

Standardized package of community-based support services to improve tuberculosis outcomes

A guide for affected community and civil society organizations, national tuberculosis programmes and policy-makers in eastern Europe and central Asia



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ABSTRACT

Ending tuberculosis by 2030 requires not only strong health systems but also investments in rights-based, people-centred care. This document was developed in the framework of the project Advancing people-centred quality tuberculosis care: TB-REP, which was funded by the Global Fund and designed to support countries in eastern Europe and central Asia in ending tuberculosis through the implementation of a new model of care for early detection of drug-resistance tuberculosis and its treatment. The document pays particular attention to key populations by recommending a set of community-based services to engage and reach vulnerable populations, and to meet the complex and comprehensive needs of affected people. The document recommends engaging affected communities and civil society actors in service delivery along patients' pathways and provides a set of practical tools for the implementation of the standards for community-based, nonmedical services. The services outlined in this guide are meant to support and complement services delivered by health-care providers and shift the focus from medical settings to the needs of people affected by tuberculosis in their community settings. The document can be used by national policy-makers, national programme managers, and community representatives to set up service delivery to affected communities and cost options for implementation purposes.

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KEYWORDS

VULNERABLE POPULATIONS, COMMUNITY HEALTH SERVICES, TUBERCULOSIS, FINANCIAL MANAGEMENT

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ABBREVIATIONS

CRG	communities, rights and gender
CSO	civil society organization
DOT	direct observed treatment
DR-TB	drug-resistant tuberculosis
EECA	Eastern Europe and Central Asia (Region)
Global Fund	Global Fund to fight AIDS, TB and Malaria
IEM	informational and educational materials
LTBI	latent tuberculosis infection
MDR-TB	multidrug-resistant tuberculosis
NGO	nongovernmental organization
NTP	national tuberculosis programme
PPE	personal protective equipment
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2 (causing COVID-19)
TB	tuberculosis
TB-REP 2.0	Tuberculosis Regional eastern Europe and central Asia Project, from the New Model of Care towards Improving DR-TB Timely Detection and Treatment Outcomes in Patients
VST	video-supported therapy

EXECUTIVE SUMMARY

Tuberculosis (TB) is a preventable and curable disease. Many countries around the world provide free diagnosis and treatment for the disease, yet the disease continues to affect over 10 million people every year, and 1.4 million people died from TB in 2019.

The first United Nations High-level Meeting on TB occurred in 2018 and the United Nations General Assembly reaffirmed the commitment to end TB by 2030. Heads of State unanimously adopted a political declaration committing to increase and accelerate national and collective actions and investments to end the TB epidemic. In October 2020 the United Nations Secretary-General outlined the priority recommendations required to accelerate the TB response and reach after receiving a progress report. Among the key recommendations, one emphasized the need to promote human rights and combat stigma and discrimination and another the need to ensure meaningful engagement of civil society, communities and people affected by TB. In December 2020 the civil society delegations to the Board of the Stop TB Partnership released a complementary report (The Deadly Divide) that looked at the status of the declaration's targets and commitments through the lens of affected communities and civil society. Both reports acknowledged that there was still a major divide between the commitments made and the reality of actual achievements and argued that communities must be at the front and centre in initiatives to end TB.

The WHO European Region has made a significant progress in tackling TB infection. Nevertheless, the high-priority countries in the Region still bear a large share of the disease burden, especially of the drug-resistant form (DR-TB), and the Region falls short of achieving the END TB targets.

In Member States of the WHO European Region most affected by TB, care and treatment are mostly seen as centred within the field of medicine. In a centralized vertical TB treatment pathway, patients are navigated from diagnosis to treatment. However, this model misses the opportunity to reach people in key and vulnerable populations and to address the particular challenges and barriers that can prevent them from accessing TB care and support services. Although TB can affect anyone, these key populations are more vulnerable, marginalized, underserved or have increased risk – and if infected with TB, have fewer chances for its detection and successful completion of treatment.

Support services are a group of nonmedical interventions that target the specific and comprehensive needs of communities and individuals with the intention of raising awareness about TB and providing assistance in the timely seeking and accepting of care. They are delivered by trained workers and include nonmedical interventions to support and compliment TB prevention, diagnosis and treatment activities delivered by the medical providers. The provision of support services acknowledges the complexities of TB as a social disease, and the subsequent complex needs of people affected by TB, in particular for key and vulnerable populations. The support services are intended to help individuals to access services and complete care by assisting them in resolving

nonclinical issues that might prevent access to services or treatment completion. Support services as a whole also help to address stigma and discrimination in communities.

The delivery of support services can be arranged in various ways depending on the national context. The services can be delivered by medical providers themselves, as well as by social workers. However, they are best delivered by the people who understand the particular circumstances of people affected by TB – members of the same community, people who have completed treatment or supporter groups.

The availability of support services as part of the TB response is relatively new but this is aligned with the people-centred model of care emphasized in the Region. Support services are not, however, well understood in terms of scope and how they can become an integral part of TB prevention, care and treatment. Competences and professional qualities of community-based service provision are also unclear given the limited regulation of these services. Consequently, it is important to understand how community-based TB support services can be organized and how governments can include these services in TB service packages.

This document is designed to help civil society organizations (CSOs) to plan, design, implement, monitor and evaluate community-based support services for TB and to help national TB programmes (NTPs) and governments to invest and integrate these services into essential TB care packages at national or local levels.

INTRODUCTION

TB is the world's leading cause of death from a single infectious agent: over 1.4 million people died from TB in 2019 (1).

TB remains a particular challenge for the WHO European Region (2). According to 2020 estimates, about 259 000 people fell ill with TB in 2018 and about 23 000 people died from TB in the Region. Most of those people lived in the eastern European and central Asia (EECA) Region (2).

Since 2010 the number of new patients with TB has been decreasing at an average rate of 5% per year in the WHO European Region. Although this is the fastest decline among all WHO regions, it will still fall short in achieving the END TB targets for the Region (2). Despite the decrease in TB burden in the Region, incidence of multidrug-resistant TB (MDR-TB) remains high, particularly in the EECA Region. This is linked to a number of issues, such as gaps between the public health and penitentiary systems; lack of laboratory facilities to conduct timely diagnosis of TB; interruption in continuity of care and provision of TB drugs; and failure to focus on rights-based and people-centred care. Weaknesses in mental health and psychosocial support services also contribute to treatment interruption and late diagnosis, particularly among vulnerable groups for TB.

It is predicted that the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the resulting COVID-19 pandemic, which started in 2019, will increase TB incidence and deaths over coming years, reversing the progress made so far.

Ending TB has gained significant political support and is one of the goals of the Sustainable Development Agenda. The United Nation High-level Meeting on TB in 2018 proposed a political declaration committing to increase and accelerate national and collective actions and investments to end the TB epidemic, and this was unanimously accepted by the United Nations General Assembly (3). The declaration set targets and commitments for TB. In 2020 a progress report was given to the United Nations Secretary-General outlining the achievements and gaps in progress (4). The report again stressed the importance of addressing key human rights challenges for people with TB and for provision of community-based services, especially for key and vulnerable populations (Articles 43 and 64; recommendations 6 and 7). Further progress is essential in order to reduce mortality and morbidity caused by TB and meet the commitments of the High-level Meeting. In December 2020 the civil society delegations to the Board of the Stop TB Partnership released a complementary report (The Deadly Divide), which highlighted the gaps and the need for mobilizing support (5). Community-based services are essential to reach more people with information about TB, diagnostic services and preventive treatment; to support treatment uptake and continuation; and to help people with TB to manage the complex social and economic challenges surrounding the disease. Practical ideas for action against TB, which is a complex social disease, are, however, more scarce than the theoretical support. The state of the TB epidemic in the WHO European Region in 2021 indicates the need to accelerate TB control activities in Member States, particularly in the EECA, which is the most affected by TB.

To end TB and, particularly, to address new challenges posed by the COVID-19 pandemic, it is important to strengthen national responses in line with the commitments of the High-level Meeting: (i) to reach all people by closing the gaps in TB diagnosis, treatment and prevention, and (ii) to transform the TB response to be equitable, rights based and people centred. The Tuberculosis Regional eastern Europe and central Asia Project, from the New Model of Care towards Improving DR-TB Timely Detection and Treatment Outcomes in Patients (TB-REP 2.0) is funded by the Global Fund to fight AIDS, TB and Malaria (Global Fund) and implemented in 11 EECA countries. Within the framework of the Project, a blueprint was designed for a people-centred model of TB care as one of the key instruments to respond to the challenge of TB in this Region (6).

The people-centred model of TB care aims to shift care of people with TB from inpatient to outpatient settings, supported by sustainable financing mechanisms and leading to better health outcomes (6). To build upon this model, a standardized package of community-based support services to improve TB outcomes (the Standardized package) has been developed. It aims to complement medical services for TB care by providing a more holistic approach to the continuum of care and, hence, improving health outcomes and prevention of TB for all, including key and vulnerable populations. The Standardized package described in this document defines the content of such services and provides guidance on the provision of nonmedical services to people affected by TB, including key vulnerable populations. The Standardized package is intended to assist EECA countries in setting up essential nonmedical services for TB by providing blueprint recommendations that can be adapted further to the national context and to meet the needs of all those with TB or at risk of it.

Community-based services are a crucial part of the people-centred model of care. They allow services to be focused on the health needs and expectations of people and communities rather than focusing only on the needs and expectation of patients (7).

Community-based TB services in this document include a range of nonmedical services, such as awareness raising, case management and psychosocial support, that can be carried out in different settings by different stakeholders, including community-based organizations, peer supporters, social workers, family members, private entrepreneurs and medical personnel themselves. The aim is to improve access and quality of TB services throughout the whole continuum of TB care – from prevention to diagnosis, to treatment uptake and completion. It is highly recommended that community organizations, particularly those representing TB populations, should be engaged in service provision, as those organizations work closely with their communities and can reach specific populations. They can serve as an invaluable resource to any setting, supporting timeliness and effectiveness of TB control activities. Community-based services should follow individuals through the whole continuum of care and cover all domains of TB care – prevention, detection and diagnosis, treatment, management of side-effects and after-care. They can also guide people with TB to mental health, psychosocial, nutritional and socioeconomic support, including to reduce stigma and discrimination.

The goal of community-based TB services is to support individuals with TB and people affected by TB, especially in key and vulnerable populations, in addressing the comprehensive and complex needs related to TB, particularly in seeking help to resolve medical and nonmedical issues, address barriers to care, access education about TB, receive regular medical examinations, and maintain and complete treatment.

The Standardized package of community-based support services to improve TB outcomes has benefits for all stakeholders, including people affected by TB, local communities, community-based service providers, NTPs and health authorities. Annex 1 contains a glossary of term used in this document; Annex 2 gives the details of the costing tool for use of the Standardized package while Annex 3 summarizes the comments of experts on the utility of the Standardized package and its Costing Tool.

SECTION 1 KEY PRINCIPLES AND CONSIDERATIONS FOR THE IMPLEMENTATION OF COMMUNITY-BASED SUPPORT SERVICES TO IMPROVE TB OUTCOMES

Community-based support services focused on and organized around the health needs and expectations of people and communities, rather than those of patients or diseases, are an essential component of a people-centred model of care. These services are not well established in the EECA Region. This Standardized package contains guidance on establishing and improving such services, building on the people-centred model of TB care from the WHO Regional Office for Europe and the approaches and recommendations from key political, policy and technical documents from different countries. Recommendations and service arrangements in this document are guided by the key principles and considerations for implementation outlined below. It is also important to remember that the needs of people affected by TB and the role that community-based organizations can play in a country will go beyond these recommendations and may change over time.

KEY PRINCIPLES

Ensuring human rights-based TB response

Human rights are at the core of United Nations declarations, the WHO End TB Strategy and the Stop TB Partnership Global Plan to End TB 2018–2022. A human rights-based TB response supports and enhances public health measures and good clinical practice. The approach is founded on the dignity and autonomy of people affected by TB and the critical role they must play in all aspects of the disease response (8). A rights-based approach places special focus on key and vulnerable populations for TB; it demands a gender-sensitive response, and it leverages existing international, regional and national laws to strengthen the response. These include the rights to health, non-discrimination, privacy and confidentiality, provision of information, and liberty. Respect for these human rights promotes the health and well-being of individuals and, in doing so, protects public health.

Co-production of TB control

People-centred care requires the involvement of people in the design, implementation, monitoring and evaluation of service delivery. People with TB and people at elevated risk of TB (key populations) should be provided with the relevant education and support they need to make decisions about their own health and well-being and to participate in their own care. The concept of co-production means that services are delivered in an equal and reciprocal relationship between professionals, people using care services, their families and the communities to which they belong. It implies a long-term relationship between individuals, providers and health systems where information, decision-making and service delivery become shared (7).

A co-production approach calls for a change in the role of people with TB and TB key populations from passive recipients of services to people who are engaged, informed and empowered. In order to serve

this purpose, community-based support services should consider characteristics and circumstances of individuals affected by TB through an individual approach to service delivery.

Combining standardized and individual approaches in service delivery

To improve TB health outcomes and ensure adherence to the principles of people-centred care, community-based support services should bring together two opposite approaches: (i) use standardized algorithms and criteria of services, and (ii) combine/respond to individual needs and preferences of people with TB.

This can be accomplished by applying the Standardized package as a constructor set. Each service provider should assess an individual's situation and needs and use this information to inform the service delivery process.

Gender sensitivity

TB is a social disease, which is reflected in its inequitable distribution worldwide. The risk factors and social determinants for TB include poverty, employment conditions, access to education and gender parity. Gender-related risks and barriers to TB services take many forms, affecting everyone (9).

Globally, men and boys account for 64% of TB cases. This means that approximately two men become infected with TB for every woman or girl. Men are also less likely to have their TB detected and reported than women, and men account for 63% of deaths from TB among HIV-negative people. Men may also be more affected in terms of morbidity and mortality through biological differences, incarceration rates, common places of employment for men (such as construction sites and mines) and their greater tendency to use harmful substances or have poorer health-seeking behaviours. However, it is not universally true that men have a higher TB burden. For example, adolescent girls tend to be more susceptible to TB than adolescent boys, and extrapulmonary TB is more common in women than men.

Notably, very little is known about TB epidemiology among gender-diverse people and communities. However, it is known that pervasive discrimination and stigma discourage gender-diverse people from accessing services.

While the risks to TB disease are weighted more heavily in men, there are also risks and barriers that are more significant in women and gender-diverse communities. TB gender assessments in the Region emphasize that barriers to accessing services, including stigma, are often more frequent and more significant for women and gender-diverse communities and are impacted by the patriarchal social norms that permeate laws, policies and economic independence. Therefore, it is important to review and analyse national and local TB epidemiological data, as well as information on service utilization and barriers to services, in order to assess gender aspects that need to be considered when delivering TB support services (10,11).

Understandable language

Understandable language is communication that people with TB can understand the first time they read or hear it. Any information on health-related issues in general and TB specifically should be provided in language that is easy to understand in order to ensure and respect people's right to make informed and empowered decisions about health and well-being. Material is in understandable language if individuals can:

- find what they need
- understand information the first time they read or hear it
- apply what they find to meet their needs.

All service providers should use understandable language in written and verbal communication with individuals, including information about TB support services and their rights and responsibilities during services provision. They should also be given informational and educational materials (IEM), forms, checklist, agreements and other documents.

INTEGRATING COMMUNITY ENGAGEMENT, HUMAN RIGHTS AND GENDER IN ALL TB-RELATED SERVICES

National TB responses should be equitable, rights based, gender transformative and people centred. This means not only delivering quality medical services but also creating enabling, supportive environments that ensure that quality services are available, accessible and acceptable. This will entail creating an enabling policy and legal environment, empowering people to claim their rights and establishing mechanisms that enhance accountability.

TB can affect anyone, but some populations, the key and vulnerable populations, should be at the heart of any TB response. To reach this population, communities and civil society actors can play an important role. Furthermore, tools and approaches to reach, engage and assess the challenges faced by these populations have been developed by the Stop TB Partnership and implementing partners and used in the EECA Region, including under the TB-REP 2.0.

TB stigma assessment. Countries cannot fully support the right to the highest attainable standard of physical and mental health without assessing and addressing TB stigma as a root cause of discrimination and other human right violations. The Political Declaration from the High-level Meeting on TB committed to promote and support an end to TB stigma and all forms of discrimination. The TB Stigma Assessment Tool, developed by Stop TB Partnership, is a research-based instrument that assesses the extent to which, and how, TB stigma acts as a barrier to both accessing and providing services. It supports the development of recommendations to address TB stigma so that quality TB services are available, accessible and acceptable to all, with special considerations given to the needs of key, vulnerable and underserved populations.

Community, rights and gender (CRG) assessment. CRG assessment encompasses community responses and systems, gender and human rights with the aim of supporting catalytic and transformative actions within communities. The assessment allows countries to assess policy and legal frameworks; evaluate data for key, vulnerable and underserved populations; assess stigma, gender and other human rights violations; and develop national action plans to address the challenges.

Community-led monitoring. Community-led monitoring empowers people affected by TB to access health and support services, claim their rights, and identify and reduce stigma. OnImpact is an innovative mobile app that encourages and facilitates the participation of people affected by TB in all aspects of TB programming to support a rights-based and people-centred response. Such monitoring combats the central challenges in the TB response at the individual and community levels while generating essential information and data to better understand and combat these challenges at the programme level to end TB.

Other tools. The Patient Pathway Analysis and TB Patient Catastrophic Cost Study are tools that allow generation of evidence on bottlenecks, as well as the costs experienced by TB-affected households, which are important contributors to creating evidence for TB advocacy.

Although, this document does not define any specific standards for activities, promoting human rights, combating stigma and discrimination, addressing gender issues and other concerns for and by TB-affected communities should be an integral part of each support service standard defined by this document.

CONSIDERATIONS FOR IMPLEMENTATION

Target population for the services

TB support services should address the needs of all those affected by TB. However, certain groups in a population face significantly elevated risk of TB, as well as difficulties in accessing, starting and completing treatment. Support services should, therefore, specifically target these key populations.

The concept of TB key populations (vulnerable, underserved or at risk of TB infection and illness) is a central idea of health service delivery that considers needs, behavioural patterns and social conditions that significantly elevate risk of TB (12). There is a wealth of evidence on certain individuals, or groups in a population, being at increased risk of TB, but country context is essential in defining what these groups are. Each country will define its groups with increased risk or increased exposure to TB because of where they live or work, because they have limited access to quality TB services or because they have a higher level of biological or behavioural risk factors. Countries will then decide how to address the challenges related to these populations and how to integrate them into their national TB response and targeted interventions within an NTP or strategic plan.

The Global Plan to End TB 2018–2022 (13) provides the following guidance on defining what are the key and vulnerable populations for TB.

- People who have **increased exposure** to TB through place of residence or work: prisoners, sex workers, miners, hospital visitors, health-care workers, community health workers, living in urban slums or refugee camps.
- People who have **limited access to quality TB services**: migrant workers, women in settings with gender disparity, children, refugees or internally displaced people, illegal miners, undocumented migrants or rural poor.
- People at **increased risk** of TB because of biological or behavioural factors that compromise immune function: people living with HIV, with poor nutrition or with disorders or treatments that compromise their immune system.

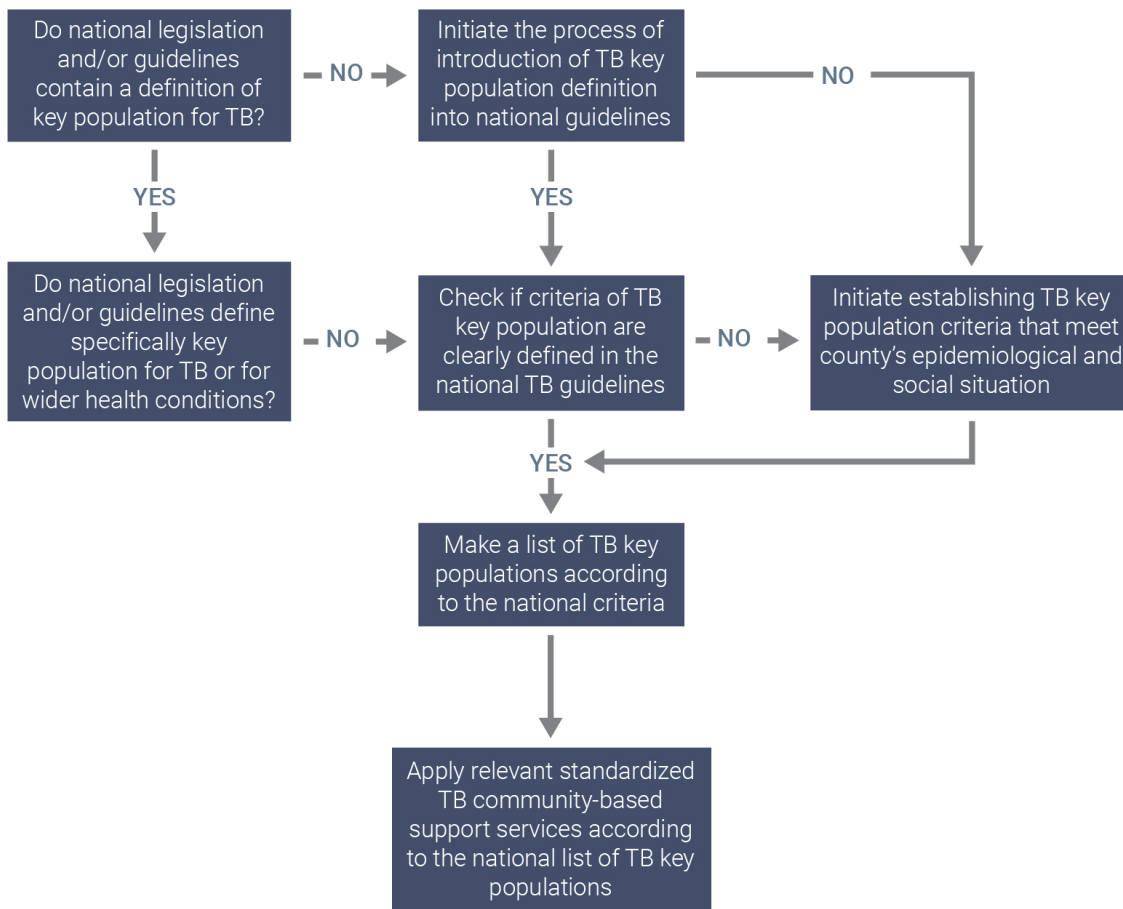
In addition to these groups, key and vulnerable populations include individuals who are at higher risk of latent TB infection (LTBI) and the risk of its activation than the general population because of their current health status, living and working environments, or legal and social standing (14). Many TB key populations overlap and those in these groups will have multiple risks.

Widespread stigma and discrimination, State and non-State violence and harassment, restrictive laws and policies and criminalization of behaviours or practices put key populations at heightened risks and undermine their access to services.

Implementation of the Standardized package in countries requires identification of key populations in order to define how these are to be targeted through community-based approaches. The CRG country assessments for TB provide valuable information about specific barriers and issues faced by individuals and groups in accessing and receiving quality TB services. The assessments and findings should be used by national counterparts to identify key and vulnerable populations and specific issues faced by these groups.

Fig. 1 gives the pathway to identify TB key populations for national policies. It is important that policies are also reflected in the implementation decisions, such as budgets and monitoring and evaluation frameworks of the national TB programmes and strategic documents.

Fig. 1. Pathway to identify TB key populations in the national policies



Human resources for support services

Delivery of community-based support services requires special training, skills, knowledge and competences for the staff. However, in many health systems in EECA countries these competencies are not well defined or documented.

Individuals engaged in the provision of services described in this Standardized package may have a background in social work or health care, or neither. Only a few of the service standards require formal (university degree or vocational) training for their provision. However, if countries can invest in the education and skills building of those professionals, these opportunities should be used.

Skills and competencies

The following lists suggested skills and competencies that the staff of a service provider should possess.

- **Education:**

- although no specific educational background is required, a degree in social work, medicine or public health would be an advantage (see exclusions below); and
- training and/or seminars on specific topics according to the content of each service, for example on motivation counselling, individual needs assessment, behavioural change communication, algorithms for TB screening and case management.

- **Knowledge and understanding:**

- TB disease epidemiology globally and for the particular setting;
- good knowledge of TB symptoms, methods of transmission and infection control measures;
- good knowledge of TB diagnosis (different types of tests and methods) including drug sensitivity, TB/HIV coinfection and treatment regimens;
- legal aspects of TB treatment, rights of people with TB and rights of key populations;
- good knowledge and understanding of medical providers at local level; and
- good knowledge and understanding of social services at local level.

- **Skills, competencies and other qualifications:**

- ability to make contact, build and maintain rapport with representatives of TB key populations;
- demonstration of patience, empathy and respect in relation to the representatives of the TB key populations;
- strong counselling and communication skills; and
- knowledge and skills of individual needs assessment, case management and other relevant domains.

- **Experience:**

- experience in motivational counselling/interviewing techniques (15) and behaviour change communication (16); and
- experience in working in field conditions on an outreach basis.

Not all services can be delivered by lay professionals and there are services that require professional and/or academic training and qualification formally acknowledged by the State:

- initial needs assessment and case management requires a degree in social work or related field (psychology or similar; as defined by the national regulations) or formal training in the field;
- psychological counselling requires a formal degree and qualification in psychology (behavioural, cognitive or similar) or psychiatry, additionally formal training in mental health care for individuals with chronic illnesses is an asset; and
- administration of directly observed treatment (DOT) should be undertaken by appropriately trained professionals based on national guidelines and may require a medical degree in a field such as in nursing.

Very often, countries do not have systems in place to support competency/professional development of workers in community-based organizations, or individuals delivering community-based services. These systems are essential to assure quality of services, as well as to generate professional human resources and to motivate and encourage workers to continuously seek new skills and development. It is strongly recommended that countries develop and adopt such systems in formal or informal ways.

Community-based service provision through contracting

Community-based service delivery through community-based organizations, or other type of non- health-care entities such as CSOs, can be a challenge in many countries. Some countries face problems in channelling public funds to non-public entities, while others may face difficulties providing funds allocated for health function to entities that are not medical facilities.

Delivery of community-based TB services in EECA countries has been historically funded by external donors, mainly by the Global Fund and the United States Agency for International Development. The Global Fund's Strategy 2017–2022 emphasizes work with all implementing countries to increase domestic resource mobilization for health, with a particular emphasis on investing in programmes that support key and vulnerable populations; the Strategy suggests that "civil society and communities must play a central role in the design, delivery and oversight of the response, including community-based service delivery" (17). Countries need to adapt or develop appropriate service delivery, contracting and funding arrangements for community-based services, which need to be further institutionalized into the existing financing mechanisms of TB care.

There is growing evidence from numerous projects implemented in different countries over recent years that involvement of CSOs in the delivery of preventive and support services can have a positive role for strengthening effective responses to HIV and TB. CSOs can often fill the gaps in service delivery and provide better outreach, particularly to vulnerable populations that may be hard to cover effectively by health-care providers.

The blueprint of a people-centred model of TB care for the EECA Region, developed by the WHO Regional Office for Europe in 2017, emphasizes the need to shift the focus of TB service organization from hospital-based settings to outpatient care to better meet the needs of people with TB (6). Outpatient care also enables more meaningful involvement of CSOs for provision of supportive community-based services for TB prevention, diagnosis and treatment. Solutions to these issues would need to be identified based on the local context, although social contracting experience from many countries could be helpful to guide local decisions.

Social contracting is considered a mechanism to enable public funding of services provided by CSOs. A global consultation on social contracting on 5–6 October 2017 in New York, held jointly by the Open Society Foundation, the United Nations Development Programme and the Global Fund,

defined social contracting as “a financing option by which governments finance programmes, interventions and other activities implemented by civil society actors” (18).

Social contracting mechanisms provide favourable options for governments to finance their disease response efforts more efficiently and effectively. Social contracting can utilize funds from national, regional or local budgets, as well other pooled public resources such as social health insurance, and can follow different procurement standards and procedures subject to the specific legal regulations in each country.

There is limited experience of social contracting in the countries of the EECA Region, and its utilization is still often driven by donors or dependent on donors. Only a few countries in the Region have so far successfully demonstrated their ability to engage CSOs with funding from the public budget.

There are numerous legal and organizational challenges that countries need to address to make social contracting sustainable over a long-term perspective. It requires:

- creating enabling legal, policy and regulatory environments;
- securing sustainable funding sources and diversification of financing mechanisms through institutionalization of social contracting programmes into public budgets; and
- ensuring free and fair competition among the CSOs by setting clear and objective selection criteria based on proven qualifications and experience, and strengthening CSOs’ capacity for better accountability and transparency through improved planning, monitoring and reporting practices.

Opportunities to advocate for, build capacity and monitor the quality of community-based services are also important and are found in the Global Fund’s community system strengthening support as part of national and regional grants, the Global Fund strategic initiatives such as the CRG portfolio and mechanisms like the Stop TB Partnership Challenge Facility for Civil Society. These supports can supplement broader social contracting efforts.

CSOs and community-based organizations make a significant contribution to service delivery by being closer to communities and having a better understanding of their needs. The additional resources offered by these organizations are essential for the improvement of TB outcomes. In addition, volunteers can provide added value to the population affected by TB by working to leverage existing resources and networks.

Continuous quality improvement

All service providers should adhere and implement continuous quality improvement as a management philosophy and style to ensure that the whole process of service delivery is concentrated primarily on efficacy and individuals' safety. Service providers should try to reduce unnecessary procedures and spending (waste), thus increasing efficiency and increasing satisfaction among both employees and service users. It is an ongoing process that should implement the framework of plan–do–study–act to continuously monitor and improve the processes of service delivery. Continuous quality improvement is based on enhancements of each TB support service delivery process and contributes to and improves the whole TB pathway for people from cough to cure.

SECTION 2 OUTLINE OF COMMUNITY-BASED SUPPORT SERVICES

Support services for communities and groups affected by TB, both for people with TB and for their families, target aspects that have important influence on health and mental, physical and social well-being and lead to improved outcomes for clinical interventions. These include nonmedical services, which should be implemented alongside medical services.

The two matrixes provided here give a condensed version of service standards to be implemented by community-based organizations (Table 1) and special considerations regarding provision of the services to particular groups at high risk of TB because of their social, economic or biological factors or because of the particular setting, such as during the COVID-19 pandemic (Table 2). These services are then considered in more detail in Section 3.

Table 1. A matrix of standardized community-based support services for TB

TB domain and subdomain	Community-based support services for TB	Purpose of service	Target audience	Service delivery settings
1. Prevention				
1.1. Health promotion	1.1.1. Awareness raising, risk communication, community engagement and mobilization	Provide accurate information about TB, raise awareness of local communities in general and key populations specifically on TB symptoms, diagnosis, treatment and care; service may be accompanied by TB screening	General population Groups at higher risk of TB	Health facilities, offices of community-based organizations or the individual's residence where infection control requirements can be met

Table 1. contd

TB domain and subdomain	Community-based support services for TB	Purpose of service	Target audience	Service delivery settings
1.2. Health education	1.2.1. Counselling of individuals at risk of TB	<p>Provide individuals at risk of TB and their family members with essential knowledge and information on TB symptoms and ways of transmission, diagnosis, treatment options and infection control measures to help them to develop necessary skills for self-care and encourage long-lasting changes in behaviour to support respiratory health</p> <p>Information on stigma, human rights, access to justice and legal remedies, as well as any additional information relevant to the needs of individuals in each particular context</p>	Individuals belonging to TB high-risk population groups and their family members	Health facilities, offices of community-based organizations or the individual's residence where infection control requirements can be met
1.3. LTBI testing and treatment	1.3.1. Nonclinical management of LTBI	Support timely identification of LTBI and treatment uptake, and reduce the progression of the disease to active stage	Target groups for systematic LTBI testing and contacts	Health facilities, community-based organizations, other facilities where targets groups for services gather, and web-based resources
2. Detection and diagnosis				
2.1. Active case finding in key populations	2.1.1. Support for active case finding	Empowering members of key population groups to seek screening and diagnostic services for TB	Individuals belonging to key populations for TB	Health facilities, community-based organizations, home setting or locations where key population groups gather

Table 1. contd

TB domain and subdomain	Community-based support services for TB	Purpose of service	Target audience	Service delivery settings
3. Treatment				
3.1. Ensuring continuity of care and avoiding interruption of treatment	3.1.1 Support for treatment observation	Organize timely and effective treatment through supervised drug intake via DOT or VST Educate people with TB and their family members on the importance of treatment adherence, minimizing defaulting, relapses and reporting of any side-effects from the treatment; individual measure of infection control	Populations groups for whom DOT or VST treatment is recommended	Health facilities, community-based organizations, home settings, web-based resources (VST)
	3.1.2 Managing loss to follow-up and preventing treatment interruption	Timely identify people with TB who have interrupted treatments; explore the reasons behind the interruption; through counselling and other interventions encourage individuals to resume the treatment	People with TB and interruptions of 2 months or more	Health facilities, community-based organizations, educational and other public facilities and home settings
4. Care and support				
4.1. Patient care and support	4.1.1. Individual needs assessment	Identify needs and life situations/circumstances of each individual, including children under 18 years of age, which can adversely affect TB treatment process and good treatment outcomes Develop an individual plan of service delivery for the client based on individual needs to prevent non-adherence to TB treatment	A person with TB and at least one of the following characteristics: <ul style="list-style-type: none"> ■ lacks information ■ demonstrates lack of understanding of the importance of TB treatment ■ lacks motivation to follow treatment regimen ■ lives in harmful or unhealthy conditions ■ is a parent, guardian or carer for children ■ has MDR-TB ■ has any other difficult social and economic life conditions related to TB, including feeling of being marginalized, discriminated, or stigmatized 	Health facilities, community-based organizations, educational and other public facilities and home settings

Table 1. contd

TB domain and subdomain	Community-based support services for TB	Purpose of service	Target audience	Service delivery settings
4.1.2. Mental health and psychological counselling and support	<p>Prevent or reduce individual stressful factors related to TB treatment and post-treatment period</p> <p>Maintain the person's mental health and psychoemotional well-being and resilience in order to enhance better TB treatment outcomes</p>	<p>People with TB who have had an initial needs assessment and have at least one of the following characteristics:</p> <ul style="list-style-type: none"> ■ have previously been diagnosed with a common mental health disorder ■ have substance use problems ■ live in highly stressful or unhealthy conditions that can negatively affect TB treatment process ■ are taking long-lasting treatment (MDR-TB) 	Health facilities, community-based organizations, educational and other public facilities and home settings, web-based resources	
4.1.3. TB case management	<p>Encourage individuals to build the systems that enable consistent behaviour to prevent, minimize or overcome individual difficult life circumstances stemming from their TB diagnosis or treatment</p>	<p>People with TB who have had an initial needs assessment and have at least one of the following characteristics:</p> <ul style="list-style-type: none"> ■ live in poor or unhealthy conditions and lacking proper nutrition ■ have low income ■ have comorbid health issues ■ face human rights violence, stigma and discrimination, legal barriers ■ experience problems in family relations 	Health facilities, community-based organizations, educational and other public facilities, home settings, web-based resources	
4.1.4. Material support	<p>Organize timely and effective material support interventions in order to help people with TB and their families in their struggle against the illness and try to alleviate some of the burdens as well as incentivize adherence to treatment completion</p>	People with TB	Home settings	

Table 1. contd

TB domain and subdomain	Community-based support services for TB	Purpose of service	Target audience	Service delivery settings
	4.1.5 Health education and counselling	Provide the client with essential knowledge on proper nutrition and tobacco cessation and how to develop necessary nutritional habits and long-lasting changes in smoking behaviour to improve health and treatment outcome	People with TB	Health facilities, community-based organizations, educational and other public facilities, home settings, web-based resources
4.2 Post-treatment support	4.2.1 Post-treatment social support and/or rehabilitation	<p>Provide the client with social support, including mental health and psychological and legal counselling</p> <p>Help clients to receive proper training in efforts to be competitive in the job market</p> <p>Target efforts towards minimizing the relapse of TB and infection control in the population</p>	People recovered from TB	Community-based organizations, educational and other public facilities and home settings

VST: video-supported therapy; MDR-TB: multidrug-resistant TB.

Table 2. A matrix of services and considerations for working with key and vulnerable populations across the whole continuum of care

Specific population	Community-based support services for TB	Beneficiaries/clients/recipients	Service delivery settings
Community-based services for the prison population	Work with the prison population, particularly during discharge planning and upon release to ensure that people with TB continue the treatment while others can access TB preventive services	Prisoners, individuals who have been released from prison, including on probation	Health facilities, prisons, community-based organizations, educational and other public facilities, web-based resources

Table 2. contd

Specific population	Community-based support services for TB	Beneficiaries/clients/recipients	Service delivery settings
Community-based services for homeless individuals	Provide outreach, support for diagnosis and treatment uptake, as well as for continuation of treatment	Homeless individuals	Outreach, shelters, health facilities, community-based organizations, educational and other public facilities
Family-based approach to TB treatment in children	Work to reduce unnecessary hospitalization and isolation of children from their families	Children with TB, their families and children living in a family affected by TB	Home setting, health-care facilities, community-based organizations
Support services for TB during the health emergencies	Attempt to maintain services during pandemic restrictions	General population, groups at risk of TB and people with TB	Home setting, health-care facilities, community-based organizations

SECTION 3 GUIDANCE FOR SERVICE STANDARDS

This section gives a detailed description of each service standard outlined in Table 1 and Table 2 to help countries and organizations to implement these services. Section 4 outlines services for specific groups with special circumstances (prisoners, the homeless and children with TB) and also considers the impact of the COVID-19 pandemic on TB services.

SERVICE 1.1.1 AWARENESS RAISING, RISK COMMUNICATION, COMMUNITY ENGAGEMENT AND MOBILIZATION

Orienting people on their rights, including the right to information, as well as ensuring awareness of TB is an essential step in TB detection, treatment and care pathway. The general population, or groups at risk of TB, is not always aware that there is a risk of infection with TB or of developing active disease. This might lead those with symptoms, or with potential exposure to TB, to delay seeking needed medical care. This pattern is further aggravated by the stigma associated with TB.

Scope and objectives

The awareness-raising risk communication and community engagement and mobilization service supports TB prevention by empowering people and increasing awareness of TB; optionally, it might also provide screening for TB and referral of people with self-observed TB symptoms to a provider. The objective is to (i) provide accurate information on TB and TB risks; (ii) orient people on their rights and raise awareness of TB in local communities in general and in key populations of TB symptoms, diagnosis, treatment and care; and (iii) equip individuals with information on how to protect themselves or others from respiratory infections.

Target audience

Target audience for the service are (i) organized groups of communities, or key populations, that share similar risks related to TB and are organized based on the territory or institution (for example live in urban slums or poorly ventilated or dusty conditions, work in environments that are overcrowded), and (ii) groups of individuals with nonspecific associations:

- **organized groups based on specific territory or institution:**
 - prisoners
 - sex workers
 - miners
 - hospital visitors
 - health-care workers and community health workers; and
- **nonspecific groups:**
 - residents of local communities particularly at risk of TB exposure
 - migrants
 - refugees or internally displaced people
 - members of the same household
 - religious groups and communities
 - participants of specific social gatherings.

The information provided should:

- explain what TB is and how it is transmitted
- describe the signs and symptoms of TB
- outline factors that make people more vulnerable to TB
- describe how TB can be prevented
- explain how TB is usually treated
- provide a self-administered survey on TB symptoms screening (optional).

For sessions with key affected communities, the content should:

- be tailored to identify and provide information relevant for the group
- describe how TB and HIV interact and affect each other.

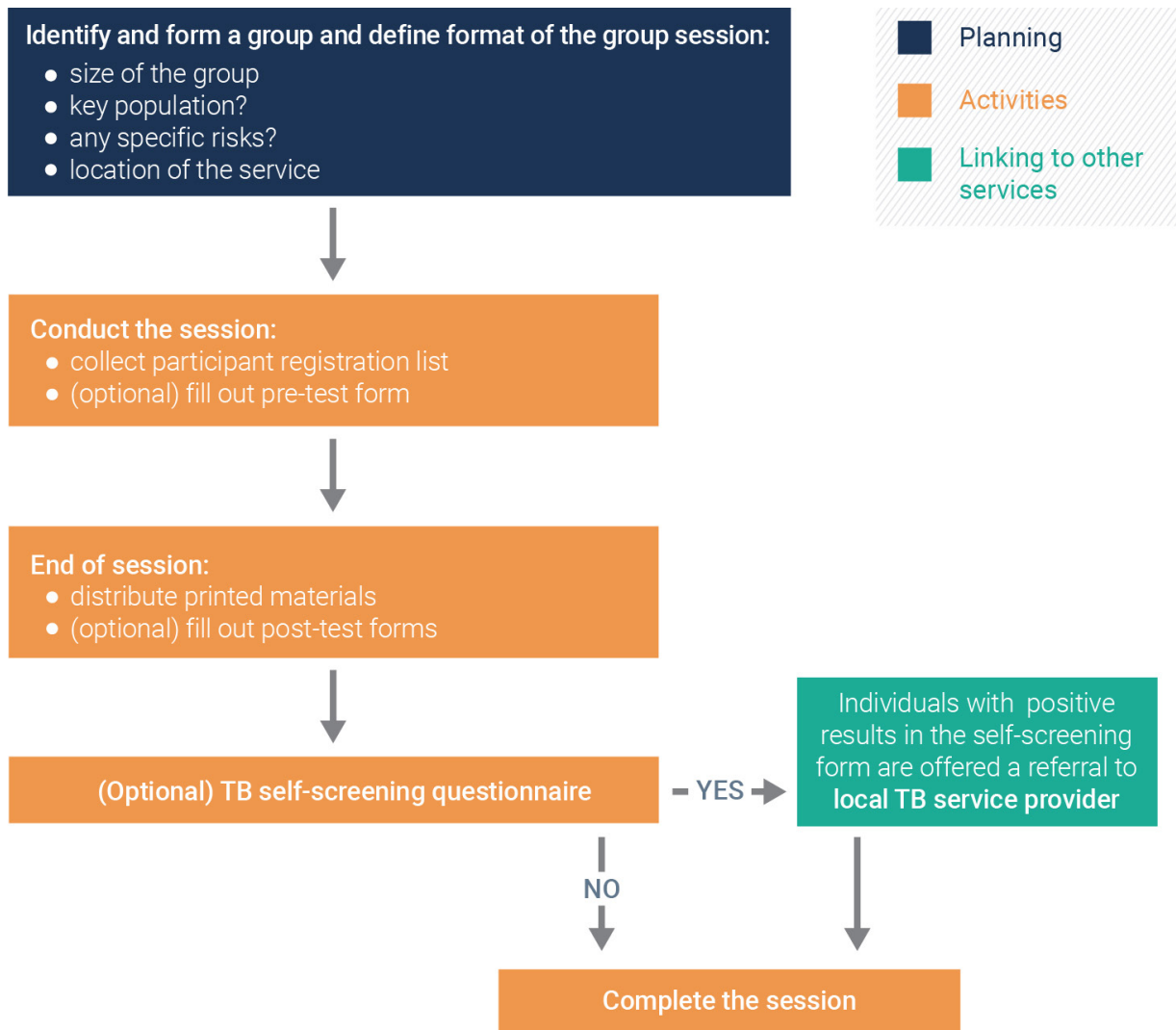
Service delivery

Initiation and planning

This service is initiated by an authorized representative of a target audience (e.g. the health representative of a miners' community) or an opinion leader in case of informal groups. Initiator and service provider agree upon the composition of the group; the time, size and the location of the session; and the equipment needed to conduct the session. Usually, the service will be provided in a location available free of charge.

Fig. 2 provides an algorithm for awareness raising, risk communication and community mobilization.

Fig. 2. Service delivery algorithm for awareness raising, risk communication, community engagement and mobilization



Awareness-raising, risk communication and community mobilization sessions may use different delivery formats based on the size of the group (Table 3).

Table 3. Awareness-raising and community mobilization sessions

Group size	Format of service delivery
Small groups (up to 10 participants)	Information session
Medium groups (10–25 participants)	Information session
Large groups (25–200 participants)	Information session, lecture, movie screening, massive open online course
Extra-large groups (more than 200 participants)	Massive open online course

Massive online open course: an information delivery format utilizing available online platforms for service delivery.

The service provider should have in advance:

- an agenda for the session to cover all topics listed in the content section, the agenda may vary depending on the type of session;
- information materials on TB (e.g. factsheets, booklets or leaflets), which should be written in plain language and be visually plausible;
- presentation and visual materials (e.g. PowerPoint presentations, videos, posters and interactive cards) depending on the format of the session;
- printed screening questionnaires adopted for self-administration if screening is included, with prior consultation with the local health-care provider to agree a format for referral of those who would have positive results in the screening questionnaire;
- tools to measure the results of the session (depending on the service delivery format); and
- contact information of the nearest health-care facility where individuals attending the session may seek TB-related services.

Duration of the service

The duration of the service can vary depending on the format of delivery and the preferences of the target audience. Most formats will require approximately the same time for planning, preparation and the session itself, except for very large groups, for which the level of effort should be defined case by case (Table 4).

Table 4. Time required for the service components and resources

Components	Time required
Initial stages	
Development of awareness-raising session agenda, presentation content and information materials	1–3 days (required only once)
Preparatory stage (forming groups, schedule, logistic activities, etc.)	8–16 hours
Resources needed by type of session	
Information session	1–3 hours
Group counselling	1–3 hours
Training	4–16 hours
Lecture	1–3 hours
Movie screening	1–3 hours
Massive open online course	56–72 hours
Time for evaluation and keeping records	Up to 8 hours

Massive online open course: an information delivery format utilizing available online platforms for service delivery.

Service delivery location

Any location can be used that is convenient for the target audience, is available/provided without cost and is suitable for such activities (e.g. classroom, office of the institution and/or service provider premises).

Resources needed for service delivery

- Identification document and personal identifier for the service provider (badge, card or other)
- IEM
- Form sheets for the TB screening questionnaire and referral sheets to the local health-care provider
- Flipchart, media projector, screen, laptop (if necessary).

Evaluation and reporting

Key indicators

- Number of people who have attended awareness-raising group sessions
- Number of sessions held
- Number of people from key populations who have attended awareness-raising group sessions
- Percentage satisfied with the session.

Documentation and record keeping

- Registration form for participants at awareness-raising events
- Feedback forms and/or pre–post event knowledge measurement questionnaire (if relevant).

SERVICE 1.2.1 COUNSELLING OF INDIVIDUALS AT RISK OF TB

Individuals at risk of TB might delay seeking medical diagnosis and starting the treatment. The reasons can vary from lack of understanding of TB risks through to fear of stigma and discrimination, as well as limited understanding of where and how to seek services. In EECA countries, TB-related medical services are provided free of charge and financial aspects of treatment should not be a barrier to seeking care, although multiple other factors may prevent individuals from receiving needed medical services.

Scope and objective

The service is intended to support TB prevention by motivating TB risk-reduction behaviour and encouraging seeking medical care at an early stage. The objectives are to (i) provide individuals with essential knowledge and information on TB symptoms and ways of transmission, diagnosis, treatment and possibilities to receive such treatment; (ii) empower individuals with self-care skills; and (iii) encourage long-lasting changes in behaviour to prevent TB, and, in case of TB, improve health outcomes. Overall, the service is intended to increase TB prevention.

Target audience

Box 1 summarizes the target audience for counselling of individuals at risk of TB.

Box 1. Target audience for counselling of individuals at risk of TB

Individuals or small groups, such as people living in one household, who belong to TB key population because of a medical condition that weakens the immune system (including HIV infection, substance abuse, diabetes, pulmonary illnesses and medical treatments such as corticosteroids or organ transplant, etc.)

AND

do not possess knowledge about TB symptoms, ways of transmission and consequences of delaying treatment;

MIGHT

require the service based on the recommendation of a treating medical professional;

AND

are not diagnosed with TB or LTBI.

Service delivery

Initiation and planning

Initiation of the service should be carried out by a health-care worker or by a community-based service provider. A health-care worker might initiate the service upon informed consent of the individuals if they require testing for TB and alertness for TB (e.g. a person living with HIV). A health-care worker should decide if a person would benefit from the health education service based on observation of the person's risks related to TB as well as knowledge about self-care and TB prevention. Community-based service providers may also identify at-risk individuals in the community (e.g. representatives of key/affected populations) and initiate the service in coordination with the local TB service provider.

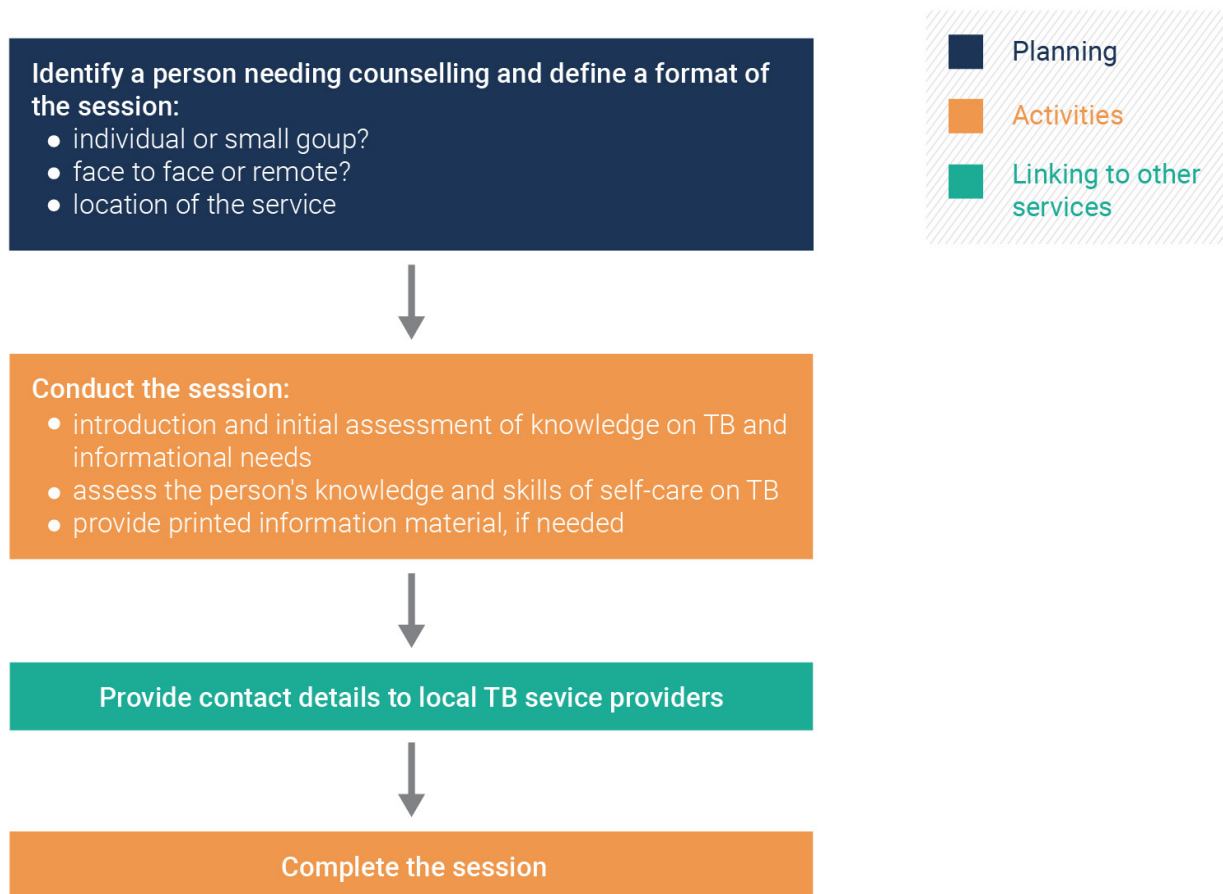
The service provider should develop in advance:

- an agenda of individual counselling sessions on TB; it is important to have a focused information relevant for particular risk groups and different genders;
- informational materials on TB (e.g. factsheets, booklets, leaflets); and
- contact information of organizations that provide TB services (e.g. health-care facility or specific clinic).

A service provider defines the number and format of individual counselling sessions (including face-to-face meetings, video-chats, etc.) based on the needs and preferences of an individual.

The service can be delivered to people individually or to small groups (up to 10 people). The algorithm in Fig. 3 outlines the pathway for counselling of individuals at risk of TB.

Fig. 3. Service delivery algorithm for counselling of individuals at risk of TB



Duration of the service

The duration of the service can vary depending on the agenda, format of delivery and preferences of the individual being supported (Table 5).

Table 5. Approximate timing for the service components

Component	Time required
Development of awareness raising session agenda and supportive materials	Once per service; timing is defined case by case based on the chosen format and target audience
Preparatory stage (coordinating with a health-care worker, forming small groups, schedule the sessions, etc.)	8–16 working hours
Conducting health education session	0.5–1.0 hours per session
Time for evaluation and keeping records	Up to 8 hours

Service delivery location

Any place and location comfortable for individuals and suitable for such activities can be used (e.g. health-care facility, classroom, office of the institution and/or service provider premises).

Resources needed for service delivery

- Identification document and personal identifier for the service provider (badge, card or other)
- IEM
- Flipchart, media projector, screen, laptop (if necessary)
- Feedback forms (optional).

Evaluation and reporting

Key indicators

- Total number of individuals who have received the individual counselling service
- Percentage of individuals satisfied with the quality of the service.

Documentation and record keeping

- Participant registration form
- Feedback forms (optional).

SERVICE 1.3.1 NONCLINICAL MANAGEMENT OF LATENT INFECTIONS OF TB

Management of LTBI is a key component of the global TB elimination strategy. People with LTBI represent a large human reservoir for the disease and, therefore, reducing the size is very important to alleviate the TB burden. Approaches to the management of LTBI vary greatly in EECA countries and most have not yet fully implemented a guidance based on WHO's programmatic management of LTBI (19).

Scope and objective

The scope of this service is to support TB prevention activities by supplementing the medical services for timely identification of individuals with LTBI and providing motivation for them to seek relevant services available in their country.

The objective of the service is to organize timely and effective identification and treatment of people with LTBI in order to reduce progression of the disease to active TB by informing individuals of the risks of LTBI, aiding them in seeking diagnostic services and supporting their adherence to treatment.

It is foreseeable that EECA countries will be gradually expanding their national policies for programme management of LTBI, and the services offered as a part of this Standardized package should be expanded accordingly.

Target audience

The target audience for the service are the at-risk groups identified in the national guidelines for the management of LTBI. Mostly, this will include individuals with LTBI who have a higher risk of progression to active TB.

Population groups for whom systematic LTBI testing and treatment are frequently recommended include adults and adolescents living with HIV, infants and children living with HIV, HIV-negative household contacts of a person with pulmonary TB, and other HIV-negative at-risk groups.

Service delivery

Initiation and planning

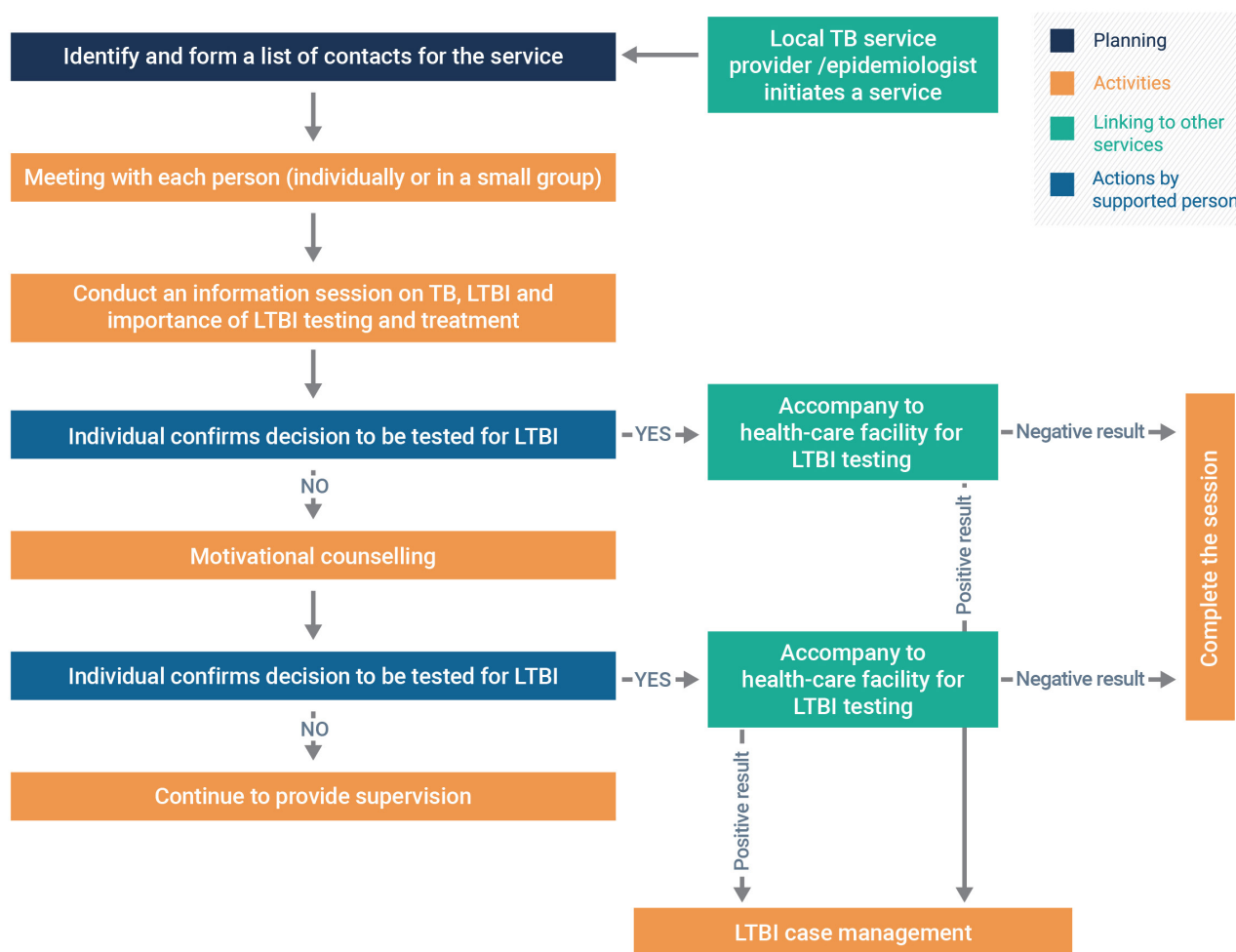
Case identification for LTBI includes screening and contact-tracing activities, which are carried out by the local TB service provider in collaboration with the epidemiologist responsible for contact tracing. The need to engage a community-based service provider should be identified by these parties.

Services

The community-based service provider can support outreach and contact-tracing activities by:

- identifying representatives of at-risk populations based on national guidelines
- assisting the epidemiologist to trace household contacts of people with pulmonary TB
- increasing awareness regarding the importance of receiving LTBI treatment
- accompanying the at-risk individuals to a local TB centre for testing
- ensuring that people with TB are supported to complete treatment.

Fig. 4. Service delivery algorithm for nonclinical management of LTBI



Duration of the service

The service continues until the individual with LTBI tests negative (Table 6).

Table 6. Approximate timing of the service

Component	Time required
One face-to-face meeting with the individual (informational session regarding LTBI and risks of conversion to active TB, general information regarding TB, and motivational counselling); engagement with family members, if feasible.	Up to 2 hours
2–3 phone calls to the individual	Up to 1 hour
Travel time to a place of meeting with the individual	Depending on location and transportation
Travel time to a health-care facility (only for accompanying)	Dependant on location and transportation
Time for logistic activities, communication with the health-care facility and keeping records	Up to 2 hours

Service delivery location

A preferred location for the recipient of the service should be used (e.g. street, home, office of institution and/or other service provider premises).

Resources needed for service delivery

- Identification document and personal identifier for the service provider (badge, card or other)
- Samples of IEM
- Appropriate personal protective equipment (PPE).

Evaluation and reporting

Key indicators

- Number of individuals who received the LTBI management service in a one-year period
- Percentage of those who sought LTBI screening, diagnostic or treatment services (based on which one was applicable) or those covered with the service (cascade).

Documentation and record keeping

- LTBI test participation form for each person with the results.

SERVICE 2.1.1 SUPPORT FOR ACTIVE CASE FINDING

TB case finding may be passive or active (see Annex 1). Passive case finding requires that affected individuals are aware of their symptoms, have access to health facilities and are evaluated by health workers who recognize the symptoms of TB and have access to a reliable laboratory service. Individuals with symptoms compatible with TB are usually identified in health facilities, and all health workers should be aware of the symptoms of TB and how to proceed if TB is suspected.

Active case finding requires systematic screening and clinical evaluation of individuals who are at high risk of developing TB, such as people who are contacts of someone who was diagnosed with TB or people living with HIV. The use of active case finding assumes that (i) groups at high risk for TB are clearly defined, (ii) procedures to screen and assess individuals belonging to these groups are well established, and (iii) health professionals and community workers who should be involved in implementing these procedures have been clearly identified.

Scope and objective

A community-based service to support active case finding is a targeted method of communication with the representatives of at-risk populations in order to identify those who may be missed by routine health services and to support early detection of TB cases. It encourages pre-defined population groups to seek TB screening by raising their awareness and motivation.

Objectives of the service are to (i) identify hard-to-reach communities and groups for the intervention, (ii) increase their awareness of TB and motivation to receive TB screening services, and (iii) facilitate access to TB screening/diagnostic services.

Target audience

This service targets people who are considered as being at increased risk of contracting TB. At-risk groups are usually defined in a national strategic plan or programme and should be targeted for national active case-finding efforts. In addition, tools such as the CRG assessment for TB provides additional information on the status of key population groups and particular vulnerabilities/barriers they have with respect to TB services, as well as broader enablers to access quality TB services (Box 2).

Box 2. Target audience for active case finding

The service targets people who belong to at least one of the at-risk groups:^a

- increased exposure to TB because of where they live or work
- increased risk for TB because of biological or behavioural factors that compromise immune function
- close contacts with a person with confirmed TB^b

AND/OR

- have limited access to quality TB services.

Those fulfilling these criteria should have one of more of the additional factors:

- present symptoms of TB such as chronic cough, weight loss, night sweats or fever;

AND

- demonstrate lack of knowledge about TB symptoms, consequences of not starting treatment and motivation to refer to a health-care facility to take a TB test;

AND

- are not diagnosed as having TB and do not receive TB treatment.

^a Usually, a national strategic plan or programme would have guidelines that define which populations belong to at-risk groups for TB for targeting in active case-finding efforts. Tools such as TB CRG assessment provides additional information on the status of key population groups and particular vulnerabilities/barriers they have with respect to TB services, as well as broader enablers to access quality TB services.

^b For a person who has been in contact with someone with TB, it is recommended that risk should be based on the amount of time with the infected person: high risk, those spending a lot of time; medium risk, those spending some time; low risk, those spending little time.

Service delivery

Initiation and planning

The service is initiated by the service provider in cooperation with a local health worker who is familiar with the local TB epidemiological situation (an epidemiologist, a TB specialist, a public health specialist or a primary care clinician). Priority groups for active case finding may also be defined in the NTP or in national guidelines. Generally, this will include contacts for anyone with confirmed pulmonary TB, as well as for vulnerable populations, such as homeless individuals or people who use drugs.

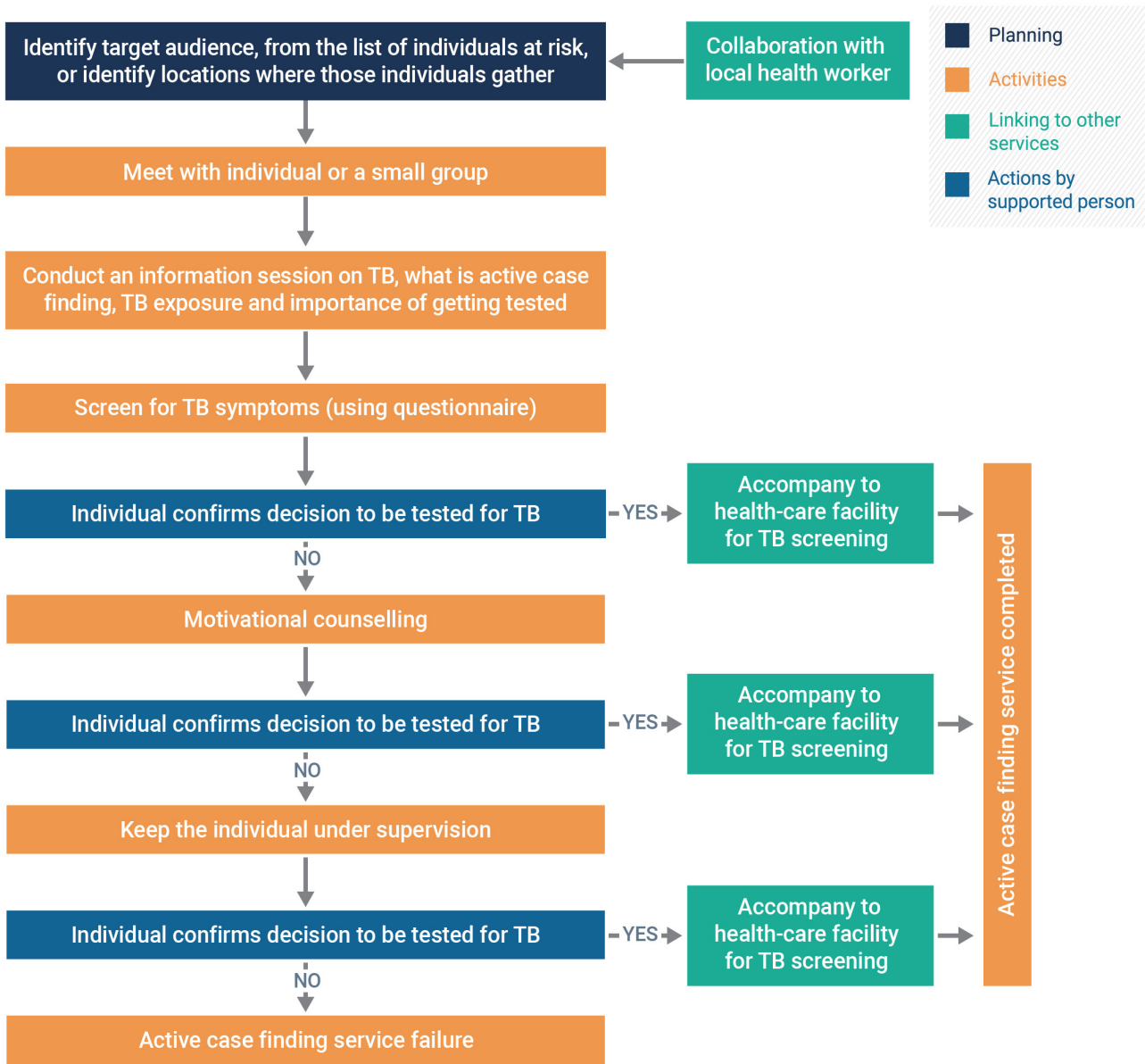
As for an individual who is a TB contact, a health specialist is responsible for filling out the epidemiological questionnaire for each patient with TB and for anyone who has been in close contact and to get informed consent about delivering the service of active case finding.

Services

Support of active case finding may include services such as case identification, information provision, motivational counselling, screening through a questionnaire and services to accompany individuals to a health-care facility for testing.

The steps in active case finding are outlined in the algorithm in Fig. 5.

Fig. 5. Service delivery algorithm for provision of support for active case finding



Duration of the service

The service should be completed during 3–5 working days (Table 7).

Table 7. Approximate timing of the service

Component	Time required
One face-to-face meeting with the individual (informational session regarding LTBI and risks of conversion to active TB, general information regarding TB and motivational counselling)	Up to 2 hours
2–3 phone calls to the individual	Up to 1 hour
Travel time to a place of meeting with the individual	Depending on location and transportation
Travel time to a health-care facility (only for accompanying)	Depending on location and transportation
Time for logistic activities, communication with the health-care facility and keeping records	Up to 2 hours

Service delivery location

The location preferred by the individual should be used (such as street, home, office of institution and/or service provider premises).

Resources needed for service delivery

- Identification document and personal identifier for the service provider (badge, card or other)
- TB screening questionnaire forms
- IEM.

Evaluation and reporting

Key indicators

- Total number of people who received the service
- Percentage opting in for a TB test after the service
- Percentage opting out of a TB test after the service.

Documentation and record keeping

The person's registration form, which includes following data:

- general information needed for identification (may contain identification code and/or name, sex, age, etc.); and
- service elements delivered to the person: (i) the informational session, (ii) screening for TB symptoms, (iii) motivational counselling and (iv) accompanying the person to a health-care facility.

SERVICE 3.1.1 SUPPORTED TREATMENT OBSERVATION

Taking pills every day and fully complying with the treatment regimen is important to ensure treatment success for individuals, as well for preventing emergence of drug resistance.

Nevertheless, many people with TB fail to adhere to treatment and the reasons why vary from limited understanding of medical information to distrust in the treatment, limited tolerability of side-effects, or personal and social needs (such as need to maintain employment, continue earning or caring for family members). Stigma and discrimination may prevent individuals complying with treatment as may a number of different legal, cultural, economic, gender and other issues. Community-based services can play an essential role in addressing such needs (covered in the service standards for care and support; see Table 1) as well as in empowering people with TB. People who are informed, capacitated and supported are much more likely to complete treatment.

Significant human and time resources are dedicated within NTPs to ensure treatment observation; however, resources needed to enable existing DOT practices on the patient's side might be even more substantial and include travel time and costs, the loss of time for earning and loss of time for fulfilling household obligations. Therefore, enabling community-based treatment observation helps to free up medical resources as well as allowing service delivery in ways that may be more acceptable for the person on treatment.

Importantly, technological advances such as video-supported therapy (VST) now allow treatment to be observed remotely through video calls and save time and expense for people on treatment, medical personnel and even community-based service providers. In addition, there are software platforms that allow reminders to be sent to individuals. Currently, coverage with such services is low, but it is growing as it allows greater comfort during treatment.

Scope and objectives

This service is intended to support the treatment phase of the TB care pathway by supplementing medical services for drug-intake supervision: DOT. It may include community-based DOT, VST or other arrangements defined in the national DOT guidelines. Engagement of community-based service providers in this area also helps to identify the needs of people with TB and provides support for adherence to treatment.

Community-based service providers organize timely and effective treatment through supervised drug intake via DOT or VST, educate people with TB and their family members on the importance of treatment adherence, facilitate reporting of any side-effects from the treatment and save time for medical personnel engaged in DOT.

While this Standardized package outlines the services complementing DOT or VST services delivered by health-care facilities, support from community-based organizations to people on treatment is not limited to these complimentary services. Such organization may engage in provision of additional services starting from legal aid to community mobilization, which are not covered by this document but are encouraged as essential aspects to address the complex needs of people with TB.

Target audience

The service is particularly important for individuals who are unable to engage in standard DOT delivery models because of issues such as disability, underlying medical conditions or remoteness of services.

DOT or VST is recommended for both those with drug-sensitive TB and those with DR-TB (including MDR-TB). Choice of DOT or VST as the delivery model should be based on the circumstances of individuals, including their work, family and community commitments; experience of stigma, discrimination and other human rights violations; gender norms; and social and economic considerations.

Service delivery

Initiation and planning

Outpatient provision of DOT to people with TB is prescribed by a qualified medical doctor and traditionally provided through daily visits of an individual to the TB facility. However, this standard approach has not met the needs of all people with TB. In addition, in order to save travel time and avoid unnecessary visits to the health-care facility, solutions are being identified to ensure daily intake of drugs without the need to visit medical facilities.

There are a few options on how community-based services can engage in achieving DOT:

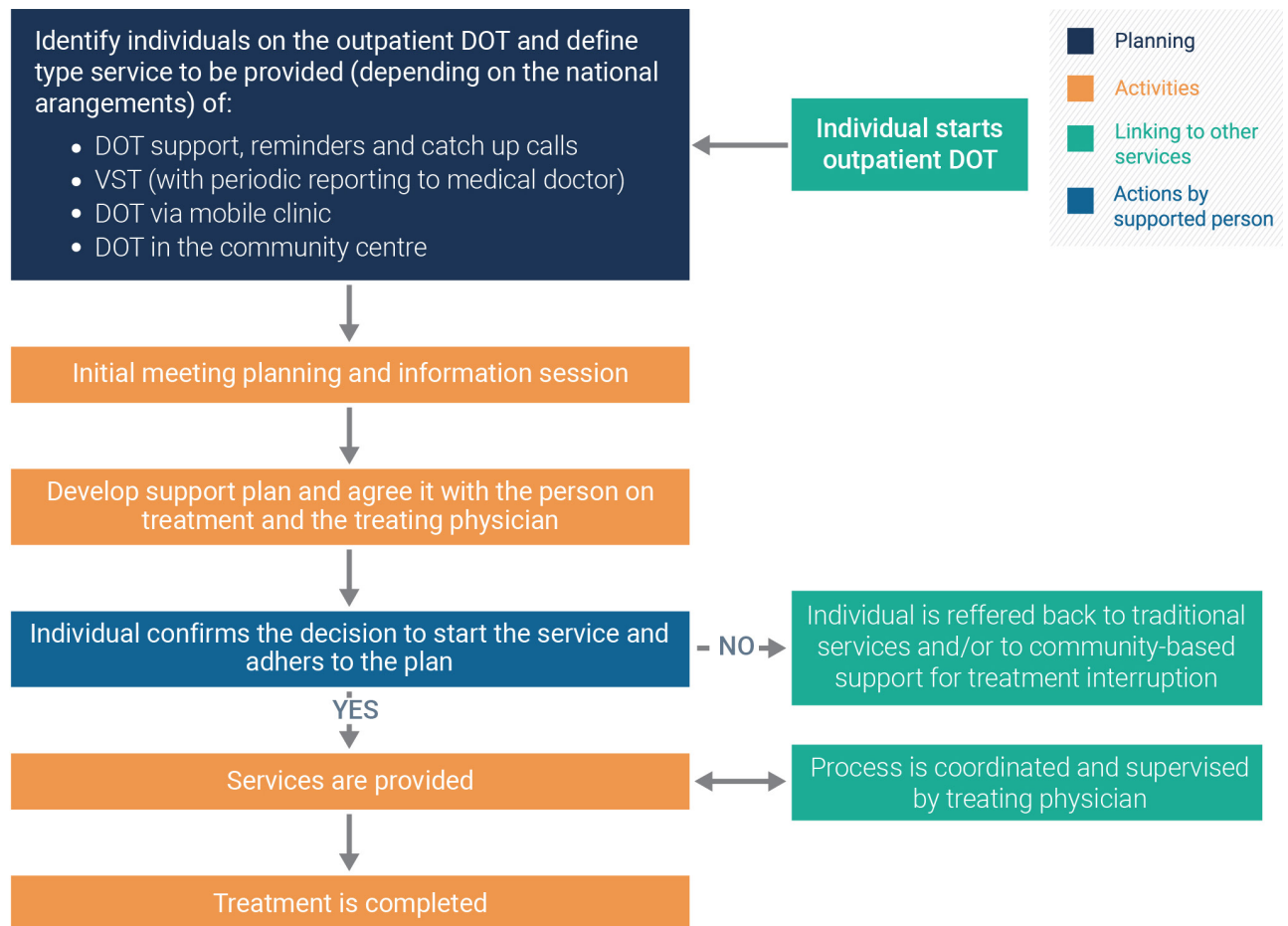
- sending reminders not to skip the drugs (and receiving responses) and making catch-up calls to encourage adherence;
- using a mobile clinic that travels to a more convenient location for the patient and delivers DOT;
- providing daily DOT in the community-based service centre if that is a preferred location for the patient (or a community worker travelling to the patient's preferred location); or
- using VST.

Although community-service providers may perform these activities, they need to ensure that detailed records are kept, including recording any adverse side-effects that the individual may experience. The process should be periodically reviewed by the physician, who should also intervene if undesirable side-effects from drugs are registered or the person experiences health complications.

Before the start of service, the community-based service provider should meet with the person on treatment to provide information about the treatment process and to agree on the format for future collaboration in the treatment process. This plan must also be agreed with the treating physician.

Fig. 6 is an algorithm for observation of supported treatment.

Fig. 6. Service delivery algorithm for observation of supported treatment



Service delivery location

DOT or VST should be delivered at home or in the community. This may include mobile service delivery centres (vehicles designated for this purpose), the office of the community-based organization equipped with needed infection control measures, or even outdoors if this works better and allows confidentially. In any case, modes of service delivery may vary based on the particular context and the particular needs of the person being supported.

Duration of the service

The service is a continuous process starting from the initiation of treatment until the individual with TB has completed the treatment course (Table 8).

Table 8. Approximate timing of the service

Component	Time required
One face-to-face meeting with the individual (informational session regarding TB and risks of conversion to DR-TB (for those with drug-sensitive TBs), general information regarding TB and individual infection control measures, and motivational counselling)	Up to 2 hours
Daily reminders to individual through telephone calls or SMS	
DOT in the community	Up to 1 hour
DOT via VST	Up to 0.5 hours

Resources needed for service delivery

- IEM
- Cell phone (for DOT reminders only) and smartphone with Internet connection and phone camera (for VST)
- Pill box
- Means of transportation
- Vehicle equipped to serve as a mobile clinic (optional).

Evaluation and reporting

Key indicators

- Total number of people receiving the DOT or VST service in a one-year period
- Percentage successfully completing the treatment among all who started treatment with DOT or VST in a one-year period
- Percentage interrupting treatment for two or more months in a one-year period.

Documentation and record keeping

A registration form for each person will include the following data:

- general information needed for identification of the person and/or a personal identity card (data content will be set by the requirements of national legislation; e.g. it may contain identification code and/or name, sex and age);
- type of service provided, such as information session, DOT support, VST support;
- number of services provided; and
- information about DOT/VST process: (i) information regarding the person's condition, (ii) time and date of drug intake and name of the drug, (iii) existing side-effects connected with the drugs.

SERVICE 3.1.2 MANAGING LOSS TO FOLLOW-UP AND PREVENTING TREATMENT INTERRUPTION

Failure to start, continue and complete treatment undermines the effectiveness of TB interventions. Loss to follow-up will include people with TB who did not start treatment or whose treatment was interrupted for two consecutive months or more; these were previously known as defaulters. Patients lost to follow-up are more likely to redevelop infectious active TB and are at higher risk of developing drug resistance.

Often factors behind treatment interruption are preventable. These include lack of understanding of the treatment process and the need to follow the doctor's guidance, social and personal factors and behavioural factors, among others. Concomitant diseases can also contribute to interruption of TB treatment. Very often, medical services do not have resources and are not positioned to locate these people and spend time on motivating them to return to treatment, or to attempt to resolve issues that might prevent them from attending for treatment (for example, transportation or day care for children). Community-based organizations are best positioned to work with such individuals: they are usually located closer to people with TB, often share similar issues and are trained to provide such services.

Scope and objectives

The objective of this service is to (i) prevent treatment interruption by identifying people at risk of interruption of treatment and providing them with the support needed, (ii) motivate people diagnosed with TB to start treatment, and (iii) locate people with TB lost to follow-up and motivate them to return back to treatment.

The service includes information provision (health education), motivational and behavioural change counselling and support in linking with appropriate treatment facilities.

It is a challenge for medical services to identify people with TB who are lost to follow up, particularly in a timely manner; and efforts should be made to make this possible. When such people are identified, they should be referred to community-based service providers.

Target audience

The service is provided to individuals who have been diagnosed with active TB and have not started, or have not completed, treatment, as well as to those who are currently on treatment but are at risk of interruption (given that interruption is classified as treatment cessation for two months or more). Such people would be referred to community-based services by treating TB services.

Service delivery

Initiation and planning

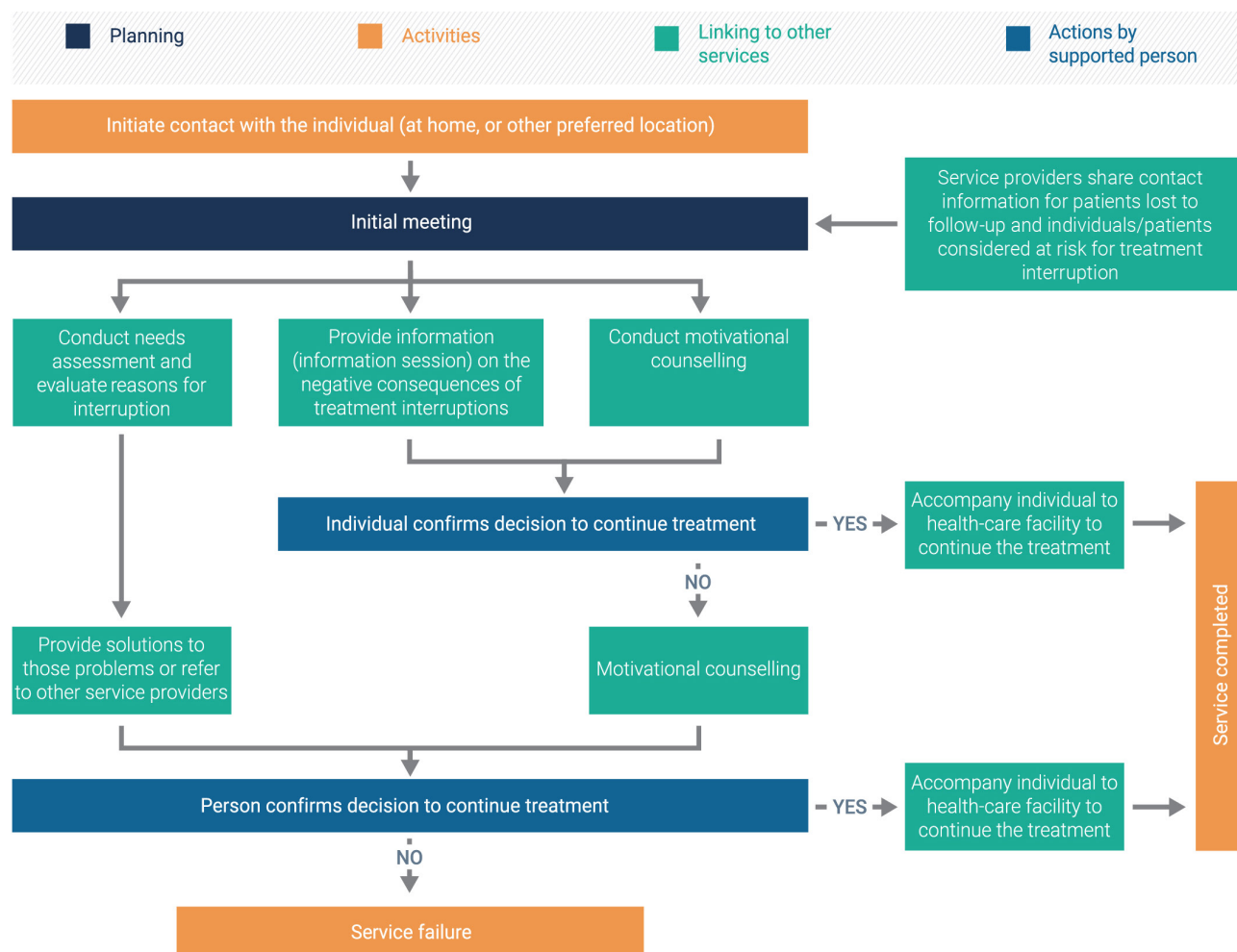
TB diagnostic and treatment services are delivered by medical services. They will be aware of

people who have been diagnosed with TB but have not started the treatment, have been out of treatment for more than two months, frequently fail to attend scheduled visits or frequently fail to take the drugs as prescribed. Outreach activities organized by a community-based service provider would typically include:

- identifying people with TB who are lost to follow up;
- getting in contact with those individuals (by visiting their place of residence or other contact location);
- identifying the cause of treatment interruption;
- conducting a consultation on TB and risks of not completing treatment (mental health counselling);
- accompanying the person with TB to a local TB service provider for continuation of treatment;
- providing additional support through adherence counselling; and
- assisting people with TB with comorbidities such as HIV, hepatitis, substance abuse and others to coordinate treatment activities.

Fig. 7 is an algorithm for management of loss to follow-up and prevention of treatment interruption.

Fig. 7. Service delivery algorithm for managing loss to follow-up and preventing treatment interruption



Duration of the service

The duration of the service varies depending on the issue that the individual is facing; those who continue the treatment would be followed up until the completion of treatment (Table 9).

Table 9. Approximate timing of the service

Component	Time required
Meeting with individuals (including educational and motivational counselling)	Timing is defined case by case according to the client's needs and level of complexity
Mental health and psychological counselling (for complex issues)	1–2 hours depending on need

Service delivery location

The service is delivered to people with TB individually. Privacy, confidentiality, autonomy and legal recourse when needed must be ensured. Consequently, the location may vary with the preference of the individual.

Resources needed for service delivery

- Identification document of service provider (badge, card or other)
- IEM that focus on treatment failure and its consequences, highlighting the importance of treatment adherence.

Evaluation and reporting

Key indicators

- Total number of people receiving the services in a one-year period
- Percentage resuming treatment after consultation among all who received the service in a one-year period
- Percentage defaulting on treatment once again after receiving the service in a one-year period
- Percentage satisfied with the quality of the service.

Documentation and record keeping

- Information documents for individuals (includes personal information, mental health evaluation, side-effect details)
- Feedback forms (if relevant).

SERVICE 4.1.1 INDIVIDUAL NEEDS ASSESSMENT

TB treatment is a lengthy process and significantly intrudes into people's way of life. Those requiring treatment for TB face a number of issues, which may challenge their decisions to go through with the treatment.

In order to support individuals with TB to complete treatment, their needs should be understood and addressed where feasible. Needs might be various, starting from social and/or material support to cover costs of income loss, transportation, housing or food through to mental health support to cope with the disease and help to get to a normal life after treatment, such as finding a job.

Review of the individual's needs at different stages of the treatment is essential. This service is best provided by community-based organizations that can dedicate time to the individual, as well as support the individual in navigating the complex field of receiving nonmedical services.

Scope and objectives

Needs assessment is a participatory individual communication with a person diagnosed with TB in order to identify and support the needs that person has that might preclude initiation and completion of treatment.

The initiation of a needs assessment is recommended for every person who has recently started outpatient treatment, as well as for individuals who are already on treatment but may have issues beyond those related to TB treatment. Based on the national context, the service may be provided to individuals who receive TB treatment in the inpatient setting.

This service should identify and document needs comprehensively (including presence of children and other individuals who could be affected by the treatment) and develop an individual plan of service delivery, including referral or provision of the following services:

- mental health counselling and support;
- social support;
- material support;
- treatment coordination planning if individual has a concomitant condition that also requires treatment (not limited to HIV and hepatitis C treatments);
- counselling and health education (such as nutrition, tobacco cessation);
- post-treatment social support and/or rehabilitation; and
- legal aid, support and empowerment with respect to issues such as confidentiality, privacy, access to information, freedom from stigma and discrimination and other legal recourse/ access to justice.

The decision on provision or referral to any of the above services is made mutually by the individual and the service provider. The individual provides informed consent for the proposed assistance.

Target audience

Box 3 summarizes the target audience for individual needs assessment.

Box 3. Target audience for individual needs assessment

The service is directed at an individual who has been recently diagnosed with TB or who is already taking TB treatment AND has been diagnosed with TB and receives TB treatment AND has at least one of the following characteristics:

- is a naïve patient (has not received TB treatment before);

AND/OR

- demonstrates a lack of understanding of the importance of TB treatment, lacks motivation to follow a regimen of treatment (based on observation and conclusion of a consulting health-care worker);

AND/OR

- lives in harmful or unhealthy conditions that can negatively affect TB treatment process (e.g. individuals who are homeless, use drugs, are migrants, were recently discharged from prison, are unemployed, live in poverty);

AND/OR

- is a parent, guardian or caregiver of a child under 18 years of age;

AND/OR

- has responsibility to care for children or other household members (e.g. elderly or disabled person);

AND/OR

- has MDR-TB.

Service delivery

Initiation and planning

Individuals are referred to the service provider by the health-care worker. It is recommended that all people with newly diagnosed TB undergo needs assessment in order to prevent future complications; other people may also be referred to the service if the health-care provider sees the need.

A community-based service provider contacts individuals with TB disease and provides them with information regarding treatment and the need for continuation, as well as assesses needs and develops a plan jointly with the individual on how to address those needs.

To provide the service, the service provider should develop in advance:

- a needs assessment questionnaire;
- an individual care and support plan template;
- a template for an agreement with an individual;
- IEM on TB; and
- a list of social and material support services available in the area, as well as contact information for social agents, lawyers and other frequently needed resource people.

At times, the frame of the service is extended to include individuals other than the person with TB: those who directly depend on the person and would be affected by the illness and treatment process (e.g. children, elderly or disabled individuals in the household).

The service is delivered individually.

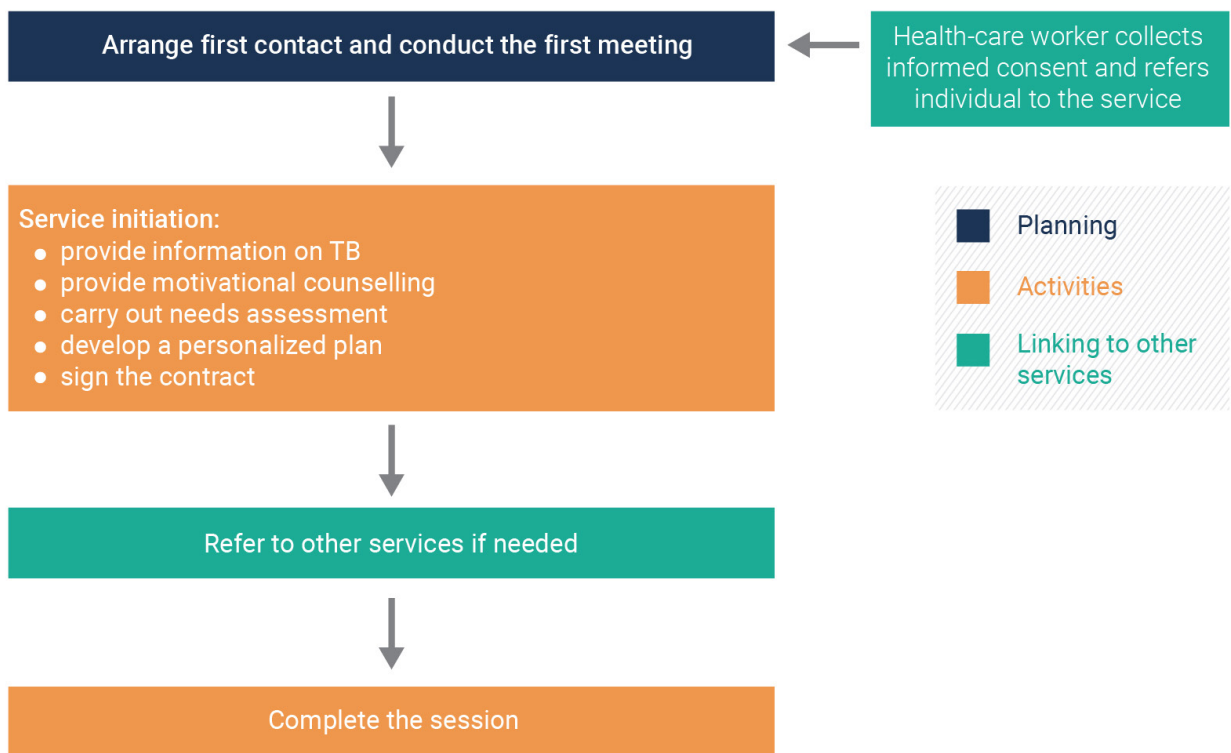
The needs assessment should include assessments of key socioeconomic determinants for TB (Table 10).

Table 10. Assessment of key socioeconomic determinants

Determinants	Aspects
Personal information	Name, age, place of residence, contact information, gender, key and vulnerable population status
Family	Marital status, children, other dependents
Health status (apart from TB)	Chronic diseases, infection diseases, substance use, disability, etc.
Psychoemotional	Feelings, fears, depression
Economic	Sources and level of income, any family members or friends who may provide financial support during the treatment period, employment, housing conditions, nutrition, debts, access to social protection systems, etc.
Social linkages and other issues	Social network and community

The pathway for effective needs assessment is outlined in Fig. 8.

Fig. 8. Service delivery algorithm for individual needs assessment



Duration of the service

The service should be completed within 1–2 working days (Table 11).

Table 11. Approximate timing of the service

Component	Time required
Preparation for service delivering (developing documentation forms etc.)	1–2 working days
1 meeting with the individual (needs assessment, discussion of individual plan, signing agreement)	up to 2 hours
2–3 phone calls to the individual	Up to 1 hour
Travel time (if needed) to a place of meeting (if meeting will be outside the service provider's office)	Depending on location and transportation

Service delivery location

Service would be delivered in a convenient location for the patient, such as at home, in a community centre or similar centre.

Resources needed for service delivery

- Identification document of service provider (badge, card or other)

- IEM that focus on treatment failure and its consequences, highlighting the importance of treatment adherence
- defined form to record the results of the needs assessment.

Evaluation and reporting

Key indicators

- Total number of people receiving the services in a one-year period
- Percentage satisfied with the quality of the service.

Documentation and record keeping

- Information documents for individuals (includes personal information, mental health evaluation, side-effect details)
- Needs assessment forms.

SERVICE 4.1.2 MENTAL HEALTH AND PSYCHOLOGICAL COUNSELLING AND SUPPORT

TB treatment may be stressful and lengthy process, which requires changes in the life of a person as well as their families. Often, people who fall ill with TB experience difficult life conditions, may live in poverty, have different behavioural and other risk factors and may lose a job or even social contacts because of the illness. Therefore, they require support throughout the treatment process (and beyond), both to start it promptly and complete it successfully.

Scope and objectives

Mental health and psychological counselling and support focus on the particular mental health and psychological needs and situation of the individual. Objectives of the service are to (i) identify and address an individual's mental health and emotional support needs and (ii) support them through the course of the treatment.

Mental health and psychological counselling might include group or individual sessions, as well as services delivered by a professional psychologist/psychiatrist or lay people from the community and peers.

When delivered in a community-based setting, the community organizations should have sufficient resources to provide the services themselves or they would be knowledgeable of when and how to refer people with TB to the friendly service provider.

Target audience

The need for support and the possibility of providing it will be defined as part of the needs assessment (Service 4.1.1). Box 4 summarizes the target audience for mental health and psychological counselling and support.

Box 4. Target audience for mental health and psychological counselling and support

In order to qualify for psychological counselling and support, an individual must:

- be diagnosed with TB and currently on treatment (or with a strong intention to start/continue the treatment);

AND

- have passed a needs assessment and developed an individual plan of care and support.

The individual should also have AT LEAST ONE OF THE FOLLOWING:

- a previous diagnosis of a mental health problem (e.g. depression, anxiety, post-traumatic syndrome, psychotic disorder),^a

AND/OR

- a substance use problem (drugs, alcohol);

AND/OR

- living in stressful or unhealthy environment that could negatively affect TB treatment (e.g. homelessness, migration, former prisoner, unemployed, financially disadvantaged);

AND/OR

- taking long-lasting TB treatment (MDR-TB).

^aIndividuals with a history of mental health illnesses, or a current such diagnosis, should be referred to a psychologist, or psychiatrist.

Service delivery

Initiation and planning

Individuals may contact community-based organizations themselves for mental health and psychological counselling and support, or they may be formally or informally referred by their treating physician or peers. However, before the initiation of the service, the service provider must:

- check the person's status to confirm TB diagnosis and whether the individual is on treatment; if an individual has interrupted treatment, he or she should be referred to the services for people with TB lost to follow-up (Service 3.1.2);
- carry out a needs assessment for the person (Service 4.1.1) to help in identify their existing needs and resources; and
- jointly develop a support plan, which is particularly important given that most people with TB would require more comprehensive support rather than only one service.

It is recommended that the service provider collaborates with the treating physician to ensure coordinated activities.

Some services require prior preparation and planning. Unlike other services, a formal qualification may be required as well.

Mental health and psychological counselling. Unless otherwise defined in national regulations or common practice in a country, psychological counselling may be conducted by an individual who has a formal qualification in psychology (clinical, behavioural, cognitive or similar field) and/or psychiatry. Psychological counselling can be performed individually or in groups.

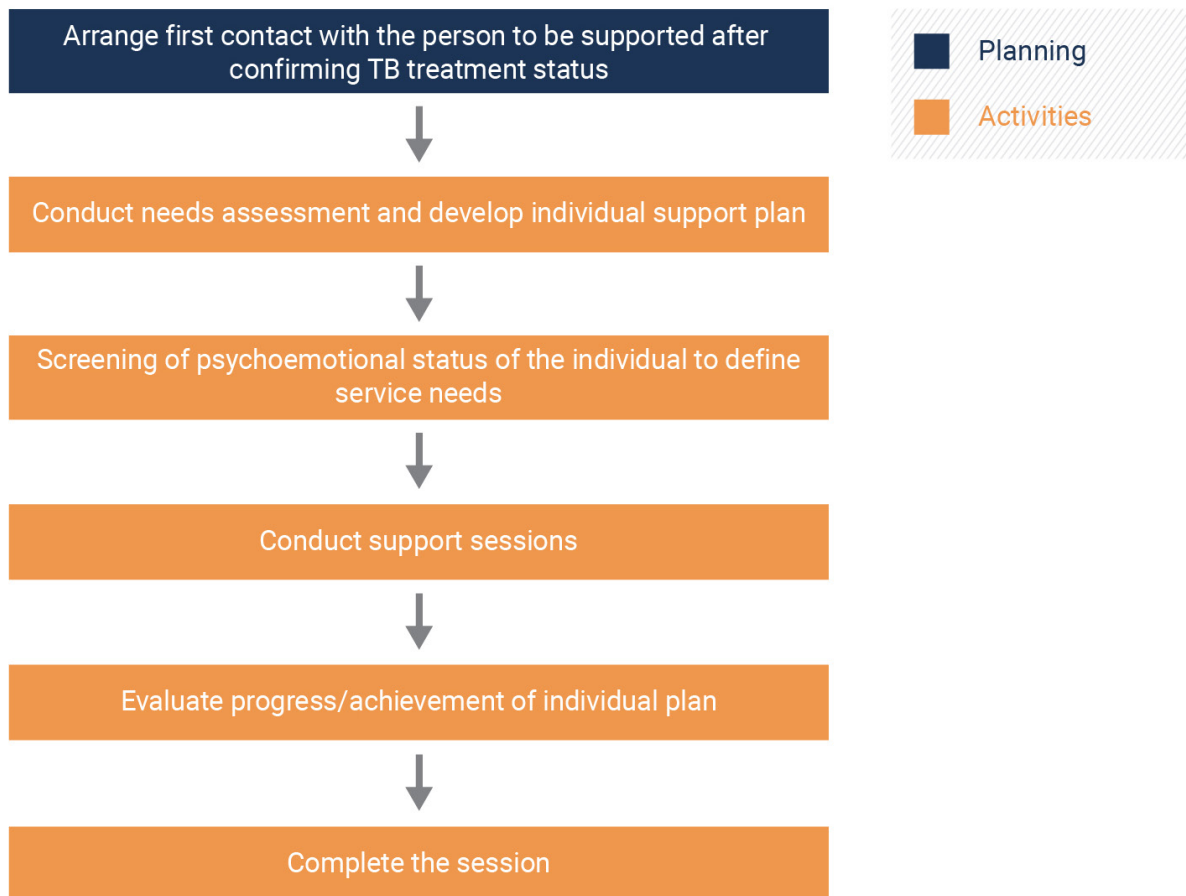
Lay professional mental health and psychological counselling. Individuals with experience and formal or informal training in providing such services, preferably peers, can deliver counselling. This can be carried out one to one or in groups.

Screening and assessment. It is recommended that standardized evidence-based scales and screening tools, such as the Patient Health Questionnaire (2 or 9), Beck Screening tools or the Hospital Anxiety and Depression Scale, are used.

Needs assessments and individual plan development. A trained community worker can carry these out, although the results should be revised in consultation with the psychologist or social worker who will be working with the person in the future.

Fig. 9 is an algorithm for delivery of mental health and psychological counselling and support.

Fig. 9. Service delivery algorithm for delivery of mental health and psychological counselling and support



Duration of the service

The duration of the service can vary depending on session type:

- short-term on-demand sessions (1–3 meetings), over not more than 10 days
- medium-term series of session (8–10 meetings), over not more than two months.

Table 12 gives the approximate timing of the service.

Table 12. Approximate timing of the service

Component	Time required
1 face-to-face meeting (conducting any type of session)	1 hour
2–3 phone calls to the person being supported	Up to 1 hour
Time for communication with a consulting health-care worker and keeping records	Up to 2 hours

Service delivery location

Service delivery location may vary. Most of the services should be delivered face to face, although remote communication can be used as well. Usually, mental health and psychological counselling is carried out at a venue arranged by the psychologist; services of a social worker may be delivered at a community-based organization or at preferred location for the individual (Table 13).

Table 13. Formats of service delivery

Staff	Individual	Small group
Professional psychologist/ psychiatrist	Mental health and psychological counselling (on demand)	Therapeutic groups (on demand)
	Psychotherapy (series of sessions)	
Nonprofessional staff	Motivational counselling (on demand)	Self-support groups (on demand)
	Behavioural change communication (series of sessions)	

Evaluation and reporting

Key indicators

- Number of individuals who received at least one individual counselling sessions (or group sessions where applicable) by type of service
- Number of people with TB who have undergone needs assessment and completed individual care plans and received service if defined in the individual care plan
- Percentage satisfied with the counselling service.

Documentation and record keeping

Individual case files should be maintained that contain the needs assessment, individual care plan, contract and reports on the services provided and received (number of sessions conducted, progress monitoring) plus the documented results.

SERVICE 4.1.3 CASE MANAGEMENT

TB treatment may be a stressful and lengthy process that requires changes in the lives of people with TB, as well as their families. Often, people who fall ill with TB experience difficult life conditions, may live in poverty, have different behavioural and other risk factors and may lose a job, or even social contacts, because of the illness. Therefore, they require a support throughout the treatment process – to start it timely and successfully complete it.

Case management is a systematic and collaborative approach for evaluating and assisting individuals to resolve immediate or long-term issues by documenting the issues, providing services and linking people with TB to relevant services. It encourages consistent behaviour to prevent, minimize or overcome individual difficult life circumstances stemming from a diagnosis of TB and its treatment.

Scope and objectives

Case management includes services focused on an individual's health; their social, economic and financial needs; and on support for mobilizing and identifying resources to resolve these issues. It can include support for getting identification documents in order, for legal actions or to receive the health and social benefits available in the country.

Objectives of case management are to (i) enhance development, problem-solving and coping capacities of individuals, and (ii) link people with TB with the systems that can provide them with the resources, services and opportunities they need.

When case management is delivered in a community-based setting, the community organizations may have sufficient resources to provide the services themselves or they would know how to refer people with TB to a friendly service provider or to assist them to get the support to which they are eligible under national regulations.

Target audience

The need and possibility to support each individual are defined as part of the needs assessment (Service 4.1.1). In order to qualify for the service, an individual must be diagnosed with TB and be currently on treatment, or with a strong intention to start/continue the treatment (Box 5).

Box 5. Target audience for case management

The individual should:

- be diagnosed as having TB and be receiving treatment (or has a strong intention to do so)

AND

- have passed a needs assessment

AND

- have developed an individual plan of care and support.

In addition the individual should have AT LEAST ONE OF THE FOLLOWING:

- lives in poor or unhealthy conditions that can negatively affect TB treatment process (e.g. homelessness, migration, former prisoner, unemployed, financially disadvantaged)

AND/OR

- has low income (e.g. unemployed, pensioners, individuals living below national poverty threshold)

AND/OR

- has comorbidities, including disability, substance use, infectious diseases, mental and neurological disorders

AND/OR

- faces human rights violations, violence, stigma and discrimination related to his or her TB diagnosis and treatment

AND/OR

- has a difficult family situation or is a caregiver for a child, children, elderly person or a disabled person.

Service delivery

Initiation and planning

Individuals may contact community-based organizations themselves or they may be formally or informally referred by their treating physician or peers. However, before the initiation of the service, the service provider must:

- confirm the individual's TB diagnosis and whether the individual is on treatment; individuals who have interrupted treatment should be referred to the services for people with TB who are lost to follow-up (Service 3.1.2);
- carry out a needs assessment for the individual (Service 4.1.1), which helps to identify their existing needs and resources; and
- jointly develop a support plan, which is particularly important given that most people with TB would require more comprehensive support than can be provided by a single service.

It is recommended that the service provider collaborates with the treating physician to ensure coordinated activities.

Case management should be delivered by someone who has a formal qualification as a social worker unless otherwise defined in national regulations or commonly practised in the country.

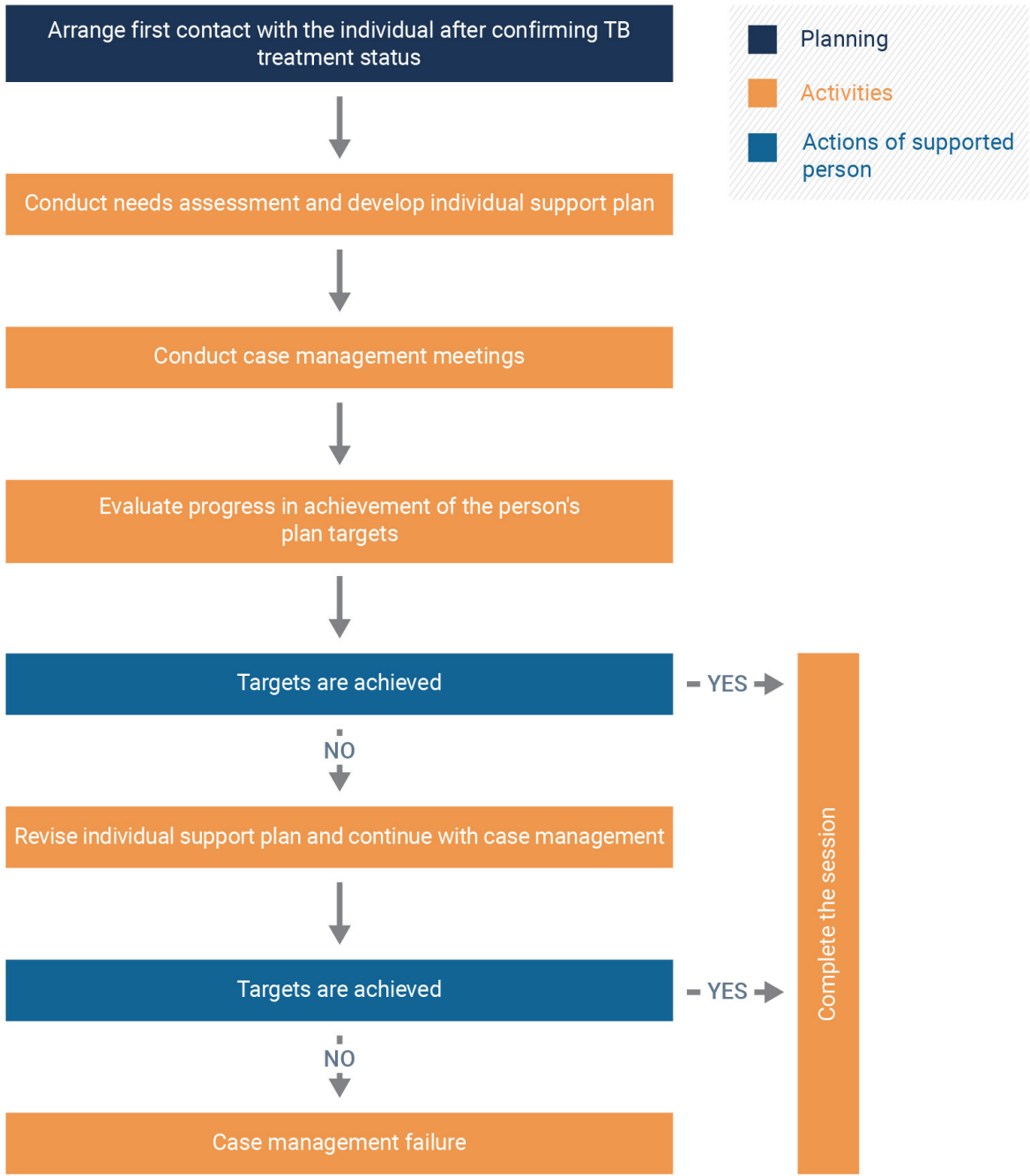
The objective of case management is to prevent, minimize and overcome difficult life circumstances (Table 14).

Table 14. Objectives of case management

Social well-being aspects	Examples of activities		
	Prevention	Minimization	Overcoming
Access to social services (welfare, pensions, issuance of an identity card, etc.)	Information on public entities, social services and welfare (contacts, procedure, etc.)	Mediation between individuals and public entities, social services, etc.	Mediation and accompanying individuals to public entities or social services, assisting in restoring documents etc.
Human rights	Information and monitoring on possible issues	Mediation and counselling and other legal remedies	Legal remedies, counselling and representation in public institutions
Economic (unemployment because of TB)	Provision of information on job opportunities	Counselling on job search	Training and counselling on job search and applications
Children (separation from children because of TB)	Information on possible issues	Mediation and counselling	Legal counselling and representing in public institutions

The algorithm in Fig. 10 outlines the pathway for case management.

Fig. 10. Service delivery algorithm for case management



Duration of the service

The duration of the service can vary depending on session type.

- short-term on-demand sessions (1–3 meetings), over not more than 10 days
- medium-term series of session (8–10 meetings), over not more than two months.

Table 15 outlines the approximate timing.

Table 15. Approximate timing of the service

Component	Time required
One face-to-face meeting (conducting any type of session)	1 hour
Phone calls to the supported person	Up to 4 hours
Time for communication with a consulting health-care worker, outsourced specialists and keeping records	Up to 8 hours

Service delivery location

The location for service delivery can vary. Most of the services should be delivered face to face, although remote communication can also be used. Services may be delivered at a community-based organization or at preferred location for the individual.

Evaluation and reporting

Key indicators

- Number of people receiving case management
- Percentage of those who had undergone needs assessment and completed individual care plans that received the service if defined in the individual care plan
- Percentage satisfied with the quality of the service.

Documentation and record keeping

Individual case files should be maintained containing the needs assessment, individual care plan, contract and reports on the services provided and received (number of sessions conducted, progress monitoring) and documented results.

SERVICE 4.1.4 MATERIAL SUPPORT

People on TB treatment often face significant financial challenges. Their financial situation is worsened (individually and for dependents) because of inability to work and earn. These complications may prevent people with TB from maintaining adherence to treatment.

Scope and objectives

NTPs often have material support available for people with TB who are on treatment. The scope of this service is to assist eligible individuals to receive the material support available, as well to assist NTPs in identifying eligible populations and delivering the services.

The objective of the service is to (i) deliver material support interventions timely and effectively in order to help people with TB and their families in their struggle against the illness, (ii) alleviate the burden generated by the disease, (iii) provide incentives for adherence to treatment, and (iv) foster the development of a community system and enabling environment for adherence.

Target audience

Target audience for the service are people with TB currently on treatment, including those with drug-sensitive TB and those with DR-TB (including MDR-TB).

Service delivery

Material support available for people with TB varies from country to country. Generally, support includes:

- nutritional support
- financial support
- financial incentives and bonuses
- transportation subsidies
- living allowance
- temporary housing
- legal aid/access to justice.

Some other types of assistance may be available. Some services will be available for all people with TB (e.g. financial incentives are generally tied to treatment adherence and not the need for such support), while others may be limited to those in need (e.g. nutritional support). Criteria for each type of support will be defined and may vary.

The role of community-based organizations is to support identification of people with TB in need of such services, inform them about the possibility of receiving such assistance, help them to link with the organization that provides such a service where the option is available, and to engage in allowance/support distributions.

Service delivery might include one face-to-face meeting with an individual, which would be an informational session regarding TB and the risks of conversion to DR-TB (for those with drug-sensitive TB), providing some general information regarding TB and motivational counselling. This meeting may last up to two hours. In some instances, community-based organizations may be engaged in identification of potential recipient of such services, which can be carried out based on the needs assessment, and in delivery of such assistance. In these cases, the level of effort by the community organization would vary.

SERVICE 4.1.5 HEALTH EDUCATION AND COUNSELLING

People receiving TB treatment might not have good and sufficient information on their health status, what to expect from the treatment process and how to care better for themselves. In addition, people are exposed to many myths about treatments and recovery, and in order to support adherence it is important to provide individuals on treatment with evidence-based information. Addressing underlying risks and unhealthy behaviours, such as tobacco use, is also important on the path of recovery and towards a healthier life afterwards.

Scope and objectives

The objective of the health education and counselling service is to provide people with essential knowledge on maintaining their health and to support them through treatment. It includes components such as proper nutrition, self-care and tobacco cessation, but it might not be limited to these based on the competence and needs among the local TB population.

Target audience

The service is targeted at people with TB, currently on treatment, particularly for those with nutritional issues and those who smoke.

Service delivery

Initiation and planning

The service should be initiated by the service provider in cooperation with the treating physician or the attending nurses (at an inpatient facility or TB centre).

The treating physician will recommend the patient to receive this service based on an assessment of the patient's physical well-being, risk habits (smoking) and any lack of knowledge on proper nutrition. The health-care worker refers the person to the service provider.

The service provider should assess the person's nutritional status, risk habits and, based on the assessment, prepare:

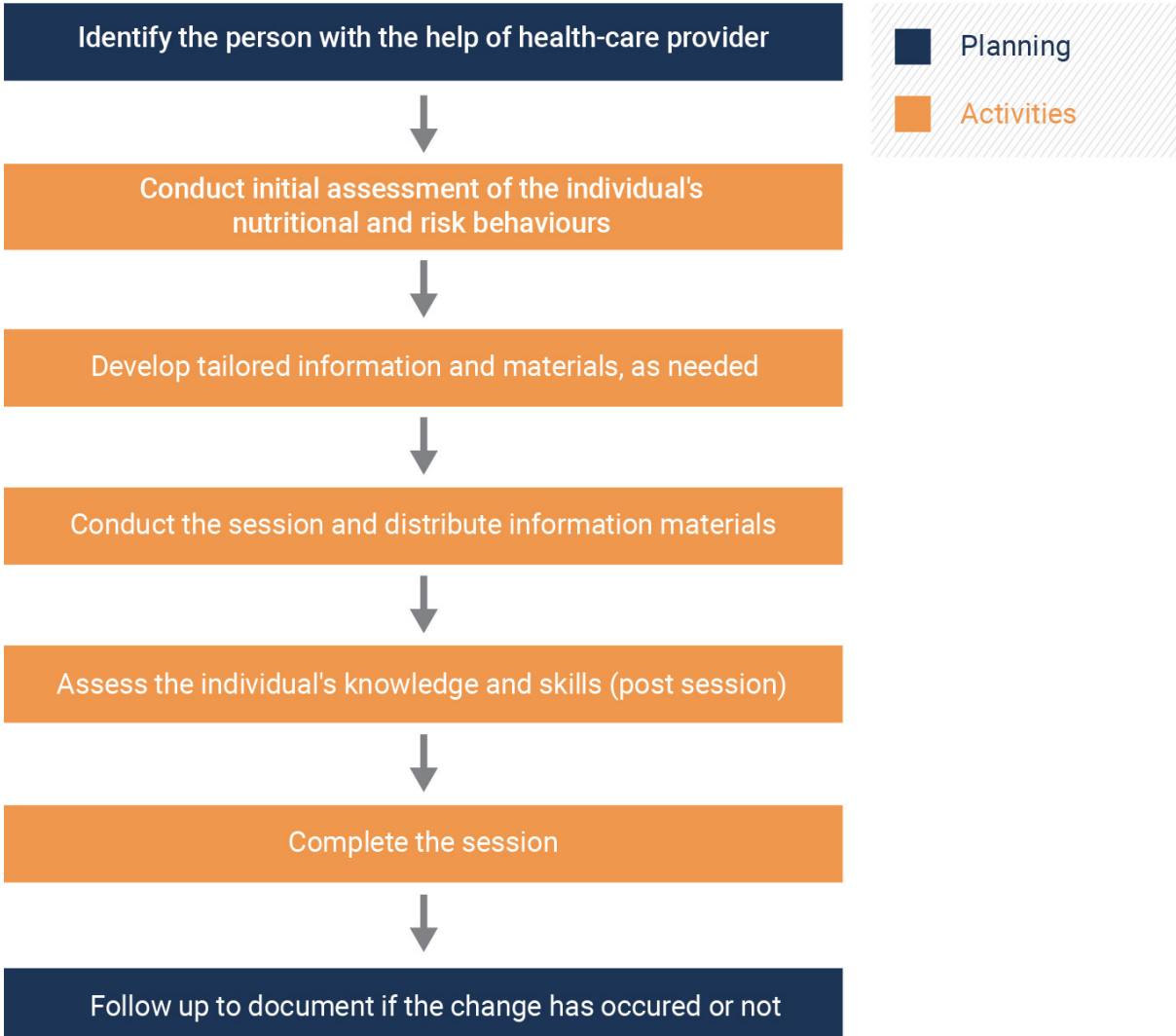
- an agenda for health education sessions on nutrition and tobacco cessation
- supportive IEM on nutrition and tobacco cessation (factsheets, booklets and leaflets).

Both the agenda for the counselling session and the supportive IEM should include proper nutrition recommendations, as well as tobacco cessation interventions and their relation to TB treatment. The IEM should be tailored to the person's characteristics (including language, legal status, gender, key and vulnerable population status, age or social status).

A service provider needs to consider the person's needs and preferences in regard to the mode of service delivery, including the frequency and format of counselling sessions (whether to use face-to-face meetings, video-chats, etc.).

The service can be delivered to people individually or in a small group (up to 10 people). Fig. 11 outlines the pathway for health education and counselling.

Fig. 11. Service delivery algorithm for health education and counselling



Duration of the service

The duration of the service can vary depending on the agenda, format of delivering and preferences of the individual (Table 16).

Table 16. Approximate timing of the service

Component	Time required
Development of health education session agenda and supportive materials	Once per service, timing defined case by case
Preparatory stage (coordinating with a health-care worker, forming small groups, schedule of sessions, etc.)	8–16 working hours
Conducting health education session	0.5–1.0 hours per session
Time for evaluation and keeping records	Up to 8 hours

Service delivery location

Any place and location comfortable for the individual and suitable for such activities (e.g. health-care facility, co-working, classroom, office of institution and/or other service provider premises).

Resources needed for service delivery

- IEM
- Flipchart, media projector, screen, laptop (if necessary)
- Feedback forms (optionally).

Evaluation and reporting

Key indicators

- Total number of people participating in the counselling sessions in a one-year period
- Percentage changing nutritional habits after receiving the service among all beneficiaries receiving the service in a one-year period
- Percentage of smokers quitting smoking in a one-year period
- Percentage satisfied with the quality of the service.

Documentation and record keeping

- Participant's registration form for the counselling session
- Feedback forms (if relevant).

SERVICE 4.2.1 POST-TREATMENT SOCIAL SUPPORT AND/OR REHABILITATION

People recovered from TB often need support to get back to normal life. This is particularly true for people who have lost their employment during the treatment process.

Scope and objectives

Post-treatment social support and/or rehabilitation is a supportive targeted communication with people who have recently completed their TB treatment in order to help them to reintegrate into society, re-establish their social links and get back to normal life.

It provides social support, including mental health, psychological and legal counselling and helps people to receive proper training to be competitive in the job market. It is expected that those efforts will minimize the relapse of TB.

Target audience

The target audience for the service are people who have recently completed treatment for TB (three months) or have been recently released from a penitentiary facility.

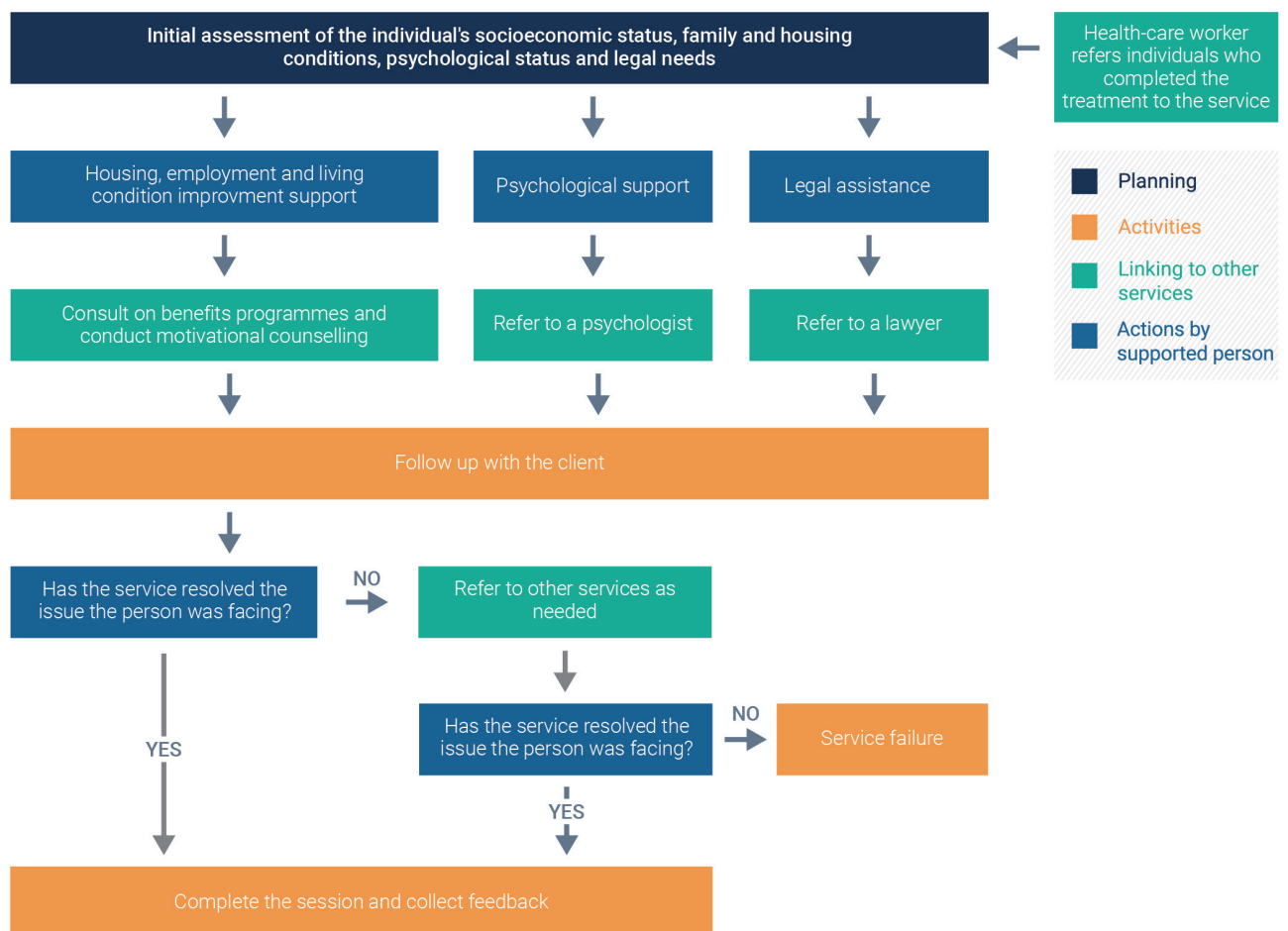
Service delivery

Initiation and planning

Individuals who have completed treatment (or have been released from a penitentiary facility) are referred to the service by their health-care service provider based on the perceived or declared need for such services. A service provider should consider the individual's needs and preferences concerning the mode of service delivery, including the frequency and format of counselling sessions (e.g. face-to-face meetings or video-chats). The service can be delivered individually or in groups.

The algorithm in Fig. 12 outlines the pathways for provision of social support after treatment.

Fig. 12. Service delivery algorithm for provision of post-treatment social support and rehabilitation



Duration of the service

The duration of the service can vary depending on the individual's needs and the complexity of the issues (Table 17).

Table 17. Approximate timing of the service

Component	Time required
Initial assessment at the beginning of the service	Once per service, timing defined case by case
Mental health and psychological counselling	Frequency and timing defined by individual's needs
Legal counselling	Frequency and timing defined by individual's needs

Service delivery location

Any location can be used that is convenient for the individual and suitable for such activities (e.g. health-care facility, co-working, classroom, office of institution and/or other service provider premises).

Resources needed for service delivery

- IEM
- Additional information and contacts of partner organizations for referral services or support if needed
- Feedback forms (optional).

Evaluation and reporting

Key indicators

- Total number of people receiving the service in a calendar year
- Percentage resuming work after completing the service among the beneficiaries who received the service within a given calendar year and are eligible to start employment (e.g. from age and ability standpoint; criteria should be defined locally)
- Percentage with TB relapse in a given year
- Percentage satisfied with the quality of the service.

Documentation and record keeping

- Participant's registration form for counselling session
- Feedback forms (if relevant).

SECTION 4 SERVICES AND PARTICULAR CONSIDERATIONS FOR KEY AND VULNERABLE POPULATIONS

Specific groups in the population may have circumstances that require a particular type of service and these are described in this section. In the light of the COVID-19 pandemic and its impact on TB services, a final subsection describes how TB services have responded to the pandemic, considerations for supporting communities and people with TB during a health emergency and restrictions resulting from responses to public health emergencies on such a scale.

COMMUNITY-BASED SERVICES FOR THE PRISON POPULATION

The prison population experiences an elevated risk of TB and TB burden compared with the general population. Level of TB prevalence in prisons can be 4–50 times higher than that of the general population (20). There are several factors contributing to the higher prevalence and incidence of TB in prisons and other types of detention and probation centres: staying in overcrowded and poorly ventilated premises, malnutrition, reduced immunity and limited access to services. The situation is further aggravated by higher prevalence of HIV and viral hepatitis in the same population.

Nonmedical factors also contribute to higher TB burden in prisons. These include socioeconomic barriers to TB prevention and management and access to general health-care services at prison premises. CRG assessments for TB carried out in 15 countries based on Stop TB Partnership tools, including four countries in the EECA Region (Georgia, Kyrgyzstan, Tajikistan and Ukraine), have identified legal, social, gender and economic barriers to accessing TB services. These include (i) punitive laws, policies and practices, which may limit access to health-care services for prisoners; (ii) stigma and discrimination, which affect the prison population and the prison setting and are often associated with a breach of confidentiality and low respect for a person's privacy and autonomy; (iii) gender norms, which many lead to increase violence, stigma and discrimination and also inhibit men from seeking care as an exhibition of masculinity; and (iv) availability and accessibility of services, where not only supply could be limited but also access as part of the prison administration (21). The CRG investment package for a prison population, developed by Stop TB Partnership, allows creation of an enabling environment for TB services within prisons with a focus on vulnerable populations (21).

TB in prisons does not stay confined, and transmission of TB occurs among prisoners as well as to prison staff and to family members. Continuation of TB treatment for detainees is another major concern for TB control activities in many countries. The regional report *Breaking the Silence: Human Rights, Gender and Discrimination Barriers to TB Services in Georgia, Kazakhstan, Kyrgyzstan, Tajikistan and Ukraine* shows that people with a history of imprisonment encounter barriers when they

do not have a national identity documents or a passport (which can occur following imprisonment) or when they do not have a domicile registration (often required to access health care) (22).

Role of community-based services

The organization of community-based TB services for the prison population is based on the collaboration between prison authorities and the civilian health-care sector, which is often very weak. Table 18 summarizes a set of potential interventions for specific subgroups of the prison population: (i) detainees and prisoners who are currently in the congested facilities, facing elevated risks of TB because of close contact with other inmates who might have active TB, overcrowding, limited access to medical services and poor living conditions; and (ii) ex-prisoners and offenders on probation, who no longer live in a prison facility but may have limited social and economic capital to maintain an acceptable standard of living, seek medical services and adhere to treatment. Individuals on probation maintain regular contact with probation system, which is an opportunity to influence treatment uptake and continuation choices for those individuals. Ex-prisoners who have no such contact may default on treatment that was commenced in prison.

Table 18. Potential interventions for specific subgroups within the prison population

TB domain and subdomain	Services for detainees and prisoners	Services for ex-prisoners and offenders on probation
1. Prevention		
1.1.1. Awareness raising, risk communication and community engagement and mobilization	<p>Possibility of providing services depends on the regulations on imprisonment and type of prison</p> <p>Group sessions will not be possible in high-security settings</p> <p>The service should be carried out jointly with the medical team</p>	<p><i>Ex-prisoners:</i> same principles as for the general population</p> <p><i>Individuals on probation:</i> in some settings, probation services might collaborate with community-based services and help to organize such sessions</p>
1.1.2. Counselling of individuals at risk of TB	Possibility to provide such services depends on the regulations on imprisonment and type of prison; most likely to be delivered by local (prison) health team	Same principles as for the general population
1.3.1. Nonclinical management of LTBI	As for 1.1.2	As for 1.1.2
2. Detection and diagnosis		
2.1.1. Support for active case finding	Work with contacts in prisons is usually carried out by medical staff; approaches such as systematic screening of inmates can be carried out by nonmedical professionals (if questionnaire-based survey is used) to save medical resources	Same principles as for the general population

Table 18. contd

TB domain and subdomain	Services for detainees and prisoners	Services for ex-prisoners and offenders on probation
3. Treatment		
3.1.1. Supported treatment observation	<p>Despite the lack of medical resources in prisons, it is still best if DOT is provided by the staff of a medical unit</p> <p>Administration of VST may be complicated because of regulations prohibiting cell phone communication, as well as regulations regarding provision of pills to prisoners for their independent intake</p>	Same principles as for the general population
3.1.2. Managing loss to follow-up and preventing treatment interruption	<p>Transfer or release may be the main reasons for loss to follow-up</p> <p><i>Transfer:</i> prison administrations should ensure that continuity of medical care, including TB treatment, is ensured</p> <p><i>Release:</i> TB services should be notified in advance to plan for services; community-based services can play significant role in following up with prisoners after they are released, although this process is better started as part of discharge planning</p>	<p>Individuals on TB treatment who have been released often do not continue TB treatment or do so after an extended period of absence</p> <p>Community-based service providers can be instrumental in locating these individuals in the community and linking them back to care, although the link to care is better started as a part of discharge planning</p> <p>An initial needs assessment should be carried out to evaluate all risks of treatment interruption and provide support based on the specific needs of the people with TB</p>
4. Care and support		
4.1.1. Needs assessment	<p>Prisoners need support during treatment similar to the general population; this includes needs assessment as well as mental health and psychological counselling and health education; social and material support services are not commonly available for prisoners (if they are available, it is important to support people with TB to receive these benefits)</p> <p>Possibility to engage community-based service providers in working with the prison population depends upon legislation, as well as on the set of TB services in the country</p> <p>If community-based services can be provided, the service provider should undergo special training to start working in prison setting; this training should be provided by prison health facilities</p>	<p>Individuals released from prison need support and the need may be greater because of a lack of social capital for these individuals</p> <p>It is important to conduct a needs assessment, evaluate risk behaviours and social, material, and psychological support needs and assist individuals to receive those required</p>
4.1.2. Mental health and psychological counselling and support	As for 4.1.1	As for 4.1.1

Table 18. contd

TB domain and subdomain	Services for detainees and prisoners	Services for ex-prisoners and offenders on probation
4.1.3. Case management	As for 4.1.1	As for 4.1.1
4.1.4. Material support	As for 4.1.1	As for 4.1.1
4.1.5. Health education and counselling	As for 4.1.1	As for 4.1.1
4.2.1. Post-treatment social support and/or rehabilitation	Not available	The same principles apply as with general population

Coordination with other services

A service provider should collaborate with other organizations and institutions that communicate with prisoners, ex-prisoners, people who are in detention centres and offenders on probation and deliver them various services, including:

- social services (public, nongovernmental organizations (NGOs) and religious organizations)
- shelters and social housing for ex-prisoners
- social welfare institutions
- police and officers of the detention and probation centres
- employment centres and agencies.

COMMUNITY-BASED TB SERVICES FOR HOMELESS INDIVIDUALS

TB is a major problem among homeless people because of their living conditions, poor nutrition and other risk factors that negatively affect their health. Homeless people are those who do not have customary and regular access to a conventional dwelling or residence (23).

A homeless person belongs to a TB key population in several aspects: high risk for TB exposure, limited access to quality health care and social services, and potentially having a weak immune system because of biological or behavioural factors.

The socioeconomic determinants of health that need to be considered when organizing delivering of support services for TB to homeless people are outlined in Table 19.

Table 19. Socioeconomic determinants of health affecting service delivery to homeless people

Socioeconomic determinant	Effects
Housing	Absence of accommodation: living on streets or in places not intended for housing, such as basements or tunnels Adverse housing: cold, no heating, bad ventilation, dirty, overcrowded
Food	Malnutrition; poor or unhealthy diet
Health	Infections: having infectious diseases or high risk of acquisition Substance use: alcohol, illegal drugs Mental health issues: common mental disorders, severe conditions, neurological illnesses Disability External factors: impact of cold or overheated conditions, poor sanitation, etc.
Social	Loneliness: lacking family or with broken family relations Offending: administrative or criminal Illiteracy Violence: human rights abuse and/or physical Stigma and discrimination
Economic	Insufficient income (low or no income); unemployment

Role of community-based services

A complex of support services for TB should be established based on public health importance and cost-effectiveness. The highest priority should be given to TB case detection and ensuring that TB treatment is completed (Table 20). Therefore, community-based supportive TB services should result in relevant outcomes of diagnosis and treatment of TB in health-care services.

Table 20. Delivery of TB support services by community-based services

TB domain and subdomain	Comments on delivery
2. Detection and diagnosis	
2.1.1. Support for active case finding	It is recommended that the full extent of this service is provided: informational session, TB questionnaire-based screening, motivational counselling and accompanying to health-care facility It is permitted to provide the active case-finding service to individuals and small groups (up to five people) A service provider should facilitate communication between a health-care facility and a homeless person who has tested positive for TB for timely start of treatment

Table 20. contd

TB domain and subdomain	Comments on delivery
3. Treatment	
3.1.1. Supported treatment observation	A service provider should organize TB treatment with consideration of the individual's housing situation and economic status It is recommended to coordinate DOT with services in the care and support domain
3.1.2. Managing loss to follow-up and preventing treatment interruption	It is important to consider that homeless people have higher risk of breaking contact and interruption of TB treatment because of behavioural issues (e.g. substance abuse, stigma and discrimination, lack of motivation to complete treatment)
4. Care and support	
4.1.1. Needs assessment	Homeless people have many social problems that may have existed before they were infected with TB; therefore, most of these problems will remain or become worse during the illness The initial needs assessment should consider all social factors that can have a negative impact on TB treatment regimens and the general condition of a homeless person; however, it is essential to develop a realistic individual care and support plan and define achievable goals that will contribute to better TB outcomes
4.1.2. Mental health and psychological counselling and support	As for 4.1.1
4.1.3. Case management	As for 4.1.1
4.1.4. Material support	As for 4.1.1

Coordination with other services

A service provider should collaborate with other organizations and institutions that communicate with homeless people and deliver them various services, including:

- social and mental health services (both public and NGOs)
- shelters and social housing
- social welfare institutions
- police
- employment centres and agencies.

FAMILY-BASED APPROACH FOR TB TREATMENT IN CHILDREN

In 2018 an estimated 1.1 million children (15 years of age or younger) were infected with TB (1). Infants and young children are more likely than older children and adults to develop life-threatening TB disease and it is also more complicated to establish an accurate and timely diagnosis among this population. Often infected children do not receive treatment in specialized TB facilities and may

be treated in general paediatric facilities or in specialized facilities, such as HIV care services (24). A family-based approach to TB treatment for children provides a model of integrated care that is adapted to the needs of the child and the needs of his or her immediate caregivers.

The family-based approach should be multidisciplinary in order to address the needs of the family since it focuses on the continuum of care for the whole family and not only on the needs of the individual patient.

The key principles of a family-based approach to TB treatment are:

- integrating TB care with other health-care services, such as for HIV, mental health or sexual and reproductive health;
- facilitating the process of clinical and nursing care provision at home to alleviate symptoms;
- managing TB to prevent opportunistic infections;
- providing counselling and psychosocial support services to the family; and
- providing educational sessions for family members and TB carers and/or other social services providers to learn about TB management.

Role of community-based services

Community-based support services for a family-based approach aim to support the family through the whole continuum of care of TB to achieve better results. This includes a complex set of services targeted at different needs of the family at each stage of TB care (Table 21). Additional services may be offered in line with national guidelines, particularly TB preventive treatment.

Table 21. Family-based approach for support services in the community

TB domain and subdomain	Service delivery details
2. Detection and diagnosis	
2.1.1. Support for active case finding	Community-based active case finding is a continuous process to help district or local health-care providers to identify families who have a high-risk of TB exposure and have children under 15 years of age; the service includes: <ul style="list-style-type: none"> ■ assessment of the socioeconomic status of the child and family, housing conditions, and mental health/psychological support needs ■ referral to a local health-care facility for testing
3. Treatment	
3.1.1. Supported treatment observation	TB treatment should be organized in a way that accommodates the child’s family situation; community-based observed treatment might be the most suited delivery method in such settings
3.1.2. Managing loss to follow-up and preventing treatment interruption	Adolescents have higher rates of defaulting and may need closer monitoring and management to ensure that treatment is completed

Table 21. contd

TB domain and subdomain	Service delivery details
4. Care and support	
4.1.1. Needs assessment	Community-based services that evaluate the particular situation of the child and the family is needed to ensure tailored support is provided Family support is essential for a child to undergo TB treatment and so care and support services should be broadened to include other members of the household, particularly other children in the family
4.1.2. Mental health and psychological counselling and support	As for 4.1.1
4.1.3. Case management	As for 4.1.1
4.1.4. Material support	As for 4.1.1

Additional services may be offered in line with the national guidelines, particularly TB preventive treatment.

Coordination with child services

Children in need of treatment lack autonomy. Therefore, all efforts should be made to ensure the protection of the child's best interests, and that the child and the family have access to available health and social services. Given that families might lack information on what services are available, or how to apply for such services, community-based service providers should assist the family in receiving available benefits if needed. For this purpose, the organization providing such services should collaborate with other organizations and institutions that deal with childcare and provide social services, including:

- social services (both public and NGOs)
- health facilities for children
- social welfare institutions
- agencies and organization working in the field of child rights
- schools and kindergartens.

SUPPORTING TB SERVICES DELIVERY DURING HEALTH EMERGENCIES

On 30 January 2020 WHO declared COVID-19 as a public health emergency of global concern. Since then, the virus has affected every country in the world, infecting millions and taking the lives of millions. Efforts to contain the transmission have led to closure of schools and public spaces, restriction of international and local travel and quarantine or isolation for millions of people (25–27). Experience gained in managing support services for TB during the COVID-19 pandemic will be important for improving understanding of community-based service delivery during health emergencies.

The COVID-19 pandemic has had a profound effect on health care by absorbing most of the available clinical or public health resources and causing disruptions in service provision. According to provisional data compiled by WHO from 84 countries, an estimated 1.4 million fewer people received care for TB in 2020 than in 2019: a reduction of 21%. In the group of 10 countries with a high burden of TB and with the largest reported shortfalls compared with 2019, the overall shortfall was 28%. It is estimated that these COVID-19-related disruptions in access to TB care could cause an additional 500 000 deaths from TB (28).

The Global Fund survey has identified disruptions in TB service delivery in 106 countries (29). Countries have transformed their TB detection and treatment facilities into COVID-19 testing facilities, leading to a steep decline in TB detection and case notification. Disruption of supply chains has led to the depletion of reserves of TB drugs and to treatment interruptions.

The impact of COVID-19 has been most significant on people with TB and on people working in this field. People with TB have faced challenges in accessing services and increased stigma because both TB and COVID-19 are seen as respiratory diseases. Frontline health-care workers have reported seeing fewer new cases of TB as attention was re-deployed to COVID-19. Finally, policies and programmes previously focused on TB have seen a decline in resources (28).

It is expected that, in near future, the need for COVID-19 testing and treatment products might divert pharmaceutical companies to decrease manufacturing of drugs and laboratory kits for other infectious diseases, such as TB, HIV and malaria. This will have a short-term as well as a long-term effect on the global effort to combat TB. In the short term, it is predicted that already infected people will become more seriously ill because of disruptions in their treatment regimens, and in the long term there will be an increase in morbidity and mortality from TB, with an increase of drug resistance (30).

Consequently, WHO recommends the continuation of TB service delivery with an emphasis on people-centred outpatient and community-based care over hospital-based care to reduce the risk of SARS-CoV-2 transmission. Integrated community-based TB services have shown to be effective in reaching target TB populations, ensuring access to health care, providing support and ensuring

continuity of care and favourable outcomes. Approaches developed by WHO, such as ENGAGE-TB (31), have demonstrated the ability not only to maintain TB-related services but also to assist with community mobilization and detection of SARS-CoV-2 infections and COVID-19. Community-based services have an important role to play during this pandemic to support the delivery of TB services and to ensure that the affected communities do not become marginalized (32).

Alternative models of service delivery, such as the use of digital health technologies, also provide an opportunity to reduce the level of disruption of TB services (33,34). During the pandemic, many countries started to supply supplying people with TB with a one-month supply of drugs to reduce the need to visit clinics. In this scenario, patient supporters play a vital role for following up with people with TB, using digital communications to ensure that they adhere to their treatments, or to provide counselling (35).

Further, there is a critical role for CRG interventions for TB to be adapted and scaled up in the context of COVID-19. The Stop TB Partnership has developed a guidance for countries on this subject, including on community-based and community-led services; community-led monitoring; stigma reduction; human rights and gender-related barriers; interventions for key and vulnerable populations; and advocacy and communications (36).

Despite its negative impacts, the COVID-19 pandemic has demonstrated the essential role that community-based TB services can play to mitigate these effects, particularly when standard medical facility-based care is out of reach.

TB prevention and case detection

- TB preventive treatment is essential for people living with HIV or for children under-5 who are contacts of people with TB. TB programmes need to scale up this preventive life-saving treatment during the COVID-19 pandemic and increase engagement of community workers in treatment monitoring.
- The use of mobile and virtual platforms is encouraged for TB case detection and for contact tracing in order to maintain services during movement restrictions and physical distancing measures, and to protect health and community workers from unnecessary exposure to SARS-CoV-2.

TB treatment and diagnosis

- It is advised that visits to health-care facilities should be limited to reduce potential exposure to SARS-CoV-2 for health-care workers and people with TB. Where facility visits are essential, precautions need to be taken such as physical distancing, health-care workers wearing PPE, streamlining patient flows and providing TB services in isolated dedicated spaces to minimize contact with people infected with SARS-CoV-2.

- Service delivery models should be adapted to maximize results, for example providing more intensive care to people starting treatment for TB or with low adherence, and less intensive care to those demonstrating higher adherence.
- Telecommunications should be ready and in place to monitor treatment adherence and adverse drug reactions.
- TB treatment must be ensured for all people with TB even for those who have been infected with SARS-CoV-2.
- Avoiding extra visits to TB facilities could be achieved through supplying individuals on treatment with a larger supply of TB medication, such as for a month or more, or distributing the medicine through community-based distribution mechanisms.
- VST would allow monitoring of treatment progress, which is crucial. During the pandemic, it is advised to use virtual solutions such as phone calls, video calls or SMS to contact individuals on treatment and follow up.

The COVID-19 pandemic has significantly set back the fight against the TB epidemic and these effects could be felt for years to come. Support services for TB will be needed to mitigate the effects of this pandemic on people with TB and communities, and to help health-care systems to recover faster in delivering the necessary care for these populations.

SECTION 5 COSTING METHODOLOGY FOR THE STANDARDIZED PACKAGE OF COMMUNITY-BASED SUPPORT SERVICES TO IMPROVE TB OUTCOMES

INTRODUCTION

The people-centred model of TB care emphasizes the role of civil society actors in providing support for detection and diagnosis of TB, as well as in supporting people undergoing TB treatment (6). Governments of EECA countries need to invest in, develop and introduce systems for ensuring the sustainability of support services provided by CSOs and community-based groups, as acknowledged through political commitments at the United Nations High-level Meeting on TB in 2018 (3).

There are different ways to fund community-based services; such as through public budget subsidies, grants and social contracts, and by using different forms of procurement mechanisms. This costing methodology is an integral part of the Standardized package and is intended to provide national stakeholders such as ministries in charge of health, NTPs and CSOs in EECA countries with a practical tool for projecting the costs of community-based support services for TB and, thus, support implementation of the Standardized package.

The costing methodology describes costing components (units), their volume, sources of information and the general costing principles for the Standardized package. It provides step-by-step instructions to cost a service package. It is accompanied by an Excel-based Costing Tool (Annex 2) that contains a set of interlinked data sheets with built-in formulae to calculate the unit cost for each service included in the Standardized package (in local currency and in United States dollars).

The Costing Tool contains separate sheets for calculating the unit costs of each service. For the 12 services included in the Standardized package, the Costing Tool contains 14 sheets covering two services (Service 1.1.1 (awareness raising, risk communication and community engagement and mobilization) and Service 4.1.2 (mental health and psychological counselling and support)). Two different options of costing inputs are considered for each service, depending on the service delivery configuration. The total cost of the Standardized package depends on the projected volume of the work (i.e. the number of service units delivered to the target population and the scope of specific services to be delivered) and the cost of units/inputs that constitute each set of services. These should be inserted by each country separately to assure that the Costing Tool reflects the national cost base. The Costing Tool allows calculation of the total package of services for a pre-defined duration of the programme (the intervention), with the possible break down by time periods (e.g. a month or a quarter).

The Costing Tool also contains two summary tables.

The budget projection table. This allows both the public purchasers and the providers of the service to calculate the budget for the selected mix of services, by multiplying unit costs of services by the projected utilization.

The revenue projection table. This enables the service providers (e.g. CSOs) to estimate their required inputs for each cost category for the overall project. Based on the given number of services to be provided and the project duration, this table helps the service providers to forecast their revenues for each specific cost component (e.g. labour, materials or transportation) and the required inputs (e.g. how many full-time workers of each specialty need to be recruited to provide the projected number of services, or how many sets of IEM need to be printed).

Users of the costing methodology should pay careful attention to the country-specific configuration of service delivery organization. Depending on the specific settings and conditions, some of the resources can be shared while providing a certain set of services. For example, health-care workers or patient supporters may combine delivery of some services during one site visit, or fixed transportation or communication costs per time period (e.g. a month) can support delivery of different types of service. Therefore, users need to consider adapting the costing methodology to their specific needs and situations.

COST CATEGORIES

Service delivery costs are grouped into two main categories: direct and indirect (or overhead) costs. Calculation of the direct costs is mandatory and constitutes the key part of the costing methodology, while calculating the indirect costs is optional and would depend on how the service delivery is organized in a particular country or a setting.

Direct costs. These are costs that can be traced to a cost object (in this case the cost object is the unit of service¹) and include labour (i.e. wages, salaries and/or bonus payments, including all relevant taxes and social charges) PPE, other materials and supplies, travel and accommodation, communication and other relevant cost items that are required to produce and deliver a particular service.

Indirect costs. These are general business expenses and include the administrative (overhead) costs of the organization (e.g. the NTP or a CSO) in charge of implementing the suggested services (if such organizations are involved).

¹The unit of service should be determined based on the service description and may, therefore, cover different number of beneficiaries. For example, for Service 1.1.1, awareness raising and community mobilization, provided through an information session, the unit of service is one session, which may include 10 to 25 participants. Other services may need to be provided on an individual basis, such as DOT, and so the unit of service will cover just one beneficiary at a time.

Direct costs represent the major share of the total cost. For each category of the direct costs, the Costing Tool provides the suggested quantitative data (unit of measurement, number of units, coefficient reflecting the frequency of utilization, etc.) based on the description of the particular service. Labour costs are calculated based on the estimated time needed to deliver a specific service, which are provided in the Standardized package and are measured in hours. For actual calculations, the unit costs for each cost category would be provided by the users based on country-specific data (e.g. the average monthly wages for each category of workers or average local transportation costs).

Indirect costs include:

- project management costs, such as salaries of the project manager, the accountant, fieldwork coordinators, drivers, administrative assistants;
- other general administrative costs, such as office rent and utility bills, printing and copying; and
- depreciation of fixed assets and other capital-related costs, including procurement and/or maintenance of equipment necessary for implementation of project activities.

DATA SOURCES FOR UNIT COST ESTIMATES

Users must refer to validated and reliable data sources while suggesting unit costs for each cost category. It is important to note that while the Costing Tool utilizes a standard approach to all services, not all cost categories would be necessarily present for each service, so users need to refer to each service description before conducting the cost calculation exercise.

Labour cost calculations. It is recommended that historical data for remuneration for NGO/CSO workers in previously implemented projects in recent years should be considered, as well as the adopted human resource policies. Users may also decide to suggest their own estimates for labour costs if no suitable data are available, based on national average monthly salaries for each type of service provider and/or an official salary grid, as applicable (e.g. for TB doctors or nurses or for community workers). These data can usually be obtained from government statistical reports or from the relevant ministries (such as ministries in charge of health or labour and social affairs). Average monthly salaries used in the cost calculations can be further adjusted to reflect the regional or other specific aspects of service delivery requirements.

Suggested staff. The tool also includes a suggested list of staff. It is not essential for each organization to have a staff member for every role suggested in the list. Users should try to reflect their existing staffing lists in the Costing Tool, considering which functions they serve.

Materials and supplies. For the cost of materials and supplies, it is recommended that a distinction is made between service-specific materials (e.g. educational leaflets and brochures),

general-purpose stationery and supplies (e.g. notepads, pens and pencils and name badges) and other material costs, such as PPE (if applicable). Unit costs for the first category should be estimated based on available historical data or projections based on the market review (e.g. printing or procurement costs for educational materials) and should be reflected in the unit cost of each service. The material costs from the second and third categories may be based on average weekly or monthly estimates for the set of supplies per community worker and can, therefore, be shared between different services, based on estimated frequency of use.

Travel and accommodation. Costs here reflect the following cost categories: public transportation (roundtrips both intra- and intercity), reimbursement of expenses for use of facility-owned or provider-owned vehicles, including fuel and insurance (if applicable), hotel accommodation and per diem allowance for the service provider. Depending on the service delivery setting and modality, all or only some of these costs may be present. For example, if the service provider needs to travel to a different city (or district/village) to reach the beneficiaries, then the intercity roundtrip fare is included in the calculations; if they also need to stay overnight, then the hotel costs are added.

Communication costs. These are intended to cover mainly the communication fees for the mobile phones that service providers need to use while performing their functions. If they are provided with dedicated mobile numbers for the duration of the project, then the cost of the monthly plan can be included; otherwise, if they use their own mobile phones during the work, then the actual cost of the work-related calls based on the billing data is included in the calculation.

Miscellaneous direct costs. Such direct costs can include any other relevant costs that are not included in previous categories, such as direct bank fees tied to payments for direct costs, insurance, office maintenance fees and other costs not classified elsewhere and directly related to the provision of the service. These cost estimates should be based on actual data obtained from relevant sources (e.g. procurement contracts).

Indirect (overhead) costs. These are calculated as a percentage (share) of total direct costs, based on the available information from similar projects either implemented in recent periods in each country or currently under implementation by the same organization. If such data are not available, they can be projected based on expert judgement.

INSTRUCTIONS FOR USING THE EXCEL-BASED COSTING TOOL

The use of the Costing Tool must be informed by this costing methodology: **users need to carefully read the costing methodology before filling in the necessary data in the Costing Tool.**

The aim of the Costing Tool is to calculate the unit cost of each service included in the Standardized package and to generate estimates of the total costs of the community-based intervention to further inform budgeting and contracting processes.

Unit Costs Table

Users must start by filling in the data in the Unit Costs Table sheet. Unit costs must be provided for each service included in the Standardized package through all cost categories described above; however, in reality not all cost categories for each service may be required, so users need to fill in the unit costs only for those cost categories that are relevant for a given mix of services and will be required for their provision.

Users also need to enter the **rate of the indirect (overhead) costs** in the Units Costs Table, which is an estimated value that can be based either on evidence from recently implemented similar interventions, or on expert judgement. This coefficient is then automatically used for calculating the total unit cost of each service standard. It is possible that, in certain situations, users may decide to skip this cost category (i.e. to use “0” as the coefficient of indirect costs); for example if the community-based service provision is organized and delivered by the NTP, which has well-established administrative and other support services and so the particular intervention implies no additional overhead costs for the NTP. In other words, this means that project management costs would be absorbed by the NTP as part of its existing administrative costs as there is no need to hire a project manager, an accountant or drivers, or to rent office space, and so on. However, in a different situation, such as when an NGO is contracted to specifically organize and deliver the Standardized package, then indirect (overhead) costs need to be assessed and added to the direct costs to reflect the full cost of the service.

Users need to provide the **exchange rate** of the national currency to United States dollars in the same Unit Costs Table; this will then automatically be used to convert the unit cost of each service (as well as the totals in summary tables) into dollars. Given the historical magnitude of exchange rate fluctuations in a given country, users may decide to use an alternative figure, such as the average exchange rate over a certain period of time (usually a year), the exchange rate at a specific date (e.g. end of the previous year or month) or the exchange rate used by the Ministry of Finance for the budget planning.

After adding all relevant data into the dedicated cells in the Unit Costs Table sheet, users move to fill in the remaining data in each service sheet. Users must note that:

- cells that are marked green contain either figures or simple formulae and must be filled in by users;
- cells that are marked yellow contain formulae, are protected and require no actions from users; and
- cells that are marked orange are linked to the Unit Costs Table, are protected and require no actions from users.

Number of Units cells

If certain cost categories are not present in the service provision process of a given service, users can either leave the Number of Units cells for that cost category blank or put in a zero, which means that the given cost category will not be reflected in the unit cost calculation of the given service.

While filling in the Number of Units cells in the sheets, users need to pay attention to the following considerations

Labour-related cost categories. The number of units must reflect the time (in hours) that each worker is estimated to spend for provision of 1 unit of service (such as a group information session or an individual counselling).

Material costs (consumables, supplies, miscellaneous). The number of units needs to be linked to the number of beneficiaries of a particular service. For example, for an information session that is planned to involve, on average, 10 people, 10 sets of IEM and five sets of PPEs will be required, assuming that all five workers on the team will take part in organizing and delivering the information session.

Travel, accommodation and communication costs. These will normally be shared between different services over the course of the project; the number of units must reflect both the project duration (in months) and the number of project team members involved in delivering a particular type of a service. For example, if five members of the team will be provided with monthly mobile phone plans for a three-month period, then the number of units is 15 (5×3). Or if four members of the team will make three intercity journeys over the project period and each time will stay for three nights in a hotel, then for both hotel and per diem cost categories the number of units will be $4 \times 3 \times 3 = 36$.

Users must pay particular attention to calculation of labour unit costs. In the Unit Costs Table, the unit cost for each category of workers is provided as the estimated average monthly salary for a full-time equivalent. However, in the cost calculation sheets of every service that monthly salary is

further transformed into the hourly rate by introducing a simple formula in the Unit Cost cells for labour. The formula has the following format:

$$\text{Hourly rate} = \text{monthly salary from the Units Costs Table}/x/y$$

where x is the number of working days per month and y is the number of working hours per day. So, for example, for a social worker working 22 days at 8 hours per day, it would be the monthly salary/22/8).

Users are free to decide on the numbers for the average number of working days per month (e.g. 21 or 22) and the average number of working hours per day (e.g. 6, 7 or 8). These values will depend on the number of working days per year as well as on labour legislation requirements for different categories of workers in specific countries.

Calculation of the utilization coefficient

An important part of using the Costing Tool is to provide necessary assumptions for calculating the utilization coefficient for each cost category. As explained above, many direct cost categories can be involved in providing several specific services at the same time; consequently, their costs are shared between these services. In addition, for practical reasons, it is advisable to use the utilization coefficient for allocating the corresponding share of a cost to a unit of service in those cases when an average cost estimate for a given cost category is provided for certain time period (e.g. a month or a week). While providing necessary information in the unit cost calculation table for determining the utilization coefficient of each cost category, users need to refer to the service description, as well as to consider the logistical considerations deriving from particular service delivery setting, location and organizational arrangements.

Utilization coefficients are calculated as follows.

Labour costs. The utilization coefficient is always 1, as the estimated number of hours (as per the service description) is spent for delivery of one unit of service; therefore, the utilization coefficient is skipped for labour costs.

Consumables, supplies and materials and miscellaneous direct categories. The utilization coefficient standard formula is $1/x/y$, where x is the estimated number of services that share the particular cost category and y is the number of services to be provided.

Travel and accommodation and communication categories. The utilization coefficient standard formula is $1/x/y$, where x is the estimated number of services that share the particular cost category and y is the number of services to be provided.

Calculating the utilization coefficients for different cost categories (under certain hypothetical assumptions) can be further illustrated and explained with the following examples.

- If the unit cost for a set of IEM is estimated for one beneficiary, then the utilization coefficient will be 1 (i.e. $x = 1$), but if the set of IEM will be shared by five beneficiaries (let say during a group counselling session), then in this case $x = 5$ and the utilization coefficient is $1/5 = 0.2$.
- If the set of PPE needs to be replaced after visiting each patient with TB or each person at risk of TB, then $x = 1$, but if a counselling session is provided on average to 2 people at the same time, then $x = 2$ and the utilization coefficient is $1/2 = 0.5$.
- If the team of 5 workers are given a monthly intracity public transport abonnement for a 3-month period (i.e. the project duration), during which they will share their time between all 12 services included in the Standardized package, and it is estimated that during that period around 50 services will be provided, then $x = 12$, $y = 200$ and the utilization coefficient is $1/12/50 = 0.0017$.
- If the service provider has to travel to a different city or village on a daily basis for a certain period of time (without overnight stay), while providing 5 different services in that location, and it is estimated that for 1 day he or she will complete 10 services of a particular type, then for the roundtrip intercity ticket cost $x = 5$, $y = 10$ and the utilization coefficient is $1/5/10 = 0.02$.
- If the service provider has to travel to a different city or village and stay there for 5 nights while providing only one type of service, with 10 services per day on average, then for both the hotel cost (overnight stay) and for the per diem allowance $x = 1$, $y = 10$ and the utilization coefficient is $1/1/10 = 0.1$.
- If a car is rented for a 3-month period, during which is used for provision of 8 services (out of 12), and 40 services of a particular type need to be provided, then $x = 8$, $y = 40$ and the utilization coefficient is $1/8/40 = 0.0031$.
- If the service provider is provided with a mobile phone with monthly subscription (plan) to provide only one type of service, and it is estimated that during that month around 200 services will be provided, then $x = 1$, $y = 200$ and the utilization coefficient is $1/1/200 = 0.005$. However, if the team of 5 workers are provided with the same monthly subscription each to use the mobile phones for provision of 12 services, then $x = 12$, $y = 200$, and the utilization coefficient will be $1/12/200 = 0.00042$.

Finalization

After completing the Unit Cost Tables, users need to input an estimated number of services for each service standard in the Budget Projection sheet, which will then generate the total estimated cost of the Standardized package.

Finally, users will need to input the project duration (in months) in the Revenue Projection sheet to complete the process. All other data in the Revenue Projection table will be generated automatically. When using the Costing Tool for real-life costing exercise, users must replace all the number (and formulae, if needed) in the green cells only, with the relevant country data as applicable.

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ANNEX 1. GLOSSARY OF TERMS

Active TB case finding. A systematic identification of people with suspected active TB, in a predetermined target group, using tests, examinations or other procedures that can be applied rapidly. Among those screened positive, the diagnosis needs to be established by one or several diagnostic tests and additional clinical assessments, which together have high accuracy (1).

At-risk population/TB key population. People who are vulnerable, underserved or at-risk of TB infection and illness (2).

Case management for TB. The coordination of the necessary medical, nursing, outreach and social service systems that ensure that all persons with confirmed, or clinically suspected, TB are started on appropriate therapy, and that all those with confirmed TB complete an appropriate and effective course of treatment (3).

Communities, rights and gender (CRG). Refers to all aspects of TB and related responses that promote and advance community system strengthening and responses, human rights, gender transformation and the inclusion of key and vulnerable populations (4).

Community-based service providers. Deliver support services for TB within communities (typically CSOs, NGOs, non-profit-making or profit-making organizations, private entrepreneurs and others according to national legislation). Service providers must meet certain requirements regarding the qualifications of staff, organizational management, infrastructure and equipment to ensure quality of their services. Community-based services can be provided by both medical and nonmedical professionals (social workers, psychologists, peer supporters, community workers, etc.) who have adequate training and skills. The Standardized package provides a framework that encourages effectiveness and quality of support services for TB among both health-care providers and governments.

Community system strengthening. Initiatives that contribute to the development and/or strengthening of community-based organizations in order to increase knowledge of and access to improved health service delivery. It usually includes capacity-building of infrastructure and systems, partnership building and the development of sustainable financing solutions (5).

Community-based TB services. A range of support services that can be carried out in different settings by different stakeholders, such as community-based organizations, patient supporters or social workers, who might not have formal qualifications.

Government. Encompasses both national government and local authorities with a remit for policy on TB control or that purchase TB services (both medical and nonmedical support services) through public funds. The Standardized package can be used to guide public procurement processes by defining content to be purchased, requirements for service providers and payment regulations.

Health-care providers. Medical service providers deliver core medical services, including prevention, detection, diagnosis and treatment, but may not be able to fully address the social and economic determinants of TB. Nonmedical support services for TB can fill gaps and support both the most vulnerable patients with TB and at-risk populations, thus contributing to better TB outcomes. Support services for TB can be complimentary and should be embedded in a national health-care system.

Health education. A combination of learning experiences designed to help individuals and communities to improve their health by increasing their knowledge or influencing their attitudes (6).

Key populations. Those experiencing both increased impact from one or more diseases and decreased access to services. Widespread stigma and discrimination, State and non-State violence and harassment, restrictive laws and policies and criminalization of behaviours or practices put key populations at heightened risks and undermine their access to services (7).

Local communities. Interest within local communities for sharing the responsibility for community-based TB services as full partners can improve outcomes and support the decision-making process for designing, planning, implementing, monitoring and evaluating support services. People can contribute to the common good of their communities, providing counselling and support to people who may have TB or have had TB. Local communities will be able to provide input and feedback to achieve better health results if they understand the requirements for nonmedical support for TB services. This is also known as community-led monitoring.

Motivational counselling/interviewing. A collaborative, person-centred form of guiding to elicit and strengthen motivation for change (8).

Needs assessment. A systematic process that provides information about social needs or issues in a place or population group and determines which issues should be prioritized for action. A needs assessment can also provide baseline data that can be used in an evaluation (9).

Patient education. The process by which health professionals and others impart information to people with TB and their caregivers that will alter their health behaviours or improve their health status.

Patient pathway analysis. A tool that aims to describe the steps people with TB take from the initial point of seeking care to the point of being cured. At the same time, the analysis reviews the availability of TB screening, diagnosis and treatment at various levels of the health system (10). To ensure a comprehensive model of care, it includes transitions, referrals and counter-referrals

and it maps optimal routes for people with TB according to their individual needs to maximize coordination and avoid duplication (11).

People affected by TB. This encompasses people ill with TB and their family members, dependents, communities and the health-care workers who may be involved in caregiving or are otherwise affected by the illness (5).

People with TB. This encompasses people who are ill with active TB. It recognizes that people with TB should not be defined solely by their condition. The term may be preferable to the word patient in certain contexts (such as nonmedical and community settings) (5).

People-centred care. A model of care that is focused on and organized around the health needs and expectations of people and communities rather than on individual patients or diseases (11). This approach to care adopts the perspectives of individuals, caregivers, families and communities as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases and respects social preferences. People-centred care also requires that people with TB have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment (12).

Service provider. An entity of any legal status according to national legislation that delivers services. In the context of this document, service providers are community-based service providers for TB care (e.g. CSOs, NGOs, non-profit-making or profit-making organizations and/or private enterprises). Service providers must meet certain requirements (including qualification of staff, organizational management, premises if necessary, etc.) to be capable to deliver the service and to ensure its adequate quality.

Social and behaviour change communication. The strategic use of communication approaches to promote changes in knowledge, attitudes, norms, beliefs and behaviours (13).

Social contracting. A set of mechanisms by which governments finance programmes, interventions and other activities implemented by civil society actors (14). It allows public organizations to channel public funds for financing non-public providers. Countries have different mechanisms and approaches to execute social contracting.

TB disease. An illness in which *Mycobacterium tuberculosis* multiplies and attacks a part of the body, usually the lungs (15). The symptoms of active TB disease include weakness, weight loss, fever, loss of appetite and night sweats. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs (pulmonary TB), the symptoms may include a bad cough, pain in the chest and coughing up blood. A person with pulmonary TB disease may be infectious and spread TB bacteria to others.

TB infection. People can have *M. tuberculosis* antigens without evidence of clinically manifested active TB disease; they do not feel sick and do not have any symptoms. This is known as latent infection (LTBI) and can act as a reservoir for active TB in the community (16).

Users of support services for TB. Those with TB and vulnerable populations have the greatest stake in the quality of support services for TB. They have the right to access, know and fully understand the content and conditions of services they are entitled to receive and for which services they are eligible. People must be able to make informed choices about services that best meet their needs and preferences and must have confidence that they will receive quality service and respect no matter which provider they choose.

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ANNEX 2. THE EXCEL-BASED COSTING TOOL

To facilitate the costing of the Standardized package of community-based support services to improve tuberculosis outcomes, we have created an Excel file that you can download at:



<https://apps.who.int/iris/handle/10665/369648>

ANNEX 3. EXPERTS' OPINIONS

CONTRIBUTOR

“At Stop TB, we are lucky to have all of the partners leading this work as members of our partnership. We are very proud to have supported so much work looking at TB CRG, barriers to access, advocating for community-led and people-centred services. I look at this package of services as a product of all of that work and am really proud that we collectively—the partners of Stop TB—have developed this. We are excited to continue to support this work and the implementation of this package of services.”

Lucica Ditiu

Stop TB Partnership
Switzerland

EXTERNAL REVIEW PANEL MEMBERS

“Considering that TB treatment is a laborious and long-term process, the results do not always depend on the work of the medical staff. Patient adherence to treatment is often linked to the patient’s own social issues. In particular, the spread of the disease directly depends on the effective cooperation of medical staff, public organizations and the patient. This is where community-based services such as TB prevention, awareness raising, psychosocial support for the patient and their family members come into play. Allocation of resources to community-based services is an urgent call to action if we want to end TB by 2030.”

Maral Achilova

National Red Crescent Society of Turkmenistan
Turkmenistan

“The current situation shows that the success of the national TB programme is largely determined by social factors, especially when it comes to key populations, such as people living with HIV, drug users, alcohol abusers, homeless people, prisoners and ex-prisoners as the existing barriers limit timely access to TB care for those, who also have the highest risk of developing drug-resistant TB. As the civil societies play crucial role in addressing those factors, it is essential that sustainable activities of NGOs in reducing the TB burden in the country are funded and supported. The governments should use the existing funding instruments, such as social contracting, to assure delivery of NGO-based services.”

Malik Adenov

National Scientific Centre of Phthisiopulmonology of the Republic of Kazakhstan, Ministry of Health of the Republic of Kazakhstan
Kazakhstan

“This guide contributes to the transition of TB services from donor to domestic funding in EECA countries. It enables governments and nongovernmental stakeholders to design, plan and budget needed nonmedical services for people affected with TB and serving the needs of key populations.”

Evgenia Geliukh

International Charitable Foundation Alliance for Public Health
Ukraine

“It is important to join forces in the support of rolling out community-based services for people affected with TB. International partners should bring their extensive experience and contribute to this significant process.”

Lasha Gogvadze

International Federation of Red Cross and Red Crescent Societies
Switzerland

”In many countries, the social adaptation of people with TB is very difficult as a result of hardships they face. It is the package of services provided by NGOs that will allow them to address their needs and focus on the treatment of TB. The mechanism of providing services through outreach workers allows the patient to realize that TB is not a death sentence. Coordinated actions of the government agencies and NGOs are those actions that are currently absent for to achieve the planned results by 2030.”

Henadz Hurevich

Republican Scientific and Practical Centre of Pulmonology and TB
Belarus

”The current state of tuberculosis control in the countries faces enormous challenges, which are exacerbated by the COVID-19 pandemic as the health-care system fails to provide the necessary volume of services for patients. There is a growing awareness that the problems with tuberculosis control at country level can only be solved through joint efforts of the state, medical institutions, community, and each individual person. For the first time, this document provides a list of services that can be delegated to local communities and NGOs, which fills in the gap for the development and implementation of comprehensive care for patients with tuberculosis in the countries.”

Ainura Ibraimova

USAID Cure Tuberculosis Project in the Kyrgyz Republic
Kyrgyz Republic

”The availability of modern methods of diagnostics and treatment of TB is not sufficient for linking population in need of medical services to the medical institutions that provide those services. This is particularly true with regards to access of key populations to TB services. Lack of awareness, stigma, gender and human rights barriers and other social determinants of health require a multisectoral approach, through involvement of civil society and communities affected by TB, is necessary to address the needs of those populations. This service package provides an opportunity for meaningful community engagement in the provision of support to medical services for TB that will improve access of key populations to TB services and achievement of the national TB control programmes goals.”

Jamilya Ismoilova

WHO TB Civil Society Task Force
Tajikistan

”Finding means to respond not only to medical, but to human rights, social and emotional needs of the communities affected with TB is essential to address complex causes of this disease. This guide helps countries to design such services and provides a clear pathway across the continuum of care for addressing the needs of people on TB treatment, after the treatment or at risk of TB. Giving guidance to national health purchasers on how to execute and monitor integrated TB is a major help in setting up such services.”

Irma Khonelidze

National Centre for Disease Control and Public Health
Georgia

”The introduction of the outpatient treatment model for TB has fundamentally changed the approaches in following up people with TB. Nevertheless, in order to influence the TB epidemic and introduce services focused on the needs of people, it is important to undertake changes at the state level and strengthen medical services with support services, which would allow people undergoing treatment to receive comprehensive assistance and support. The standardization of services contributes to uniform policy for equal access to nonmedical services for people affected with TB. Given the overburdening of health-care systems, community-based support services are important to facilitate timely access to services and increase the number of people who successfully complete treatment.”

Olha Klymenko

Charitable organization TBpeopleUkraine
Ukraine

”Unfortunately, traditional approaches for TB control have not resulted in the desired reduction of TB rates across the EECA Region, where MDR TB rates are still growing. EECA needs to make drastic changes in planning, resource allocation and approaches to TB prevention, care and treatment and these changes call for shifting the focus on people. Provision of standardized, high-quality and efficient services by medical and community-based service providers is the right step to improve outcomes and eliminate unnecessary human suffering. This approach is particularly relevant at this moment, when health systems and societies face overwhelming burden of COVID-19.”

Aida Kurtovic

South Eastern Europe Regional TB and HIV Community Network
Bosnia and Herzegovina

”Involving CSOs can make a difference when this involvement is supported by the evidence of effectiveness. Linking the work of CSOs to the standard TB indicators, carefully assessing the pilots and judiciously managing the costs can significantly advance the cause of fighting TB.”

Dumitru Laticevschi

The Global Fund
Switzerland

”The standardized package of TB community support services is a set of timely, practical and ready for implementation recommendations. The community accountability report, A Deadly Divide: TB Commitments vs. TB Realities emphasized the need for human rights-based, gender-sensitive and people-centred TB prevention, diagnosis, treatment, care and support services in order to achieve the targets and commitments of the United Nations High-level Meeting on TB. Stop TB looks forward to working with partners to help implement this package of services on the path to ending TB by 2030.”

James Malar

Stop TB Partnership
Switzerland

”The document meets and corresponds to the needs of people affected by TB, touches upon the important components of systems and policies developed and implemented in the EECA Region, which need to adapt to new realities. Recommendations and tools for engaging local communities and civil society organizations presented in the document are fully consistent with needs of TB key populations and can assure better quality of services. This document is an useful guide for health-care professionals and service providers, as well as policy- and decision-makers.”

Nikoloz Mirzashvili

Network TBpeople
Georgia

”It is unfortunate that many lives have been lost before the new tools and interventions became available for TB affected populations. The document is a rescue strategy. I truly believe that decision-makers, donors and philanthropists would feel humane obligation to allocate resource for supporting countries to implement these services before many more lives are lost, especially when we see the setback in TB detection, prevention and treatment targets due to COVID-19. While this is an actionable document, it should be juxtaposed with and complemented by a bold civil society presence in every single country of the region.”

Safarali Naimov
Stop TB Partnership Tajikistan
Tajikistan

”Many health systems in EECA lack the opportunity to fully utilize the potential of communities engaged in TB services. Community organizations can be instrumental in preventing treatment interruptions and addressing needs of TB-affected population. Therefore, the governments should consider the costs of community-based TB services as a part of the national TB programmes.”

Lena Nanushyan
Ministry of Health of the Republic of Armenia
Republic of Armenia

”The national TB programmes face the increasing need to scale up outpatient TB care and the local community and civil society organizations have an important role to play in addressing this need. However, due to various economic and/or legal reasons, the capacities of civil society communities have not been fully realized. This document, together with the costing methodology, provides clear and structured answers to many of the questions that arise during the engagement of the nongovernmental sector in the process of identifying and treating TB patients. This package of TB support services is a timely tool for the countries in eastern Europe and central Asia to implement people-centred model of TB care.”

Nargiza Parpieva
Republican Specialized Scientific and Practical Medical Centre of Tuberculosis and Physiology
Uzbekistan

”Achievements in the field of TB have suffered due to COVID-19 pandemic, and it is highly likely that the achievements in TB incidence will be reversed. That is why it is important to focus on each patient and on vulnerable groups through community services. We can do this through a strong collaboration among all four actors: CSOs, patients, medical services and the government.”

Stefan Radut
Association for Supporting MDR-TB Patients
Romania

”Community-based services should become integral part of any national health-care system that looks for changes. All service providers, from primary care to CSOs should focus on continuous quality improvement as a management philosophy. This document contributes to the delivery of services within a set of well-defined skills and competencies required for that. Strong political and structural shifts are needed at the national level in order to support people-centred delivery of TB services.”

Oxana Rucsineanu
Moldova National Association of TB Patients “SMIT”
Republic of Moldova

”Ensuring people-centred approach to care and focusing on the needs of people during TB treatment, significantly influences the formation and maintenance of a high level of adherence to treatment and directly affects its effectiveness. Services focused on meeting the need of an individual patient that can be provided at the community level are an important component of care for patients with TB. Provision of public funding to such services is the fulfilment of the state’s commitment to transition funding of support services within TB response to domestic sources.”

Yana Terleeva

Public Health Centre of the Ministry of Health
Ukraine

”This document sheds a light on community-based services, which are the integral part of TB prevention, care and treatment, but absent from many countries. It identifies the main interventions that target the health needs and expectations of communities and individuals and defines the costs of such services. Not only can the document guide the creation of capacities to deliver such services at local level, but it can serve as a tool to allocate funding for such services – whether from public budgets or through inclusion of the services in the proposals for donor funding.”

Parvana Valiyeva

Saglamliga Khidmat
Azerbaijan

”Provision of high-quality services that meet the needs of people with TB requires the engagement of the communities that have first-hand experience of problems faced by TB patients and their families. This document provides tools to advocate for funding community-based services, which will expand the range of services and contribute to sustainable development and achievement of the goal to end TB globally.”

Valentina Vilc

National TB Response Programme, Institute of Phthisiopneumology “Chiril Draganiuc”
Republic of Moldova

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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