines strategically in high-volume clinics, improve their sputum transportation system, and others), while at the same time increase the number of machines to diagnose more patients – subject to available resources.

Opportunities may also exist to share GeneXpert machines for other diseases (HIV viral load, HIV EID, Ebola, COVID-19, and others). However, TB should be prioritized for diagnostics, as HIV viral load is mostly used for monitoring treatment. Other new rapid diagnostic technologies recommended by the WHO could also be used.

- ✓ **Prompt initiation of appropriate treatment for all people with DS and DR-TB and adequate patients follow-up.**

Prompt start of the right TB regimen is essential to cut the infection transmission chain within communities and to increase the chance of successful outcomes for the patients.

TB treatment and care should be offered using a people-centered approach (including integrated services and community approaches) and with patient support and ensuring all people with TB/DS-TB/DR-TB, latent TB infection (LTBI) have access to free-of-charge life-saving treatment.

This includes injection-free regimens to all and child-friendly formulations for children with active TB together with appropriate enabler/treatment support. This includes digital adherence technologies (e.g. video observed therapy (VOT)) and follow-up care and support to ensure successful treatment outcome. Appropriate tools to follow-up patients and to monitor drug-safety, and ancillary drugs to prevent/treat possible SLDs side effects, should be accessible when needed. Considering rapid

molecular testing expansion and consequent increase in the number of patients diagnosed with MDR-TB, countries should plan for adequate health services and timely preparation to offer quality DR-TB care.

- ***Scale up Innovative community-based TB interventions***

Successful detection of TB, particularly for at risk and vulnerable populations, requires strong health systems, robust community response for empowerment and social mobilization, and innovative approaches.

Improved and systematic screening of TB among the most vulnerable may require service re-organization, decentralization, integrated service delivery and community approaches to reach all contacts of people with TB, PLHIV, workers exposed to silica dust, prisoners, migrants, nomads and people living in urban slums and remote rural areas. Approaches that worked in some populations or settings can still be adapted and applied to other groups or settings.

Community health workers and community-based service providers may help in finding missing people with TB and improving TB outcomes through patients' follow-up and support. Leveraging and scaling-up these local resources to deliver local and context-specific TB solutions can provide an important opportunity to strengthen critical linkages between health services and local communities.

Community approaches can also support contact tracing and evaluation and provision of TB Preventive Therapy (TPT). New shorter and safer drugs (such as 3HP and 3RH) should be considered for TPT.

- ***Improve TB care and prevention among vulnerable groups, including children and PLHIV***
 - ✓ **Adoption of innovative service delivery models to help eliminate barriers faced by children and other vulnerable populations in accessing TB prevention, diagnostic and treatment services.**

Efforts to increase case finding and to improve patient follow-up and treatment outcomes are necessary both at health facility level (including integrated services) and at community level.

Scale up programs to support integrated community and family-based approaches to TB and DR-TB care, and to remove access barriers, reduce delays in diagnosis and improve management of TB in men, women, children and adolescents, and the elderly. Innovative and "ad-hoc" TB case finding, and treatment support approaches are needed for prisoners and hard to reach populations such as nomads, refugees and others.

TB case detection and provision of TPT among children can be significantly improved by scaling up the implementation of comprehensive child contact management (including community approaches). Strengthening systematic screening of children at the pediatric outpatient, maternal, nutrition and child health departments in both public and private health facilities should be prioritized. Children with TB should receive the new child-friendly paediatric formulations that improve uptake and outcome. New shorter and safer drugs (such as 3HP and 3RH) should be considered for TPT.

- ✓ **TB/HIV Collaborative activities**

A significant reduction of TB incidence and elimination of HIV-associated TB deaths can be achieved by adopting and scaling up policies that ensure integrated, patient-centered delivery of effective prevention, early diagnosis, and prompt treatment of TB and HIV. This requires intensifying collaboration between TB and HIV programs, integration of TB/HIV services where appropriate, joint

programming, implementation, supervision and monitoring, and strong political commitment for the buy-in by TB and HIV Programs.

All TB patients should be tested for HIV and those co-infected with HIV should have prompt access to HIV care and treatment and Cotrimoxazole prophylaxis. HIV services should provide regular TB screening to all PLHIV and those with presumptive TB should be investigated further using the most sensitive and accurate diagnostic tools available. Linkages to TB and HIV care should be ensured and patients' support and follow-up provided to ensure compliance with treatment and monitoring of drugs interactions and safety. Contacts should be evaluated and TPT should be offered when appropriate. Joint TB/HIV community approaches can also help to optimize the use of resources and to increase coverage and impact of community interventions.

- ***Local technical assistance to support in-country operationalization***

One of the key challenges in implementation and scale up of interventions in several countries in the region is that there is not enough local technical expertise to satisfy the demand. Through this initiative, countries can work with local experts to support planning, implementation and monitoring of activities. The expertise can be for medium and long term depending on the needs. This expertise can come from training institutions, universities and other stakeholders in the country

- ***Strengthen in-country and regional high-level engagement***

Although TB is among the top cause of morbidity and mortality in many countries in the region, the disease has not been a priority among high level officials, stakeholders and public in general. Through this initiative, countries should advocate for TB among high-level officials and stakeholders and increase awareness about the disease among the public. Countries should also advocate for mobilization of more resources for TB from domestic sources to support critical TB activities. The initiative should also foster high-level engagement at the regional level.

For more information on priority TB interventions and best practices, see [TB Information Note](#) and documentation on [Best Practices and Lessons Learned from West and Central Africa](#).

4.4 Strategic Initiative for Technical Assistance for Matching Funds

In order to operationalize Matching Funds, countries may also be eligible to receive technical assistance through Strategic Initiatives. The details on how to access this support will be communicated at a later stage.