PBMEF Project-Level Indicators: Standard Indicator Reference Sheets (IRS)

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SN_STGMA_NSP: TB stigma reduction in NSP
SN_STGMA_ASSESS: TB stigma assessment/gap analysis available

Project Level Indicators

Indicator name and number	DT_SCRN_COMM: Number of people screened for TB disease outside of health facilities *Previously [PV-1]*
Definition	Number of people screened for TB disease outside of health facilities by a community health worker or other qualified person (according to national screening protocols) during the reporting period. "Outside health facility" refers to TB screening activities in the community, including in and outside household or occupational settings (ex. as part of contact investigation). It may also refer to routine outreach, and event- or location-based screening carried out by community health workers or any other trained/qualified health personnel, for example, a community health fair or prison-based screening activity. Additionally, this term could refer to screening efforts targeted to specific populations that may not have access to facility based testing and are at high risk for TB. "Screening" is defined at a minimum as verbal screening for TB symptoms to identify people to be referred for further clinical evaluation or testing for TB disease. It may include mobile chest X-ray, an increasingly important intervention in high TB burden settings. It may also include testing for TBI by TST or IGRA.
Numerator	Number of people screened for TB disease outside of health facilities by a community health worker or other qualified person during the reporting period.
Denominator	N/A
Category	Prevent
Indicator type	Outcome
Level	Project
Unit of measure	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex, location type (e.g., workplace, prison, community outreach, school, etc.), population group (e.g., migrant, prisoner, mineworker, member of a tribal population, etc.)
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly

Data source(s)	The data sources for this indicator may vary country to country. In some settings, data will be found in community health worker registers, contact investigation registers, or screening registers at health facility and district level.
Importance	Screening for active TB at community level or other locations outside of health facilities is important for improving early TB detection in specific groups that are at high risk of TB, have poor access to health care facilities, or both. Detecting people with TB only from persons presenting themselves to health facilities with suggestive symptoms is not sufficient to close the case detection gap, particularly among vulnerable populations (e.g. migrants, refugees, prisoners, homeless, members of indigenous groups). Additionally, the persistence of delays in diagnosis and the accompanying continued transmission in the community, highlight the need for active approaches to detect TB early. This indicator helps track the extent of a TB screening program by capturing the number of people screened in non-healthcare settings. These may include community settings, prisons, shelters, other congregate settings (such as the military), refugee camps, and workplaces.
Data use	This indicator is one of four indicators reported to the U.S. Congress requested on an annual basis. See *Report to Congress on the Prevention of Tuberculosis*. Comparing the current number of people screened outside of health facilities to previous years can reveal the growth of efforts to improve systematic screening in different risk groups and outside formal health care settings. If this data is disaggregated and analyzed by subpopulation, and yield of new TB cases detected, evaluators can assess if previously identified subpopulations or high-risk groups are being sufficiently reached. Example charts/graphs: ● TB preventive treatment cascade ● Trends over time comparisons by sub-populations Number of individuals screened for TB disease outside of health facilities by population group for each quarter

Indicator name and number	DT_SCRN: Number of people screened for TB *Previously [PS-1]*
Definition	The number of people who are screened for signs or symptoms of active TB disease either by verbal screening or other methods including chest X-ray. "Screening" is defined as verbal screening for signs and symptoms of TB which identifies persons who are symptomatic, or radiologic screening using chest X-ray and further referral for clinical evaluation and/or diagnostic testing. Screening may also include assessment for TB infection combined with or without testing by tuberculin skin test (TST) or interferon-gamma release assay (IGRA).
Numerator	Number of people screened for TB during the reporting period
Denominator	NA
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex, screening method (symptoms only, CXR), location of screening (health facility, community)
Reporting level	National and subnational
Reporting frequency	Monthly, Quarterly
Data source(s)	The data sources are basic management unit TB register, screening register, presumptive TB register, cough register, outpatient department registers, electronic management information systems available at health facility and district level.

Importance	Active case-finding (ACF) or systematic screening for tuberculosis is an important tool to reach missing TB patients. It helps to reduce diagnosis and treatment delays, and prevents the spread of the disease. Screening for active TB may reduce TB incidence, prevalence, and mortality; however, yield of ACF interventions varies substantially across populations. Passive case finding, putting the burden of care seeking for TB on the patient, alone will not achieve the 90% treatment coverage target set out in many National Strategic Plans and global strategies. In high burden TB settings and among populations with poor access and uptake of TB diagnosis and care, systematic screening of people, particularly those in high-risk groups (i.e. HIV positive, contacts, prisoners), at both health facility-based and community based are crucial. Careful monitoring of TB screening is needed to continuously evaluate and improve ACF activities to ensure effective planning and implementation.

Data use	This indicator should be evaluated in relation to the number of people eligible for screening. When the percentage of people screened is low, then ACF strategies should be evaluated in a way to reach target populations (i.e. more community-based volunteers, or better screening tools at facilities, etc.).
	
	Understanding the cascade from ACF TB program data is crucial in order to correct gaps that could result in missing TB diagnoses and steps to take in addressing the barriers. Improved case finding is only relevant when people are initiated on treatment and when they successfully complete their treatment.
	
	Example chart/graphs:
	
	● Trends over time and comparisons by risk group, geographic areas and by location (i.e. community-based or facility-based)
	● ACF cascade
	    o Number of people eligible for screening
	    o Number of people screened for TB
	    o Number of people with presumptive TB
	    o Number of people with presumptive TB tested
	    o Number of people with presumptive TB diagnosed with TB
	    o Number of people with confirmed TB starting TB treatment
	
	Case Finding Cascade showing number of people screened for TB disaggregated by sex

Indicator name and number	DT_PRES: Number of people with presumptive TB *Previously [PS-2]*
Definition	Number of people with presumptive TB identified during the reporting period. *Presumptive TB: people who screened positive for any signs or symptoms of TB are considered to have suspected TB disease and are said to have presumed TB; these people should receive diagnostic testing with a WRD.*
Numerator	Number of people with presumptive TB identified during the reporting period.
Denominator	NA
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex
Reporting level	National and subnational
Reporting frequency	Monthly, Quarterly
Data source(s)	The data sources are basic management unit TB register, screening register, presumptive TB register, cough register, outpatient department registers, contact investigation register, electronic management information systems available at health facility and district level.
Importance	Active case-finding (ACF) or systematic screening for tuberculosis is an important tool to reach missing TB patients. It helps to reduce diagnosis and treatment delays, and prevents the spread of the disease. Screening for active TB may reduce TB incidence, prevalence, and mortality; however, yield of ACF interventions varies substantially across populations. Passive case finding, putting the burden of care seeking for TB on the patient, alone will not achieve the 90% treatment coverage target set out in many National Strategic Plans and global strategies. In high burden TB settings and among populations with poor access and uptake of TB diagnosis and care, systematic screening of people, particularly those in high risk groups (i.e. HIV positive, contacts, prisoners), at both health facility-based and community based are crucial. To achieve universal access to early accurate diagnosis of TB and enhancing case finding efficiency, identification of people with presumptive TB at the first point of care and linking them to the best available diagnostic tests is essential to program management and strategy of patient centered care.
Data use	The indicator helps to demonstrate how effective the screening process is at identifying people who might have TB. Screening and diagnosing patients with appropriate tests and strategies will largely help project and national program response to TB case finding. It measures case detection efforts by the NTP and stakeholders.

A high rate of presumptive TB can mean that clinicians only send patients with advanced disease for diagnostic testing and are unaware of the symptoms of tuberculosis. On the contrary, if the rate is low the screening tools have a low specificity and are not picking up people who are likely to have TB.

Cascade analysis of the screening and diagnosis program data will be helpful to highlight the gaps in case finding and steps to take in addressing the barriers. In addition, trend analyses will be appropriate to help the use of information.

Example charts/graphs:

- Trends over time and comparisons by risk group, geographic areas and by location (i.e. community-based or facility-based)
- ACF cascade
  - o Number of people eligible for screening
  - o Number of people screened for TB
  - o Number of people with presumptive TB
  - o Number of people with presumptive TB tested
  - o Number of people with presumptive TB diagnosed with TB
  - o Number of people with confirmed TB starting TB treatment

Number of Individuals with Presumptive TB Highlighed in Active Case Finding Cascade
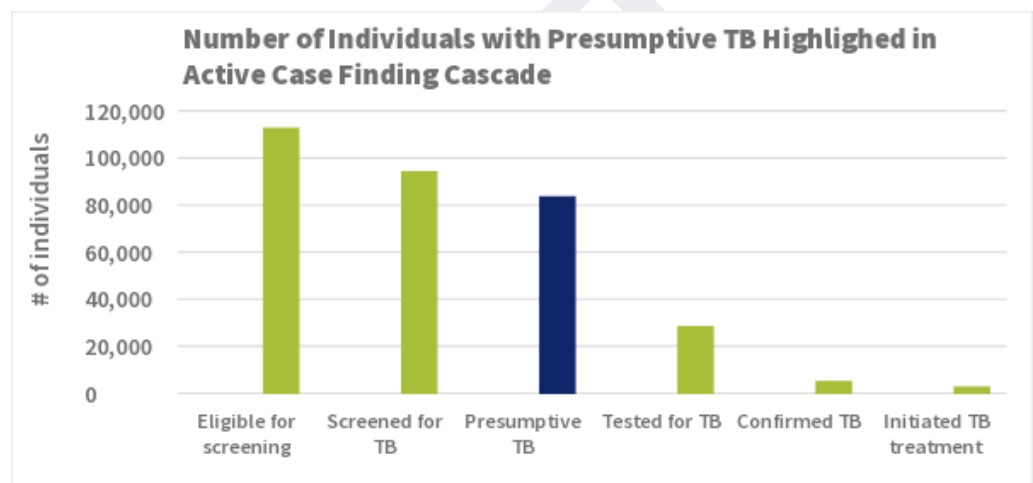
Indicator name and number	DT_TST: Number of people with presumptive TB who received diagnostic testing *Previously [PS-3]*
Definition	Number of people with presumed TB who received diagnostic testing to confirm or exclude active TB disease during the reporting period. Diagnostic testing for active TB disease includes smear, culture, and WHO-recommended rapid diagnostics (WRD) (Xpert MTB/RIF & Ultra, Truenat MTB, MTB Plus & Rif Dx, Loopamp MTBC TB-LAMP, Abbott RealTime MTB & MTB RIF/INH, BD MAX MDR TB, Roche cobas MTB & MTB RIF/INH, Hain FluoroType MTB & MTBDR or Determine TB LAM).
Numerator	Number of people with presumptive TB who were tested for TB during the reporting period.
Denominator	NA

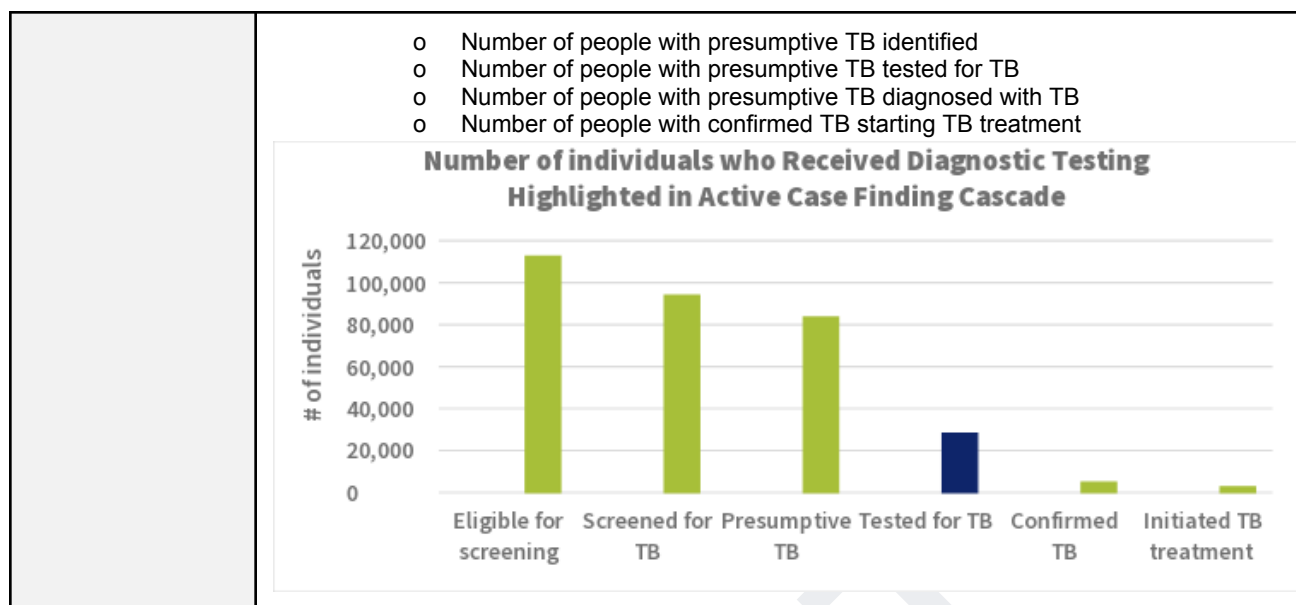| Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex
Reporting level	National and subnational
Reporting frequency	Monthly, Quarterly
Data source(s)	The data sources are basic management unit TB register, screening register, presumptive TB register, laboratory register, electronic management information systems available at health facility and district level
Importance	Active case-finding (ACF) or targeted systematic screening is an important method to find undiagnosed TB among people in a community. ACF reduces time to diagnosis and initiation of treatment, and prevents further spread of the disease. Screening for active TB may reduce TB incidence, prevalence, and mortality; however, yield of ACF interventions varies substantially across populations. Passive case finding, putting the burden of care seeking for TB on the patient, alone will not achieve the 90% treatment coverage target set out in many National Strategic Plans and global strategies. In high burden TB settings and among populations with poor access and uptake of TB diagnosis and care, systematic screening of people, particularly those in high risk groups (i.e. HIV positive, contacts, prisoners), at both health facility-based and community based are crucial. To achieve universal access to early accurate diagnosis of TB and enhancing case finding efficiency, identification of people with presumptive TB at the first point of care and linking them to the best available diagnostic tests is essential to program management and strategy of patient centered care.
Data use	This indicator measures access to laboratory services and how many of the identified presumptive TB patients get tested for TB in a timely manner using WHO recommended rapid diagnostic testing. This is about availability of testing services and accessibility by the community. Cascade analysis of the screening and diagnosis program data will be helpful to highlight the gaps in case finding and steps to take in addressing the barriers. In addition, trend analyses will be appropriate to help the use of information. Additional information can be collected on (1) number who submitted specimens, (2) number of specimens sent to the lab, and (3) number of results reported. Example charts/graphs: - Trends over time and comparisons by risk group, geographic areas and by location (i.e. community-based or facility-based) - ACF cascade - Number of people eligible for screening - Number of people screened for TB

- o Number of people with presumptive TB identified
- o Number of people with presumptive TB tested for TB
- o Number of people with presumptive TB diagnosed with TB
- o Number of people with confirmed TB starting TB treatment

Number of individuals who Received Diagnostic Testing Highlighted in Active Case Finding Cascade

Indicator name and number	**DT_WRD: Number of people with presumed TB who were tested with a rapid diagnostic test** *Previously [DT-14]*
Definition	Number of people who screened positive with signs and symptoms of TB (i.e., presumptive TB) and who were tested with a rapid diagnostic test to confirm or exclude active TB disease during the reporting period. Rapid diagnostic testing for active TB disease includes WHO-recommended rapid diagnostics (WRD) WHO-recommended diagnostic test (WRD) (Xpert MTB/RIF, Truenat, TB-LAMP, Abbott, BD, Roche, Hain or LF-LAM).
Numerator	Number of people with presumed TB who were tested for TB with a WRD during the reporting period.
Denominator	NA
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex
Reporting level	National and subnational

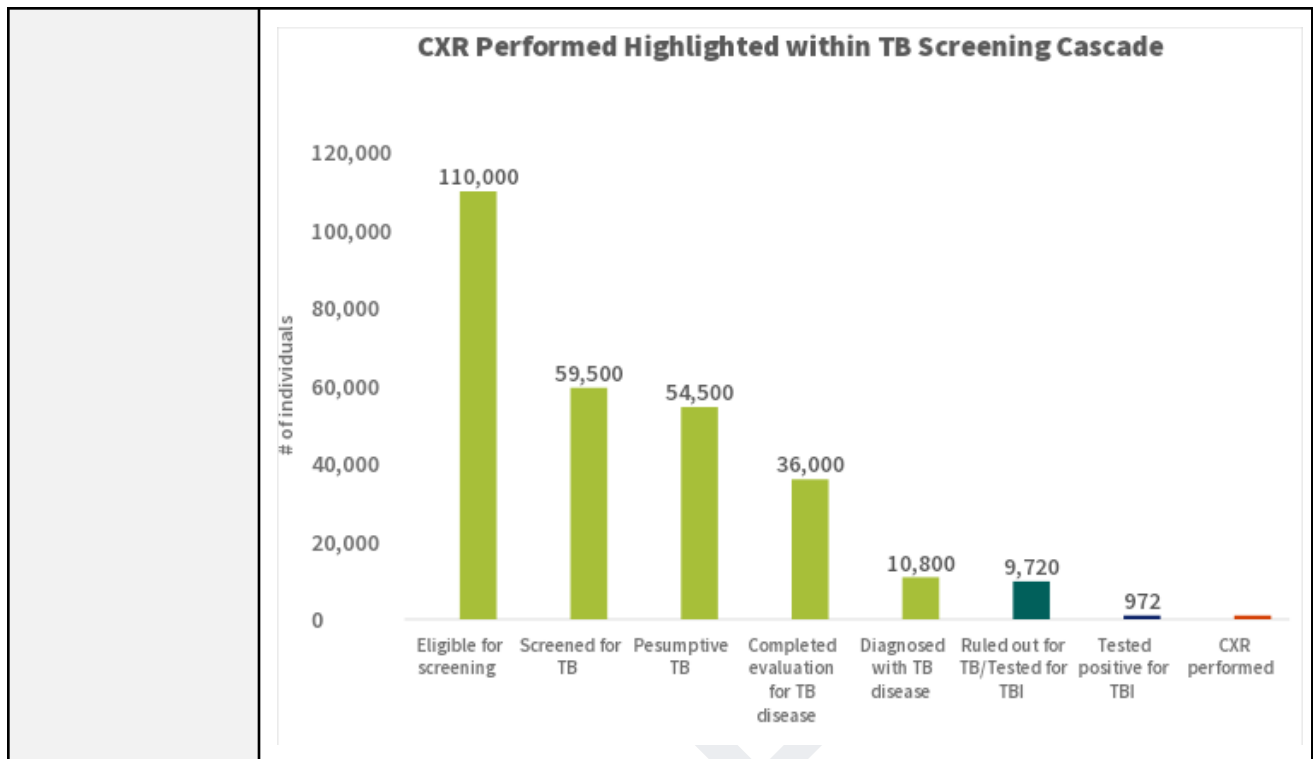| Reporting frequency	Monthly, Quarterly
Data source(s)	The data sources are basic management unit TB register, screening register, presumptive TB register, laboratory register, electronic management information systems available at health facility and district level
Importance	Active case-finding (ACF) or systematic screening for TB is an important tool to reach missing TB patients. It helps to reduce diagnosis and treatment delays, and prevents the spread of the disease. Screening for active TB may reduce TB incidence, prevalence, and mortality; however, yield of ACF interventions varies substantially across populations. Passive case finding, putting the burden of care seeking for TB on the patient, alone will not achieve the 90% treatment coverage target set out in many National Strategic Plans and global strategies. In high burden TB settings and among populations with poor access and uptake of TB diagnosis and care, systematic screening of people, particularly those in high risk groups (i.e. HIV positive, contacts, prisoners), at both health facility-based and community based are crucial. To achieve universal access to early accurate diagnosis of TB and enhancing case finding efficiency, identification of people with presumptive TB at the first point of care and linking them to the best available diagnostic tests is essential to program management and strategy of patient centered care.
Data use	This indicator measures access to laboratory services and how many of the identified presumptive TB patients get tested for TB in a timely manner using WHO recommended rapid diagnostic testing. This is about availability of testing services and accessibility by the community. Cascade analysis of the screening and diagnosis program data will be helpful to highlight the gaps in case finding and steps to take in addressing the barriers. In addition, trend analyses will be appropriate to help the use of information. Additional information can be collected on (1) number who submitted specimens, (2) number of specimens sent to the lab, and (3) number of results reported. Example charts/graphs: ● Trends over time and comparisons by risk group, geographic areas and by location (i.e. community-based or facility-based) ● ACF cascade o Number of people eligible for screening o Number of people screened for TB o Number of people with presumptive TB identified o Number of people with presumptive TB tested for TB o Number of people with presumptive TB diagnosed with TB o Number of people with confirmed TB starting TB treatment

Rapid Dx Testing Highlighted within Active Case Finding Cascade

Indicator name and number	DT_CXR: Number of people with presumptive TB who received a chest X-ray (CXR) *Previously [PS-7]*
Definition	Number of people with presumed TB who had a chest X-ray (CXR) to further rule out active TB disease during the reporting period.
Numerator	Number of people with presumed TB who had a chest X-ray (CXR) to further rule out active TB disease during the reporting period.
Denominator	N/A
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources are basic management unit TB register, contact investigation register, screening register and electronic management information systems available at health facility and district level.

Importance	TB screening is essential for public health and its final step is enabling detecting people with active TB. The screening procedure used influences the percentage of evaluated people who are diagnosed with tuberculosis. A screening procedure that identifies only people at high risk for tuberculosis (e.g. cough lasting more than two weeks) may result in a high diagnostic rate, but it also misses many people with TB that do not have such strong signs of TB risk. A screening procedure that identifies more people for testing (e.g., any TB symptom and/or abnormal chest x-ray) may result in a lower diagnostic rate, but it may also be successful in diagnosing more people with TB. This indicator is the next in sequence after PS-2, depending on the national algorithm for TB screening. It provides the next layer of granular data, and helps to supplement the core and core plus as well as MEL national indicators for measuring the ability of NTPs to systematically identify and screening for active TB and TBI. Reporting of these indicators enables conducting detailed analysis such as constructing cascade analysis for better understanding of the programmatic performance and track progress for improving TB preventive treatment.

Data use	The number of presumptive TB patients with chest X-ray (CXR) performed provides a good comparison to determine the performance of CI activities. It can be analyzed as a trend over time or compared across regions to understand contact-tracing performance. Comparisons with a country's CI coverage targets will provide the impetus to further strengthen the implementation of CI strategies within an NTP.
	
	Another comparison could be made between the number of contacts investigated per index case. Simply charting the trend of the average number of contacts investigated per index case can also give an understanding about how effective the contact investigation is.
	
	Example charts/graphs:
	● Trends over time by geographic area, risk group, and by location (i.e. community-based or facility-based)
	● TB screening cascade
	   o Number of people eligible for screening
	   o Number of people screened for TB
	   o Number of people with presumptive TB identified
	   o Number of people with presumptive TB tested for TB
	   o Number of people with presumptive TB diagnosed with TB
	   o Number of people with presumptive TB tested for TBI
	   o People with presumptive TB tested positive for TBI
	   o People with presumptive TB with chest x-ray performed

CXR Performed Highlighted within TB Screening Cascade

Indicator name and number	**NNS: Number needed to screen** *Previously [AF-7]*
Definition	The number needed to screen (NNS) is the number of people that must be screened for symptoms of active TB disease to identify one person with TB during the reporting period. "Screening" is defined at a minimum as verbal screening for TB symptoms to identify people to be referred for further clinical evaluation or testing for TB disease. It may include mobile chest X-ray, and increasingly important intervention in high TB burden settings.
Numerator	Number of people diagnosed with TB in a given reporting period.
Denominator	Number of people screened for TB in a given reporting period.
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people
Data type	Integer

Disaggregate by	Age, sex, setting
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources are basic management unit TB register, screening register, presumptive TB register, laboratory register, electronic management information systems available at health facility and district level.
Importance	USAID invests in a variety of case finding approaches with the goal of closing the gap between estimated and notified people with TB. This indicator is important to help identify how effective these case finding strategies are.
Data use	The screening procedure used influences the percentage of evaluated people who are diagnosed with tuberculosis. A screening procedure that identifies only people at high risk for tuberculosis (e.g. cough lasting more than two weeks) may result in a low number needed to screen, but it also misses many people with TB that do not have such strong signs of TB risk. A screening procedure that identifies more people for testing (e.g., any TB symptom and/or abnormal chest x-ray) may result in a higher number needed to screen, but it may also be successful in diagnosing more people. As the incidence of tuberculosis falls, it should become more difficult to find active TB. As a result, it is reasonable to expect that if the comprehensive approach to TB succeeds in reducing TB incidence over time, the percentage of people diagnosed with TB will decrease. This is not to say that active case-finding efforts should be halted. Example charts/graphs: ● Trends over time comparisons ● Comparisons public vs private, rural vs urban and high risk sub-groups

Indicator name and number	**NNT: Number needed to test** *Previously [AF-8]*
Definition	The number needed to test is the number of individuals that must be tested with a bacteriological test to identify one person with TB during the reporting period. These tests include all WHO-recommended bacteriological testing options, including Xpert MTB/RIF™ and Ultra™, Truenat™, TB-LAMP™, Abbott™, BD™, Roche™, Hain™ or LF-LAM™.
Numerator	Number of people with presumptive TB tested with bacteriological confirmation of TB disease during the reporting period or for a specific case finding approach.
Denominator	Number of people with bacteriologically confirmed TB during the reporting period or for a specific case finding approach.
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people

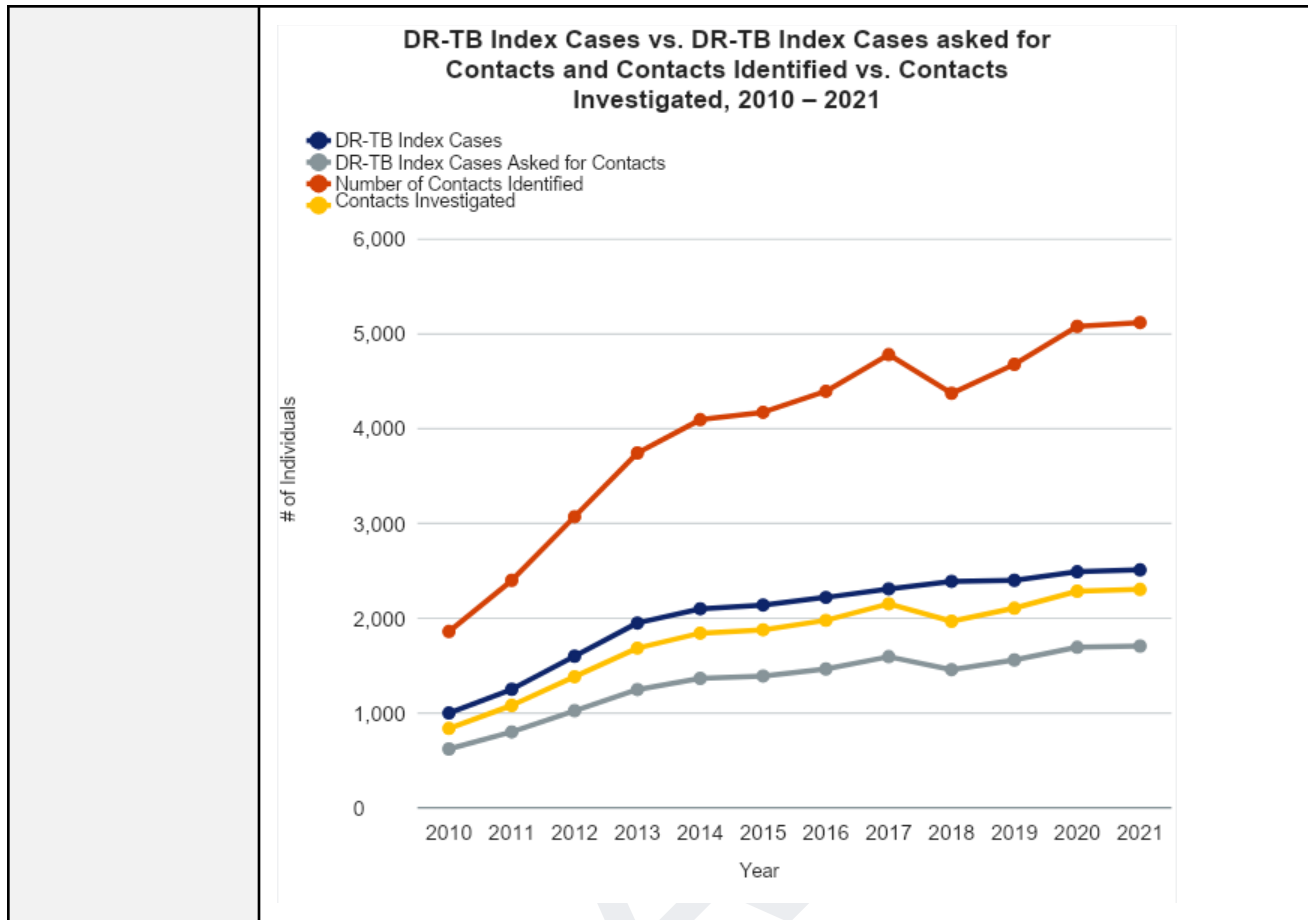| Data type	Integer
Disaggregate by	Age, sex, setting
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources are basic management unit TB register, screening register, presumptive TB register, laboratory register, electronic management information systems available at health facility and district level.
Importance	USAID invests in a variety of diagnostic technologies and case finding approaches with the goal of closing the gap between the number of estimated and notified people with TB. This indicator is important to help identify the most promising case finding strategies that will reach the population in need in the most efficient manner.
Data use	The screening and testing algorithm used influences the percentage of evaluated people who are diagnosed with tuberculosis. An algorithm that identifies only people at high risk for tuberculosis (e.g. cough lasting more than two weeks) may result in a low number needed to test, but it also misses many people with TB that do not have such strong signs of TB risk. An approach that identifies more people for testing (e.g., any TB symptom and/or abnormal chest x-ray) may result in a higher number needed to test, but it may also be successful in diagnosing more people. As the incidence of tuberculosis falls, it should become more difficult to find active TB. As a result, it is reasonable to expect that if the comprehensive approach to TB succeeds in reducing TB incidence over time, the percentage of people diagnosed with TB will decrease. This is not to say that active case-finding efforts should be halted. Example charts/graphs: ● Trends over time comparisons ● Comparisons public vs private, rural vs urban and high risk sub-groups

Indicator name and number	DR_CI_INIT: Percent of people with DR-TB who had contact investigations initiated *Previously [CI-8]*
Definition	Percent of people with notified DR-TB who had a contact investigation initiated. Contact investigation initiated: The process of enumeration of all known contacts to an index DR-TB case and the investigation of contacts to determine if any of those contacts have active TB disease or TB infection (TBI) through symptom screening, diagnostic testing, CXR or clinical evaluation. Index case: Person with DR-TB who is notified to health authorities.
Numerator	Number of people with notified DR-TB who had a contact investigation initiated.
Denominator	Number of people with notified DR-TB.
Category	Reach/Prevent

Indicator type	Outcome
PBMEF level	Project
Unit of measure	Percent of people
Data type	Percentage
Disaggregate by	Age (0-4, 5-14, 15+), sex
Reporting level	National, subnational, health facility, project
Reporting frequency	Quarterly, monthly, weekly (at health facility/project level)
Data source(s)	The data sources are basic management unit TB register, contact investigation register, laboratory register and electronic management information systems available at health facility and district level.
Importance	Contact investigation (CI) is important both for active case finding and TB preventive treatment (TPT). DR-TB patients should all have a contact investigation initiated to identify additional people who may have DR-TB and reduce community spread. This indicator provides data to identify gaps in the first step of CI service delivery, specifically to DR-TB patients.
Data use	The percent of people with DR-TB with CI initiated is calculated from the number of people with notified DR-TB who had a CI initiated divided by the total number of people with notified DR-TB. This metric provides a measure of how thoroughly programs are conducting CI activities among DR-TB patients. When analyzed over time, it can provide insights into gaps in case detection or opportunities to identify contacts that may require a TPT regimen specific for exposure to a person with DR-TB. It can be analyzed as a trend over time or between subnational units to understand contact-tracing performance trends and inform plans for scale up. Example charts/graphs: ● Contact investigation cascade ● Trends over time comparisons ● Scatterplot comparing coverage of people with TB with CI done and CI completed for contacts identified DR-TB Contact Investigation Cascade, 2021

DR-TB Index Cases vs. DR-TB Index Cases asked for Contacts and Contacts Identified vs. Contacts Investigated, 2010 – 2021

Indicator name and number	CON_TBI_TST: Number of contacts tested for TBI
Definition	Number of contacts of new/relapse pulmonary TB patients who were tested for TBI during the reporting period (TBI testing includes TST, IGRA).
Numerator	Number of contacts of new/relapse pulmonary TB patients who were tested for TBI during the reporting period (TBI testing includes TST, IGRA).
Denominator	N/A
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people

Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex, diagnostic method (bacteriologically confirmed vs clinically diagnosed)
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources are basic management unit TB register, screening register, presumptive TB register, cough register, outpatient department registers, contact investigation register, electronic management information systems available at health facility and district level.
Importance	This indicator provides data for TBI testing in the process of evaluating contacts and provides the next layer of granular data to understand screening practices.It helps to supplement the core and core plus as well as MEL national indicators for measuring the ability of NTPs to systematically identify and screen for TBI. Reporting of these indicators enables conducting detailed analysis such as constructing contact investigation cascade analyses for better understanding of the programmatic performance and track progress for enabling TB preventive treatment initiations.
Data use	The number of contacts who were tested for TBI provides a good comparison to determine the magnitude of individuals who are infected with TB but do not have active TB disease. In some settings, this is an important first step for initiating TB preventive treatment. It can be analyzed as a trend over time or compared across regions to understand performance in TBI testing among contacts. Comparisons with a country's targets for TBI testing will provide the impetus to strengthen the implementation of CI strategies within an NTP. Example chart/graph: • Trends over time by geographic area, risk group, and by location (i.e. community-based or facility-based) • Contact investigation cascade TB Preventive Treatment (TPT) Cascade among Household Contacts, 2021

Indicator name and number	CON_TBI_POS: Number of contacts tested positive for TBI *Previously [PS-6]*
Definition	Number of contacts of people with new/relapse pulmonary TB who tested positive for TB infection during the reporting period.
Numerator	Number of contacts of people with new/relapse pulmonary TB who tested positive for TB infection during the reporting period.
Denominator	N/A
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources are basic management unit TB register, contact investigation register, laboratory register and electronic management information systems available at health facility and district level
Importance	This indicator presents the next in sequence after PS-5, and it provides the next layer of granular data, and helps to supplement the core and core plus as well as MEL national indicators for measuring the ability of NTPs to systematically identify and screening for TBI. Reporting of these indicators enables conducting detailed analysis such as constructing cascade analysis for better understanding of the programmatic performance and track progress for improving TB preventive treatment.
Data use	The number of contacts tested positive for TBI provides data on the number of people who do not have active TB disease but are confirmed to have latent TB infection. This can be an important step for initiating TB preventive treatment. It can be analyzed as a trend over time or compared across regions to understand TBI prevalence and positive yields of TBI testing. Comparisons with a country's CI TBI testing targets will provide the impetus to strengthen the use of TBI testing within an NTP. Example charts/graphs: ● Trends over time by geographic area, risk group, and by location (i.e. community-based or facility-based) ● Contact investigation cascade

TB Preventive Treatment (TPT) Cascade among Household Contacts who tested positive for TBI, 2021
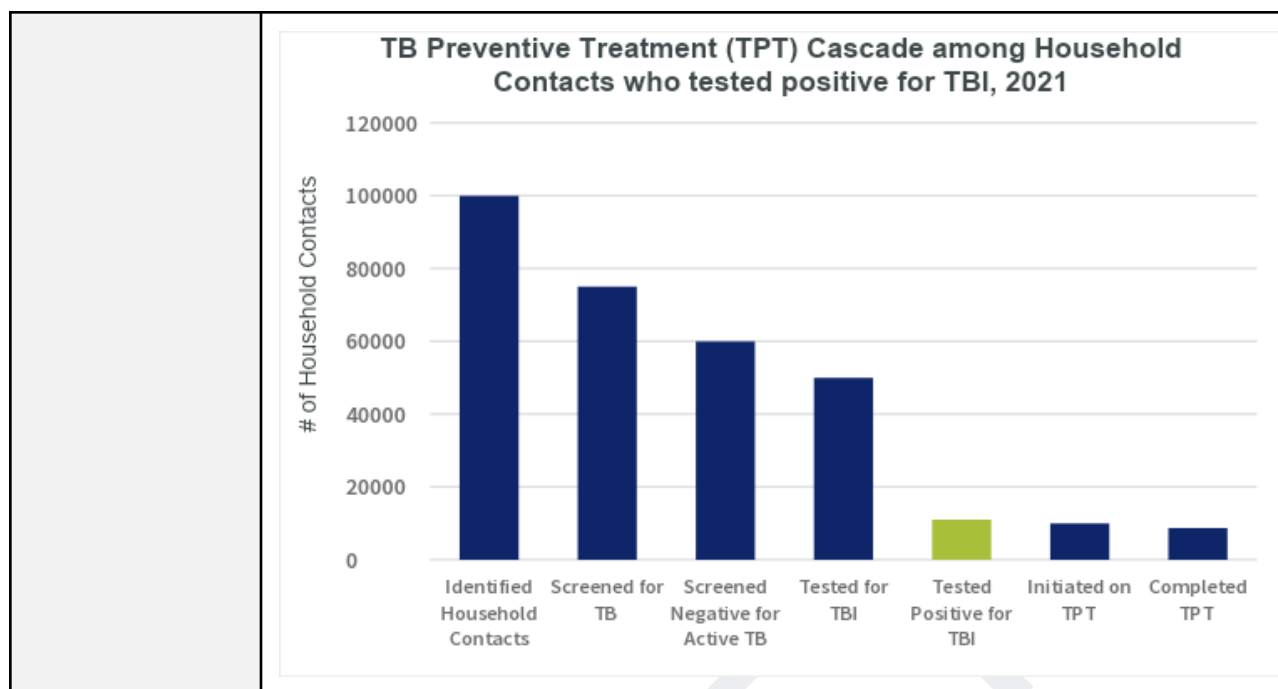
Indicator name and number	TX_DR_SUPPORT: Percent of people on DR-TB treatment who received treatment support
Definition	Percent of DR-TB patients who received nonmedical interventions or benefits, aimed at improving treatment adherence and reduction of catastrophic cost during a specified period, among people with DR-TB who were initiated on treatment during the reporting period. This may include adherence support, food assistance, psychological, educational, mental counseling, transportation reimbursement, or other social or economic support.
Numerator	Number of DR-TB patients who receive nonmedical interventions or benefits, aimed at improving treatment adherence and reduction of catastrophic cost during a specified period.
Denominator	Number of people with DR-TB who were on treatment during the same reporting period.
Category	Cure
Indicator type	Output
Level	Project level
Unit of measure	Percent of people
Data type	Percentage
Disaggregate by	Age (<15, 15+), sex
Reporting level	National and sub-national

Reporting frequency	Annually, quarterly, monthly
Data source(s)	The data sources for this indicator may vary country to country but will likely be found in a national or centralized registry for social support. Also, depending on whether TB support packages are rolled out nationwide or only through NGO or community organizations, this data could also be found in records kept by implementing partners.
Importance	Treatment support for people on DR-TB treatment is essential to ensure successful outcomes. Support packages may include adherence support, food assistance, psychological, educational, mental counseling, transportation reimbursement, or other social or economic support to people on DR-TB treatment. Support packages help to ensure that people on treatment have access to key nutritional assistance which can lead to better treatment outcomes; additionally these packages work to minimize or prevent the catastrophic costs that can be associated with DR-TB. These associated costs can include the transport needed to get to and from the health facility, healthcare costs such as visit fees, medicine fees, testing fees, and the loss of income due to illness or missing work in order to access the necessary care. Catastrophic costs incurred by people diagnosed with DR-TB can negatively affect their treatment and lead to long-term financial hardship even after successful DR-TB treatment. This is particularly important given the long duration of DR-TB treatment. This indicator works to measure efforts being undertaken by countries to minimize or prevent the catastrophic costs associated with DR-TB. Understanding the percent of people on DR-TB treatment who have received these support packages demonstrate the reach of these support services and can highlight existing gaps.
Data use and visualization	The percent of people on DR-TB treatment who have received support packages can help countries monitor the reach of these support programs. When disaggregated, this indicator can help highlight differences or gaps in the distribution or utilization of these support services by multiple factors including reach in specific geographies, across specific populations, particularly high-risk groups, and between genders. Understanding who is and who is not receiving TB support packages can help national TB programs identify populations or groups that need additional coverage and target their resources accordingly. For data visualizations, the percentage of DR-TB patients receiving TB support packages can be plotted over time for a particular country or regions. These visuals could also show important dis aggregations such as gender. Example charts/graphs: ● Graph of Percent of DR-TB patients receiving TB support packages over time for each region of a given country ● Graph of Percent of DR-TB patients receiving TB support packages over time disaggregated by gender (stacked bar graph)

Indicator name and number	**TX_DS_SUPPORT: Percent of people on DS-TB treatment who received treatment support**
Definition	Percent of DS-TB patients who received nonmedical interventions or benefits, aimed at improving treatment adherence during the reporting period. This may include adherence support, food assistance, psychological, educational, mental counseling, transportation reimbursement, or other social or economic support.

Numerator	Number of new and relapse TB patients (all forms) who received any non-medical treatment support during the reporting period.
Denominator	Number of new and relapse TB patients (all forms) enrolled on DS-TB treatment in the same reporting period.
Category	Cure
Indicator type	Output
Level	Project level
Unit of measure	Percent of people
Data type	Percentage
Disaggregate by	Age (<15, 15+), sex
Reporting level	National and sub-national
Reporting frequency	Annually, quarterly, monthly
Data source(s)	The data sources for this indicator may vary country to country but will likely be found in a national or centralized registry for social support. Also, depending on whether TB support packages are rolled out nationwide or only through NGO or community organizations, this data could also be found in records kept by implementing partners.
Importance	Support for people with DS-TB is essential to ensure successful treatment for TB disease. TB support packages may include adherence support, food assistance, psychological, educational, mental counseling, transportation reimbursement, or other social or economic support to people on TB treatment. Support packages help to ensure that people on treatment have access to key nutritional assistance which can lead to better treatment outcomes; additionally these packages work to minimize or prevent the catastrophic costs that can be associated with TB. These associated costs can include the transport needed to get to and from the health facility, healthcare costs such as visit fees, medicine fees, testing fees, and the loss of income due to illness or missing work in order to access the necessary care. Catastrophic costs incurred by people diagnosed with TB can negatively affect their TB treatment and lead to long-term financial hardship even after successful TB treatment. This indicator measures efforts being undertaken by countries to minimize or prevent the catastrophic costs associated with TB. Understanding the percent of people on TB treatment who have received these economic or support packages demonstrate the reach of these support services and can highlight existing gaps.
Data use and visualization	The percent of people on TB treatment who have received support packages can help countries monitor the reach of these support programs. When disaggregated, this indicator can help highlight differences or gaps in the distribution or utilization of these support services by multiple factors including reach in specific geographies, across specific populations, particularly high-risk groups, and between genders. Understanding who is and who is not receiving TB support packages can help national TB programs identify populations or groups that need additional coverage and target their resources accordingly. For data visualizations, the percentage of DS-TB patients receiving TB support packages can be plotted over time for a particular country or regions. These visuals could also show important dis aggregations such as gender. Example charts/graphs:

	● Graph of Percent of DS-TB patients receiving TB support packages over time for each region of a given country ● Graph of Percent of DS-TB patients receiving TB support packages over time disaggregated by gender (stacked bar graph)

Indicator name and number	**HCW_SCRN: Percent of HCWs screened for TB** *Previously [HW-1]*
Definition	Percent of healthcare workers (HCWs) screened for active TB disease during the reporting period, in line with national policies for HCWs. National policy for screening of HCWs may include specific high risk settings, ex. TB clinics, OPDs, ER, staff providing inpatient care, laboratory workers, CHW or CBVs involved with mobile outreach or TBCIs.
Numerator	Number of HCWs screened for active TB disease in line with national policy during the reporting period.
Denominator	Number of HCWs who were working in the country in the clinical or community settings in line with national policy during the reporting period.
Category	Prevent
Indicator type	Outcome
Level	Project level
Unit of measure	Percent of HCWs
Date type	Percentage
Disaggregate by	Sex, workplace setting (hospital, TB clinic, TBCI staff, OPD, ER, other clinical or community setting), type of HCW (e.g., nurse, doctor, CHW\CBV)), type of facility (private or public)
Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources are health care worker screening register, contact investigation register and electronic management information systems available at health facility and district level
Importance	HCWs are at an increased risk of occupational transmission of TB infection (TBI) from patients. They are known to be at high risk of latent TBI and active TB disease through occupational exposure to patients with active TB. Because of this increased risk, it is important that HCWs be regularly screened for TB to achieve the WHO End TB Strategy goal of early detection and treatment of all TB patients and USAID's fundamental tenets of TB to detect, diagnose, treat, and prevent. This metric is one indicator that measures the robustness of a country's TB screening program.
Data use	The percent of HCWs screened for TB can be analyzed over time and/or by comparing the percent of HCWs screened by various disaggregations, such as sub-region, private versus public health facilities, sex of HCWs, or age of HCWs (e.g., under 30, 30-39, 40-49,

50-59, 60 and older). This can provide insight into which regions or facilities have strong HCW screening protocols and which ones may be lagging; if there are discrepancies in screening by age or sex of HCWs; or if screening HCWs has improved, declined, or maintained over time.

Additionally, using a cascade analysis can indicate where there are gaps along the TB screening, notification, and treatment continuum for HCW. This analysis will provide a useful explanation for why a country may or may not be achieving its targets, what course corrections may be needed to address nosocomial transmission of TB, and which gaps in programming may require additional resources.

Examples of data visualizations:
- Bar graph of percent of HCWs screened by type of HCW
- Bar graph of percent of HCWs screened by region over a 10- or 20-year period
- Stacked bar graph of percent of HCWs screened by region, by sex
- Healthcare worker screening cascade
  - HCW screened for TB
  - Presumptive TB
  - Confirmed TB
  - Screened negative of TB
  - Tested for TBI
  - Tested positive for TBI
  - Initiated on TPT
  - Completed TPT

Healthcare Workers Screening Cascade

Indicator name and number	**HCW_TBI_POS: Percent of HCWs diagnosed with TBI** *Previously [HW-5]*
Definition	Percent of healthcare workers (HCWs) tested positive for TB infection (TBI) during the reporting period, among those who were tested for TBI.
Numerator	Number of healthcare workers (HCWs) tested positive for TB infection (TBI) during the reporting period.
Denominator	Number of HCWs who were tested for TBI during the reporting period.
Category	Prevent
Indicator type	Outcome
Level	Project level

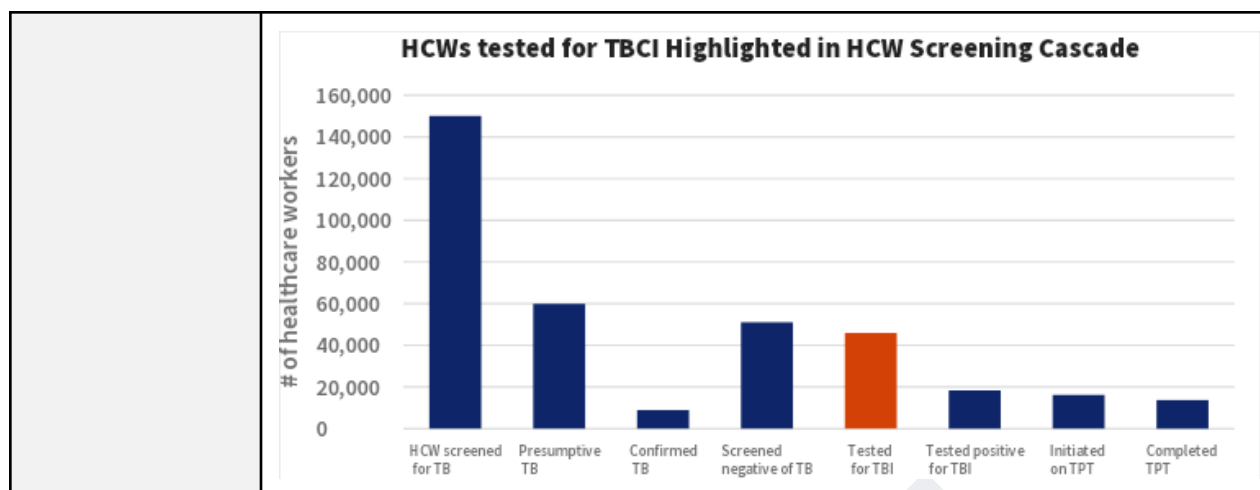|	
Unit of measure	Percent of HCWs
Data type	Percentage
Disaggregate by	Sex, type of HCW (e.g., nurse, doctor, community outreach worker), type of facility (private or public), TBI diagnostic method, (e.g., TST or IGRA)
Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources are basic management unit TB register, healthcare worker screening register, contact investigation register, laboratory register and electronic management information systems available at health facility and district level
Importance	This indicator complements indicator HW-1, "Percent of HCWs screened for TB." It is important to diagnose TB infections in HCWs to prevent nosocomial transmission, particularly among immunocompromised patients. If HCWs are diagnosed with infectious TB, the impact of TB transmission at the health facility can be considerable because of immunocompromised patients in healthcare systems. Therefore, periodic screenings and preventive treatment for TBI for HCWs at high-risk of TB infection HCWs are recommended. This metric is one indicator that measures the robustness of a country's TB screening program.

Data use	The percent of HCWs screened for TBI can be analyzed over time and/or by comparing the percent of HCWs screened by various disaggregations, such as sub region, private versus public health facilities, sex of HCWs, or age of HCWs (e.g., under 30, 30-39, 40-49, 50-59, 60 and older). This can provide insight into which regions or facilities have strong HCW screening protocols and which ones may be lagging; if there are discrepancies in screening by age or sex of HCWs; or if screening HCWs for TBI has improved, declined, or maintained over time.
	
	Additionally, using a cascade analysis can indicate where there are gaps along the TB screening, notification, and treatment continuum for HCW. This analysis will provide a useful explanation for why a country may or may not be achieving its targets, what course corrections may be needed to address nosocomial transmission of TB, and which gaps in programming may require additional resources.
	
	Examples of data visualizations:
	● Bar graph of percent of HCWs screened for TBI by type of HCW
	● Bar graph of percent of HCWs screened for TBI by region over a 10- or 20-year period
	● Stacked bar graph of percent of HCWs screened for TBI by region, by sex
	● Healthcare worker screening cascade
	   o HCW screened for TB
	   o Presumptive TB
	   o Confirmed TB
	   o Screened negative of TB
	   o Tested for TBI
	   o Tested positive for TBI
	   o Initiated on TPT
	   o Completed TPT

HCWs tested for TBCI Highlighted in HCW Screening Cascade

Indicator name and number	**HCW_TRN: Percent of HCWs who received TB-related training**
Definition	Percent of healthcare workers (HCWs) trained on the use of new TB diagnostic tools (ex. POC testing, TST, IGRAs, digital x-rays), new treatment therapies as they become available, or approaches to expand TB active case finding, contact investigations, and patient support during the reporting period. HCW: A frontline HCW who is providing direct services including TB screening, contact evaluation, diagnosis, treatment, and patient care or support. Trained: This can refer to in-service training or continuous professional development in TB. "In-service training" refers to any training provided to HCWs who are currently employed in the health workforce to develop or update skills relevant to their job. "Continuous professional development" refers to the requirement by licensing bodies as a condition of renewing licensure that HCWs accumulate professional credits to keep their skills updated and perform to current standards.
Numerator	Number of HCWs trained on the use of new TB diagnostic tools and treatment therapies, expanded TB active case finding, contact tracing, and patient support.
Denominator	Number of HCWs who were working in the country during the reporting period.
Category	Sustain
Indicator type	Output
PBMEF level	Project
Unit of measure	Percent of HCWs
Data type	Percentage
Disaggregate by	Sex, type of HCW (e.g., nurse, doctor, community outreach worker), training topic, type of facility (public or private)

Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources are NTP activity reports, project records, or a national training database or human resource information system, where available
Importance	This indicator monitors the percent of frontline HCWs that have already entered into the health workforce that receive training to develop a specific TB skill, such as through technical updates. The field of health is constantly evolving and new national and international standards and technology are being introduced. This indicator provides information on how many HCWs in the country have received training to keep their TB skills up-to-date. Note that this indicator does not measure the quality of the training nor if the HCWs mastered relevant knowledge or skills as a result of the training.
Data use	This data can be used to monitor where HCWs are being trained and on which topics to strengthen human resources for TB care and services. When a new TB diagnostic tool is introduced, for example, by looking at number of HCWs trained by region or facility, one can see where trainings have been rolled out and where they are still needed. Example charts/graphs: ● Trends over time by geographic coverage, by type of training and by type of HCW trained

Indicator name and number	PR_BAC_CON: Percent Bacteriologically Confirmed in Private Sector
Definition	Percent of new and relapse pulmonary TB notifications in the private sector that are bacteriologically confirmed. Bacteriologically confirmed: Smear positive for TB or culture positive for TB or positive for TB by a World Health Organization-recommended rapid diagnostics test (WRD) (Xpert MTB/RIF™ and Ultra™, Truenat™, TB-LAMP™, Abbott™, BD™, Roche™, Hain™ or LF-LAM™). Calculation: (Numerator/Denominator) x 100
Numerator	Number of new and relapse bacteriologically confirmed pulmonary TB notifications in the private sector (smear positive or culture positive or positive by WHO-recommended rapid diagnostics test (WRD)) during the reporting period.
Denominator	Number of new and relapse pulmonary TB notifications in the private sector (bacteriologically confirmed plus clinically diagnosed) during the reporting period.
Category	REACH
Indicator type	Outcome
Level	Project level
Unit of measure	Percent of people
Data type	Percentage
Disaggregate by	Age (0-4, 5-14, 15+), sex

Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data sources	The data sources for the private sector may vary country to country. Private sector facilities within the NTP network should report their data to the NTP where it would be captured in the basic management unit TB register, laboratory register and electronic management information systems at health facility and district level.
Importance	Engaging with private sector healthcare providers is essential to achieve universal access to TB prevention and care services. Countries that have prioritized private sector engagement show increases in the contribution of the private sector to overall TB case notifications. Global and national goals in TB cannot be achieved unless private providers are engaged on a large scale.
	This indicator measures the percent of people with new and relapse pulmonary TB who were notified by private non-NTP providers that are bacteriologically confirmed —which is the starting point for ensuring that people with TB identified by private providers will receive quality diagnosis and care.
	Contributions from private facilities and care providers to the total number of TB notifications should be regularly monitored. Introducing and using simplified case reporting for the private sector through electronic reporting or app-based reporting are some of the interventions to encourage private sector reporting, but intermediary agencies who can engage with diverse private providers are typically also necessary.
Data use and visualization	The percent of people with privately notified pulmonary TB who are bacteriologically confirmed TB can be analyzed over time and/or between sub regions. They can also be compared to the total number of TB notifications to determine the percent of all TB notifications that are coming from the private sector.
	A further analysis of this indicator using granular data can also provide valuable insights into who these private providers are in terms of their geographic and institutional locations, as well as their share in private sector notifications. It may be possible that the majority of all private sector notifications come from just a few regular private sector institutions. Better understanding of these high and low performers may help to expand the private sector notification base. For countries with large contributions from private providers, a richer set of standard indicators could be used to distinguish contributions from (a) private for-profit vs. private not-for-profit; (b) providers at different levels of the healthcare system (pharmacies vs. primary care vs. secondary/tertiary care); and (c) private referrals vs. private case management.
	Limitations in data use include inconsistent reporting on private sector notifications from countries and non-disaggregated data on nonprofit and for-profit private providers.
	Below are examples one can use when presenting this indicator: - Percent of public vs private sector bacteriologically confirmed TB case notifications (bar charts, or trend lines over time) - DS-TB cascade (disaggregated by public vs private)

Bacteriologically Confirmed vs. Clinically Diagnosed TB Cases in Private Sector, 2010 – 2021
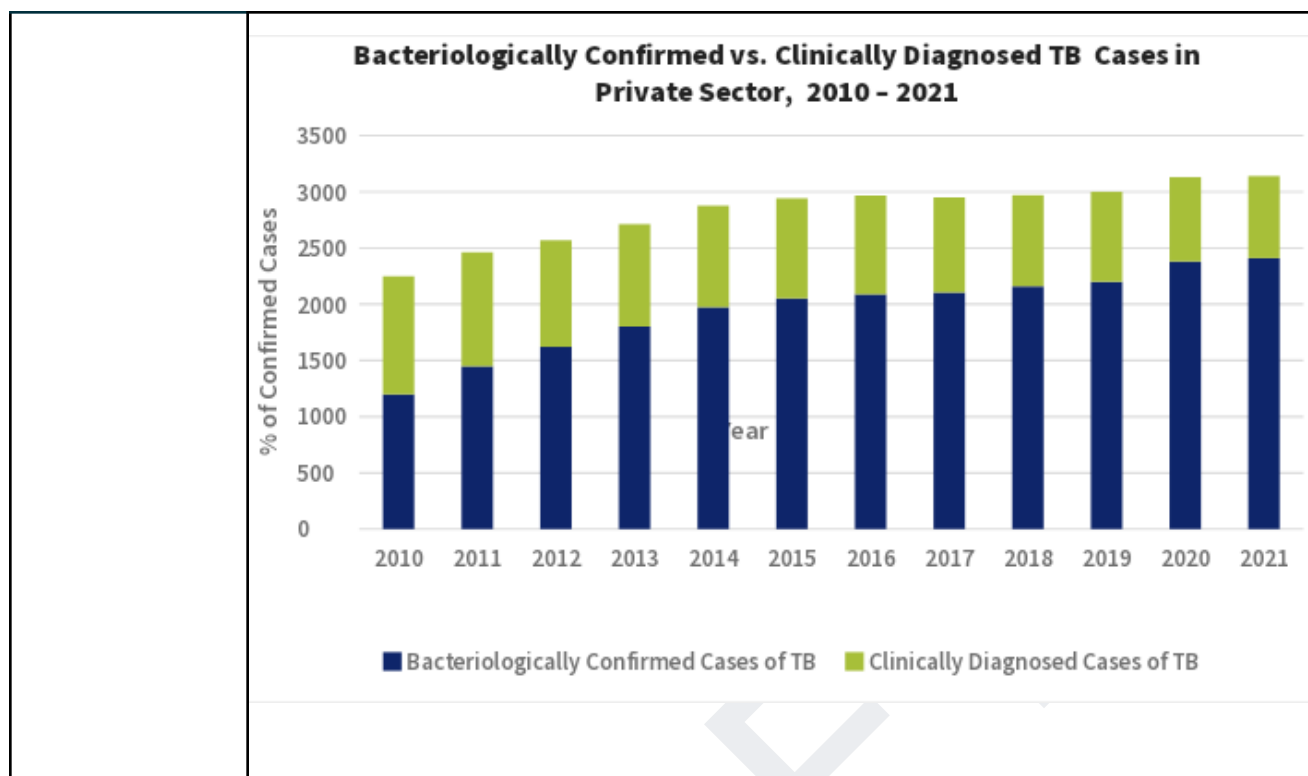
Indicator name and number	**TPT_ADR: Adverse reactions to TPT**
Definition	Number of people on TPT who developed at least one adverse drug reaction (ADR) to treatment during the reporting period. An ADR (often referred to as an "adverse event") is any negative medical occurrence that presents in a person during TB preventive treatment with a WHO approved regimen that may or may not have a causal relationship with the prescribed treatment.
Numerator	Number of people on TPT who developed at least one ADR to treatment during the reporting period.
Denominator	N/A
Category	Prevent
Indicator type	Outcome
Level	Project level
Unit for analysis	Number of people
Data type	Integer
Disaggregate by	Age (0-4, 5-14, 15+), sex, type of adverse reaction (e.g., rash, nausea, vomiting, dizziness, reduced appetite, gastritis, jaundice), severity (1 = mild, 2 = moderate, 3 = severe (requiring hospitalization), 4 = life threatening, 5 = death), TPT regimen (1HP, 3HP, 3HR, 4R, 6H)

Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources are the TPT register or electronic management information systems at health facility and district levels.
Importance	Monitoring ADRs can help health programs with preventing and managing ADRs, reduce patient suffering, and improve treatment outcomes. ADRs can lead to people on TPT interrupting treatment before completion, resulting in ineffective preventive treatment. Therefore, it is important that adverse reactions be monitored in people taking TPT. Systematically gathering this data assists with drug safety monitoring and the ability to detect, manage, and report suspected or confirmed drug toxicities. Unlike other monitoring activities inherent to TB programs, programs have not consistently monitored adverse reactions to TPT in the past. Once monitoring of this aspect of TPT becomes more common, it is expected that its value will extend beyond the individual patient monitored, to benefit other patients from improved knowledge of the medicines tracked as well as endowing programs with a robust mechanism to enable the introduction of future TPT treatments at an accelerated pace. .
Data use and visualization	Number of TPT patients who developed an ADR to treatment can be analyzed as a trend showing whether adverse reactions for TPT patients are improving or getting worse over time. This data can be disaggregated by type and severity of ADR to determine which adverse events are more likely to be associated with a specific TPT regimine. The data may also be analyzed by sex to see if males or females are disproportionately affected.

Adverse Reaction to TPT, by Type of Reaction, 2021

■ Male ■ Female

# of Adverse Reactions

Type of Reaction	Male	Female
Vomitting	20	25
Dizziness	7	10
Reduced Appetite	9	15
Gastritis	9	3
Weakness and Fatigue	17	16
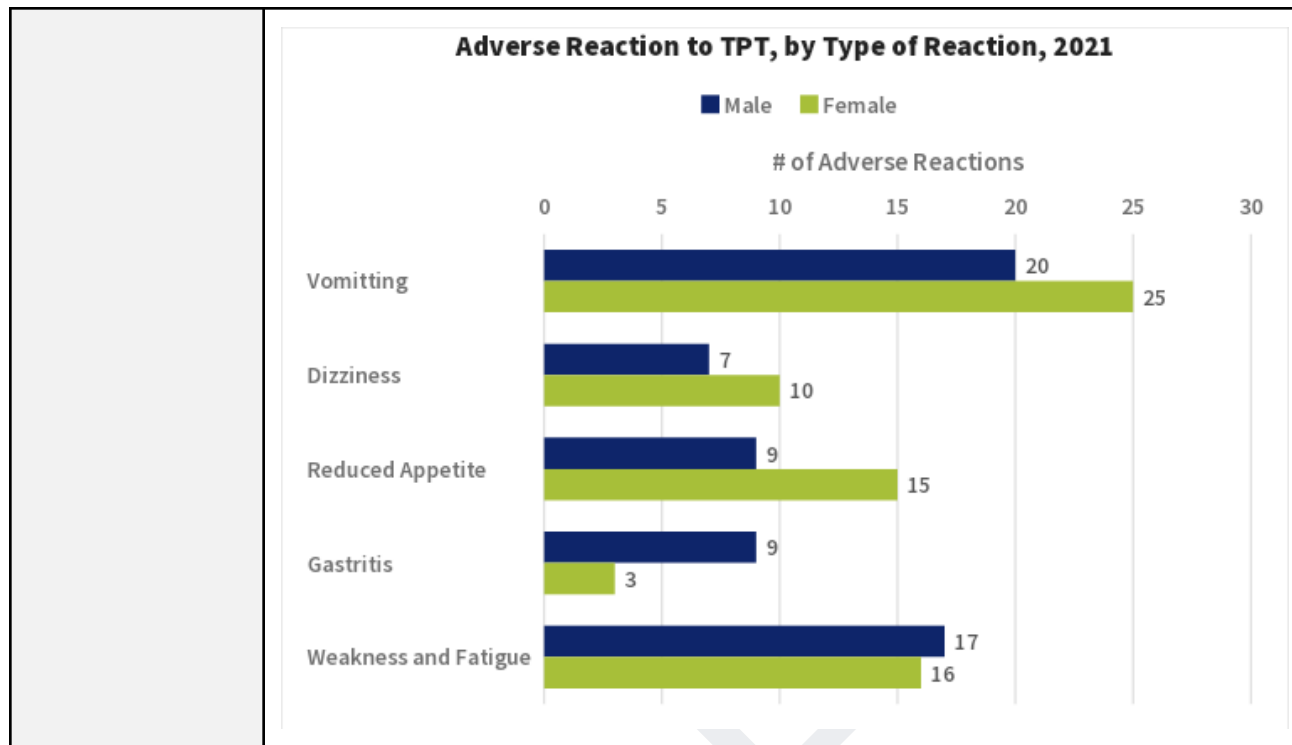
Indicator name and number	SN_IPC: Congregate settings with IPC
Definition	Percent of congregate settings with infection prevention and control (IPC) measures in place.

Congregate settings: A mix of institutional (non-healthcare) settings where people reside in close proximity to each other. Congregate settings include correctional facilities (prisons and jails), homeless shelters, refugee camps, army barracks, dormitories and nursing homes. (WHO guidelines on tuberculosis infection prevention and control, 2019 update)

IPC measures include designated IPC focal person, IPC facility committee and plan, regularly scheduled meetings, monitoring of HCWs for TB and TBI through annual screening with TST, IGRAs or CXR. , |
Numerator	Number of congregate settings with infection prevention and control measures in place.
Denominator	Number of congregate settings in the given area.
Category	Prevent
Indicator type	Output
PBMEF level	Project
Unit of measure	Percent of congregate settings
Data type	Percentage

31

Disaggregate by	Congregate setting type (jails/prisons)
Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	Data source may vary from country to country and include administrative reports from relevant Ministry on congregate settings, NTP reports, survey of congregate setting facilities; supervision visits
Importance	TB is airborne disease and congregate settings are one of the high-risk environments for its transmission. Hence, TB prevention and control measures are among the major interventions to reduce transmission in areas with minimal circulation of air such as congregate settings. TB prevention and control measures consist of a combination of measures designed to minimize the risk of M. tuberculosis transmission within populations. A three-level hierarchy of controls comprising administrative controls, environmental controls and respiratory protection has been shown to reduce and prevent the risk of transmission and exposure to M. tuberculosis (*WHO guidelines on tuberculosis infection prevention and control, WHO, 2019*). The use of respiratory isolation or separation measures applies to all settings with a high risk of M. tuberculosis transmission including congregate settings where health care services, including hospitalization is provided, such as correctional facilities, regardless of the burden of TB disease in the community. Similarly respiratory hygiene measures apply to people with confirmed or presumed TB in settings with a high risk of M. tuberculosis transmission including congregate settings such as correctional facilities, and refugee and asylum centers. Such respiratory hygiene must be implemented at all times. The use of surgical masks, in particular, is of utmost importance in waiting areas, during transport and in any situation which can lead to temporary exposure to M. tuberculosis (e.g. in physician offices). The use of poorly designed or poorly maintained ventilation systems, leading to inadequate airflow, can result in health care associated transmission of M. tuberculosis. Inadequate ventilation also increases the risk of transmission in other non-health care congregate settings such as correctional facilities, and refugee and asylum centers. Hence, this indicator measures the existence of infection control measures in the congregate settings and it is one of the required reports for the End TB Now Act that specifically mentions hospitals, clinics and prisons.
Data use	Tracking the percentage of congregate settings with infection prevention and control measures in place can be indicative of the coverage and success of TB infection control activities. It is usually measured and reported with focus on health care settings, and the purpose of including this indicator in the MEL project category is to emphasize the significance of implementing infection control in community settings especially in those areas where the risk of transmission is very high. In terms of visualization, it can be visualized with basic graphs to show trends in IPC coverage in the defined congregate setting over a period of time. This data can also be plotted alongside geographical mapping of congregate settings and highlighting those where infection and control and prevention is implemented. Since infection control includes a long list of interventions, data can also be presented with additional details depending on the scope of IPC measures in place in the particular setting and its degree of implementation. Example charts/graphs: ● Trends over time by geographic coverage, types of facilities, types of infection control

Indicator name and number	MH_SCRN: Percent of people diagnosed with TB and screened for mental health disorders
Definition	Percent of people diagnosed with TB who are screened for mental health disorders.
Numerator	Number of people with notified TB who were screened for mental health disorders.
Denominator	Number of people with notified TB.
Category	Reach/Cure
Indicator type	Outcome
PBMEF level	Project
Unit of measure	Percent of people
Data type	Percentage
Disaggregate by	Age (<15, 15+), sex, mental health screening result (positive, negative)
Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources may be project databases (community, facility), Electronic Medical Records, or patient registers.
Importance	This indicator allows programs to monitor detection of mental health disorders among patients with all forms of TB.
Data use	Increase the detection of mental health disorders in people with TB and who are referred to appropriate services.

Indicator name and number	MH_TX: Percent of people with TB who received psychotherapeutic interventions
Definition	Percent of people diagnosed with TB who received evidence-based psychotherapeutic interventions, among those who were identified as having mental health disorders.
Numerator	Number of people diagnosed with TB who received evidence-based psychotherapeutic interventions.
Denominator	Number of people diagnosed with TB who were identified as having mental health disorders.
Category	Cure
Indicator type	Output

33

PBMEF level	Project
Unit of measure	Percent of people
Data type	Percentage
Disaggregate by	Age (<15, 15+), sex, mental health disorder, type of intervention
Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources may be project databases (community, facility), Electronic Medical Records, or patient registers.
Importance	This indicator allows programs to monitor treatment coverage of mental health disorders among patients with all forms of TB. Additional resources from the WHO on mental health can be found below: Mental health action plan for the WHO South-East Asia Region 2023–2030: https://www.who.int/publications/i/item/9789290210689 Integrating psychosocial interventions and support into HIV services for adolescents and young adults: https://www.who.int/publications/i/item/9789240071476 mhGAP Intervention Guide - Version 2.0: https://www.who.int/publications/i/item/9789241549790
Data use	This indicator will provide information on the provision of quality, evidence-based interventions to patients with mental health disorders.

Indicator name and number	DM_SCRN_POS: Percent screened positive for diabetes among people with confirmed TB
Definition	Percent of people diagnosed with TB who were screened for diabetes before initiating TB treatment and who screened positive for diabetes. Screening for diabetes may include symptoms eg, polyuria, polydipsia, urine dipstick, blood glucose, or Hemoglobin A1c (HbA1c).
Numerator	Number of people diagnosed with TB who screened positive for diabetes before initiating TB treatment.
Denominator	Number of people diagnosed with TB who were screened for diabetes.
Category	Cure
Indicator type	Output
PBMEF level	Project
Unit of measure	Percent of people

Data type	Percentage
Disaggregate by	Age (<15, 15+), sex
Reporting level	Project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating. National data may also be reported if available.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources may be project databases, electronic medical records of the NTP, HMIS, etc.
Importance	Diabetes mellitus is associated with a two- to threefold increase in the risk of developing TB disease, and a twofold risk of death during TB treatment, a fourfold risk of TB relapse after treatment completion and a twofold risk of MDR-TB. In 2019, over 15% of people with TB were estimated to have diabetes. Addressing comorbidities like diabetes is central to the patient-centered, integrated care. This indicator allows programs to monitor the coverage of testing for diabetes among people diagnosed with TB.
Data use	Data from this indicator will be used to monitor diabetes diagnosis for people with TB and diabetes. Proper detection will enable early initiation of treatment for both conditions, which will ultimately improve both TB treatment adherence and positive TB treatment outcomes.

Indicator name and number	TAT_SUBMIT: Turnaround time (TaT): Percent of specimens submitted to a laboratory within specified target timeframe *Previously [DT-30]*
Definition	Percent of specimens submitted to a laboratory for WHO-recommended rapid diagnostic (WRD) testing within a specified target turnaround time for collection to lab submission during the reporting period. The specified turnaround time should align with the NTP standard for target turnaround times for specimen collection, submission, testing and reporting, which may vary from country to country.
Numerator	Number of specimens submitted to a laboratory for WRD testing within a specified turnaround time for time from collection to submission.
Denominator	Total number of specimens submitted to a laboratory for WRD testing during the reporting period.
Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Percent of specimens
Data type	Percentage
Disaggregate by	Type of specimen

Reporting level	National, subnational, project
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources for this indicator may vary country to country. In some settings, data will be found in basic management unit TB registers, laboratory registers or electronic management systems at health facility and district level.
Importance	Turnaround time acts as a quality indicator to evaluate the effectiveness and efficiency of the testing process. As countries intensify efforts to improve TB diagnosis and treatment and close the gap between the number of people with TB notified and the number estimated, the number of people with notified TB that are bacteriologically confirmed needs to be monitored to ensure that people are correctly diagnosed and started on the most effective treatment regimen as early as possible. This indicator measures a program's capacity for timely submission of specimens to the laboratory for WRD testing during the reporting period. This indicator is meant to measure the timeliness of specimen submission for diagnostic specimens only.
Data use	Early detection of TB is critical to achieving desirable treatment outcomes and interrupting the chain of transmission in the community. Timely specimen collection and submission to a laboratory using a mWRD and reducing the time to TB diagnosis reflects multiple processes, including availability and access to adequate bacteriological diagnostic services (trained staff, equipment, etc.), quality of laboratory testing, and adherence to TB guidelines and functional sample transport system. By measuring this indicator, countries can track the efficiency of sample collection and submission, including sample transport systems. Additionally, this indicator can be compared against national and global standards or targets as a proxy for measuring laboratory performance or capacity within a country. Example charts/graphs: ● Trends over time comparisons ● Infographics demonstrating turnaround times

Indicator name and number	TAT_TST: Turnaround time (TaT): Percent of specimens received at testing laboratory and tested within specified target timeframe *Previously [DT-31]*
Definition	Percent of specimens received at laboratories for WHO-recommended rapid diagnostic (WRD) testing and tested within specified target timeframe during the reporting period. The timeframe should align with the NTP standard for target turnaround times for specimen collection, submission, testing and reporting, which may vary from country to country.
Numerator	Number of specimens received at the laboratory for WRD testing and tested within a specified target timeframe during the reporting period.
Denominator	Number of specimens received at the laboratory for WRD testing during the reporting period.
Category	Reach
Indicator type	Output
Level	Project

Unit of measure	Percent of specimens
Data type	Percentage
Disaggregate by	Type of specimen
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources for this indicator may vary country to country. In some settings, data will be found in basic management unit TB registers, laboratory registers or electronic management systems at health facility and district level.
Importance	As countries implement efforts to improve TB diagnosis and treatment and close the gap between notified and estimated TB cases, the number of people with notified TB that are bacteriologically confirmed needs to be monitored to ensure that people are correctly diagnosed and started on the most effective treatment regimen as early as possible. This indicator measures a program's capacity for timely testing of specimens once they are received in the laboratory during the reporting period.
Data use	Early detection of TB is critical to achieving desirable treatment outcomes and interrupting the chain of transmission in the community. Timely testing of specimens after they are collected and submitted to a laboratory using a mWRD and reducing the time to TB diagnosis reflects multiple processes, including availability and access to adequate bacteriological diagnostic services (trained staff, equipment, etc.), quality of laboratory testing, and adherence to TB guidelines and functional sample transport system. By measuring this indicator, countries can track the efficiency of sample processing in laboratories and identify bottlenecks to fast turnaround time.. Additionally, this indicator can be compared against national and global standards or targets as a proxy for measuring laboratory performance or capacity within a country. Example charts/graphs: ● Trends over time comparisons ● Infographics demonstrating turnaround times

Indicator name and number	**TAT_RPRT: Turnaround time (TaT): Percent of specimens tested and results reported to the referring facility (or provider) within specified target timeframe** *Previously [DT-32]*
Definition	Percent of specimens tested at laboratories using a WHO-recommended rapid diagnostic (WRD) test and with results reported back to the referring facility or provider within specified target timeframe during the reporting period. The timeframe should align with the NTP standard for target turnaround times for specimen collection, submission, testing and reporting, which may vary from country to country.
Numerator	Number of specimens tested using a WRD with results reported to the referring facility (or provider) during the reporting period within specified target timeframe.
Denominator	Number of specimens tested using a WRD with results reported to the referring facility (or provider) during the reporting period.

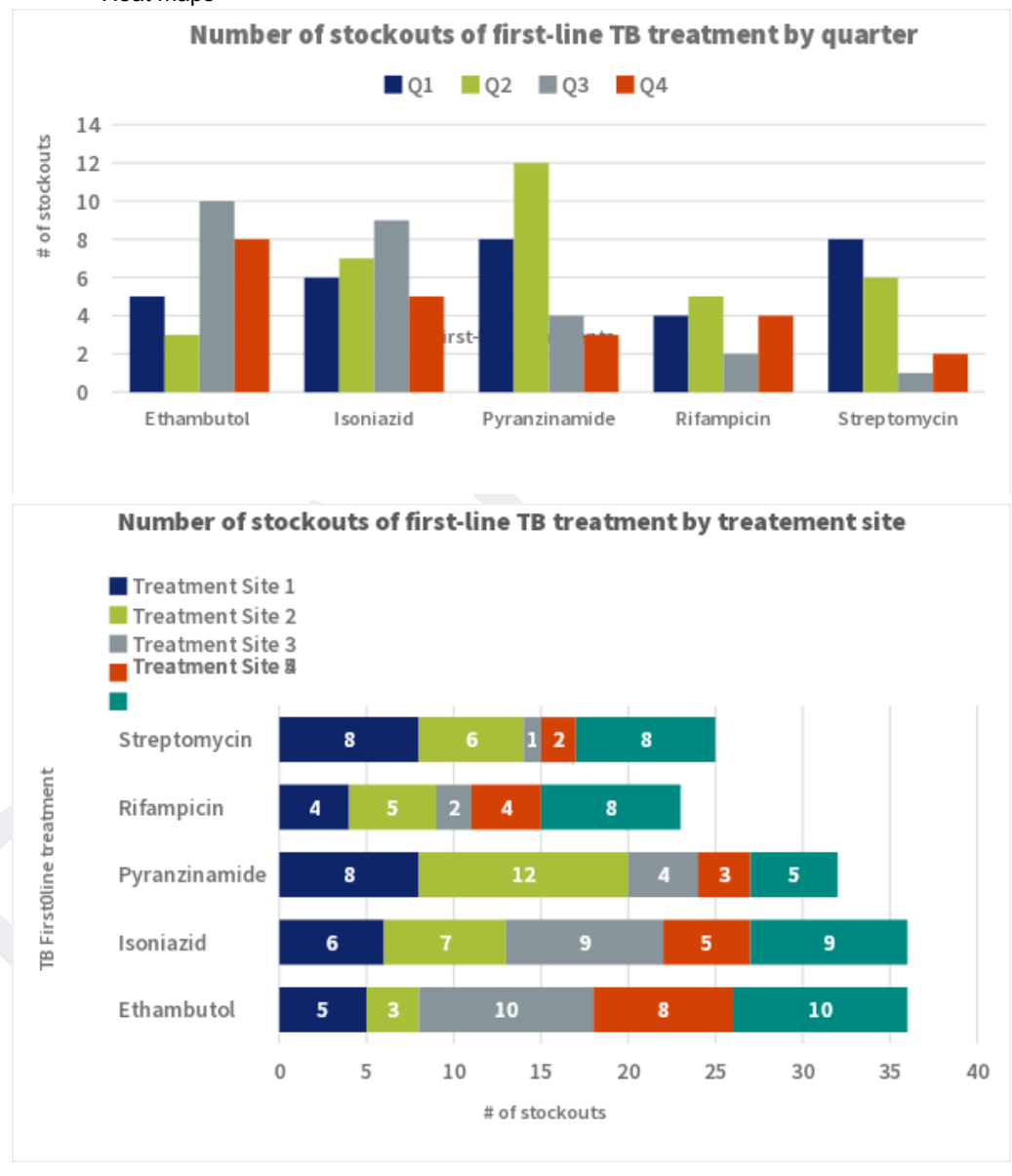| Category	Reach
Indicator type	Output
Level	Project
Unit of measure	Percent of specimens
Data type	Percentage
Disaggregate by	Type of specimens
Reporting level	National, subnational
Reporting frequency	Quarterly, monthly
Data source(s)	The data sources for this indicator may vary country to country. In some settings, data will be found in basic management unit TB registers, laboratory registers or electronic management systems at health facility and district level.
Importance	This laboratory turnaround time (TAT) is the time from when a sample is received at the laboratory to when the results are reported to the clinician.As countries implement efforts to improve TB diagnosis and treatment and close the gap between notified and estimated TB cases, the number of people with notified TB that are bacteriologically confirmed needs to be monitored to ensure that people are correctly diagnosed and started on the most effective treatment regimen as early as possible. This indicator measures a program's capacity for timely reporting of test results for specimens after they are processed in the laboratory. This is important to detect TB accurately and rapidly using new diagnostics and to increase the percentage of cases confirmed bacteriologically by scaling up the use of recommended diagnostics that are more sensitive than smear microscopy.
Data use	Early detection of TB is critical to achieving desirable treatment outcomes and interrupting the chain of transmission in the community. Timely reporting of test results after specimens are collected, submitted and processed using a mWRD and reducing the time to TB diagnosis reflects multiple processes. These include availability and access to adequate bacteriological diagnostic services (trained staff, equipment, etc.), quality of laboratory testing, adherence to TB guidelines, functional sample transport system and communication systems to ensure that the results are reported to the provider so that they can make a treatment decision and the person may start the appropriate regimen as quickly as possible. These systems may include connectivity solutions to facilitate reporting. By measuring this indicator, countries can track the efficiency of communication between laboratories and providers and identify bottlenecks to fast turnaround time. Additionally, this indicator can be compared against national and global standards or targets as a proxy for measuring laboratory performance or capacity within a country. Example charts/graphs: ● Trends over time comparisons ● Infographics demonstrating turnaround times

Indicator name and number	STKOUT_FLD: Stockout of any first-line TB treatment drugs *Previously [SN-42]*
Definition	Occurrence of stockout of one or more first-line drugs (FLD) for TB treatment at any TB treatment site (i.e., Basic Management Unit) or drug storage facility during the reporting period (quarter/annual). WHO defines a stockout as the complete absence of a required drug at a storage point or delivery point for at least one day.
Numerator	This is a Yes/No response for the initial part of the indicator Only if Yes, then detailed disaggregated data should be provided Generic names of TB treatment drugs Geographic locations Treatment site/drug storage facility Central/regional/ district level
Denominator	NA
Category	Sustain
Indicator type	Output
Level	Project
Unit of measure	Yes/No, if yes: name of FLD, location, site, level
Data type	Boolean (yes/no)
Disaggregate by	Generic names of TB treatment drugs, treatment site/drug storage facility, central/regional/district level
Reporting level	National, sub-national
Reporting frequency	Quarterly
Data source(s)	Data for this indicator can be extracted from routine commodity management information systems, facility survey or routine supervision reports at facility and district levels
Importance	A reliable, effective procurement and supply chain management (PSCM) system is the backbone of the TB program to ensure (1) All TB medicines are available to the patient for treatment without any interruption; (2) All TB diagnostics and supplies are available in the healthcare centers where presumptive TB patients are diagnosed; (3) Regular and timely delivery of the TB products to the health centers; and (4) Quality assurance is adhered to and affordably priced products are delivered on time. An effective PSCM requires timely and reliable quantification of all TB products (medicines, diagnostics, consumables) based on regular inflow of information from the healthcare facility to the central ordering authority. This information should include the consumption, stock in balance, and the quantities needed for the next ordering cycle. Ideally healthcare facilities would have tools available for quantification and timely placement of a "Procurement Order" including the necessary "Lead time".
Data use	During visit to the program and for the purpose of evaluation; indication of an effective PSCM would be: ● No STOCKOUT of any TB medicine ● No STOCKOUT of any TB diagnostic product

● No EXPIRY (expiration) of products both medicines and diagnostics as a result of underutilization or overstocking due to incorrect quantification (over-ordering)

With overstocking, one would need to consider underutilization as a result of changes in the treatment regimens as recommended by WHO; for example, shortened treatment regimens for DR-TB, the use of second-line injectables that are no longer recommended, or a change in TPT regimine from 6H to 3HP.

Example charts/graphs:
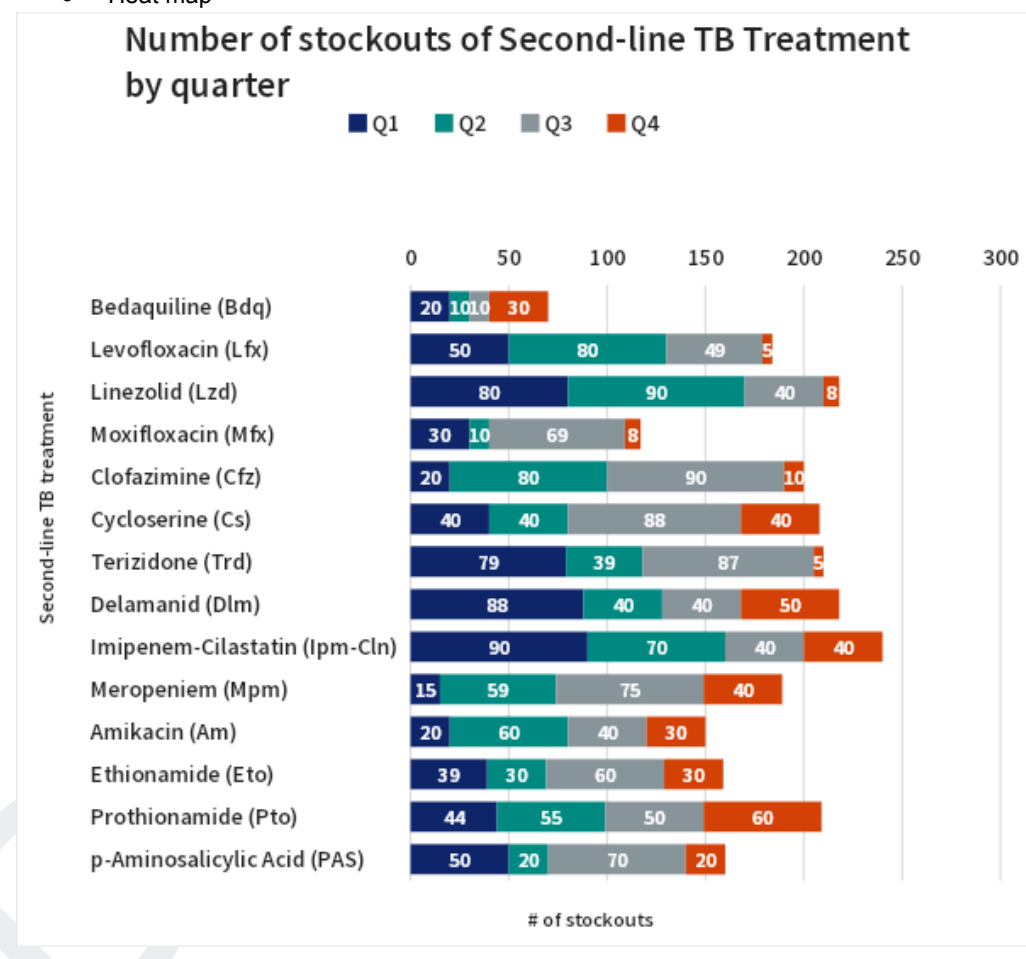● Charts or infographics by facility or aggregated by geographic location
● Heat maps

Number of stockouts of first-line TB treatment by quarter

Number of stockouts of first-line TB treatment by treatement site

Indicator name and number	STKOUT_SLD: Stockout of any second-line TB treatment drugs *Previously [SN-43]*
Definition	Occurrence of stockout of one or more second-line drug (SLD) for TB treatment at any TB treatment site or drug storage facility during the reporting period (quarter/annual). WHO defines a stockout as the complete absence of a required drug at a storage point or delivery point for at least one day.
Numerator	This is a Yes/No response for the initial part of the indicator Only if Yes, then detailed disaggregated data should be provided Generic names of TB treatment drugs Geographic locations Treatment site/drug storage facility Central/regional/ district level
Denominator	NA
Category	Sustain
Indicator type	Output
Level	Project
Unit of measure	Yes/No, if yes: name, location, site, level
Data type	Boolean (yes/no)
Disaggregate by	Generic names of TB treatment drugs, treatment site/drug storage facility, central/regional/district level
Reporting level	National, sub-national
Reporting frequency	Quarterly
Data source(s)	Data for this indicator can be extracted from routine logistic management information systems, facility survey (i.e. SARA or QTSA) or routine supervision reports at facility and district levels
Importance	A reliable, effective procurement and supply chain management (PSCM) is the backbone of the TB program to ensure (1) All TB medicines are available to the patient for treatment without any interruption; (2) All TB diagnostics and supplies are available in the healthcare centers where presumptive TB patients are diagnosed; (3) Regular and timely delivery of the TB products to the health centers; and (4) Quality assurance is adhered to and affordably priced products are delivered on time. An effective and reliable PSCM requires timely and reliable quantification of all TB products (medicines; diagnostics; consumables) based on a regular inflow of information from the healthcare facility to the central ordering authority. This information should include the consumption, stock in balance, and the quantities needed for the next ordering cycle. Ideally healthcare facilities would have tools available for quantification and timely placement of a "Procurement Order" including the necessary "Lead time".
Data use	During visit to the program and for the purpose of evaluation; indication of an effective PSCM would be: ● No STOCKOUT of any TB medicine.

- No STOCKOUT of any TB diagnostic products
- No EXPIRY (expiration) of products both medicines and diagnostics as a result of underutilization or overstocking due to incorrect quantification (over-ordering)

With overstocking, one would need to consider underutilization as a result of changes in the treatment regimens as recommended by WHO; for example, shortened treatment regimens for DR-TB, the use of second-line injectables that are no longer recommended, or a change in TPT regimine from 6H to 3HP.

Example charts/graphs:
- Charts or infographics by facility or aggregated by geographic location
- Heat map

Number of stockouts of Second-line TB Treatment by quarter

■ Q1   ■ Q2   ■ Q3   ■ Q4

Second-line TB treatment	Q1	Q2	Q3	Q4
Bedaquiline (Bdq)	20	10	10	30
Levofloxacin (Lfx)	50	80	49	5
Linezolid (Lzd)	80	90	40	8
Moxifloxacin (Mfx)	30	10	69	8
Clofazimine (Cfz)	20	80	90	10
Cycloserine (Cs)	40	40	88	40
Terizidone (Trd)	79	39	87	5
Delamanid (Dlm)	88	40	40	50
Imipenem-Cilastatin (Ipm-Cln)	90	70	40	40
Meropeniem (Mpm)	15	59	75	40
Amikacin (Am)	20	60	40	30
Ethionamide (Eto)	39	30	60	30
Prothionamide (Pto)	44	55	50	60
p-Aminosalicylic Acid (PAS)	50	20	70	20

# of stockouts

Indicator name and number	STKOUT_WRD: Stockout of TB rapid molecular tests and related commodities *Previously [SN-44]*
Definition	Occurrence of stockout of one or more WHO-recommended rapid diagnostic tests or related testing commodities at any facility (e.g., Basic Management Unit) or storage facility (central or subnational) at the end of reporting period (quarter/annual). WHO defines a stockout as the complete absence of a required commodity at a storage point or delivery point for at least one day.

Numerator	This is a Yes/No response for the initial part of the indicator Only if Yes, then detailed disaggregated data should be provided Names of TB diagnosis commodities Geographic locations Diagnostic site/commodity storage facility Central/regional/ district level
Denominator	NA
Category	Sustain
Indicator type	Output
Level	Project
Unit of measure	Yes/No, if yes: name of commodity, location, site, level
Data type	Boolean (yes/no)
Disaggregate by	Names of TB diagnosis commodities, locations, diagnostic site/commodity storage facility, central/regional/district level
Reporting level	National, sub-national
Reporting frequency	Quarterly
Data source(s)	Data for this indicator can be extracted from routine logistic management information systems, facility survey (i.e. SARA or QTSA) or routine supervision reports at facility and district level
Importance	A reliable, effective procurement and supply chain management (PSCM) is the backbone of the TB program to ensure (1) All TB medicines are available to the patient for treatment without any interruption; (2) All TB diagnostic reagents and consumables are available in the healthcare centers where presumptive TB patients are diagnosed or where specimens are collected for transport to a TB diagnostic facility; (3) Regular and timely delivery of the TB products to the health centers; and (4) Quality assurance is adhered to and affordably priced products are delivered on time. An effective and reliable PSCM requires timely and reliable quantification of all TB products (medicines; diagnostics; consumables) based on a regular inflow of information from the healthcare facility to the central ordering authority. This information should include the consumption, stock in balance, and the quantities needed for the next ordering cycle. Ideally healthcare facilities would have tools available for quantification and timely placement of a "Procurement Order" including the necessary "Lead time".
Data use	During visit to the program and for the purpose of evaluation; indication of an effective PSCM would be: • No STOCKOUT of any TB medicine used in the treatment • No STOCKOUT of any diagnostic products used in the healthcare center • No EXPIRY of products both medicines and diagnostics as a result of underutilization or overstocking due to incorrect quantification (over-ordering) With overstocking, one would need to consider underutilization as a result of changes in the treatment regimens as recommended by WHO; for example, shortened treatment regimens for DR-TB, the use of second-line injectables that are no longer recommended, or a change in TPT regimine from 6H to 3HP. Example charts/graphs: • Charts or infographics by facility or aggregated by geographic location

● Heat map	

Indicator name and number	**SN_STGMA_NSP: TB stigma reduction in NSP** *Previously [SN-32A]*
Definition	TB stigma reduction is included in the National TB Program (NTP) Annual Plan and/or National Strategic Plan (NSP) and includes three elements: Interventions; Indicators; Assigned budget line

The NTP Annual Plan and/or NSP state that it is illegal to discriminate against anyone with TB, citing law where relevant, and includes interventions aimed at reducing stigma as a barrier to TB services; specifically:

i) the NTP/NSP mentions activities to reduce stigma, including stigma against vulnerable populations who may already be stigmatized when accessing the health system;
ii) the NTP/NSP provides data from a stigma assessment;
iii) appropriate context-specific activities are described to respond to stigma;
iv) indicators with targets are included to reduce stigma; and
v) a defined budget is allocated for stigma-reduction activities |
| **Numerator** | Use the following scoring system:
0 = No mention of any of those three elements in the NTP Annual Plan/NSP
1 = One element (out of 3 elements) is included in the Annual Plan/ NSP
2 = Two elements (out of 3 elements) are included in the Annual Plan/NSP
3 = All three elements are included in the Annual Plan/NSP |
Denominator	NA
Category	Sustain
Indicator type	Output
PBMEF level	Project level
Unit of measure	Score 0-3
Data type	Integer
Disaggregate by	NA
Reporting level	Though this is a project-level indicator, this data should be reported at the national level to reflect the country's NSP.
Reporting frequency	Annually
Data source(s)	The data sources for this indicator may include extracting information from a country's National Strategic Plan for TB or NTP Annual Plan. The Stop TB Partnership also conducts an annual survey and publishes data relevant to this indicator in their report *"Governance of TB Programmes: An assessment of practices in 18 countries"*.
Importance	Research highlights that stigma and discrimination limit access to TB services and have a negative impact on the quality of life for people with TB. It is essential for countries to understand the levels and dimensions of TB stigma in order to address the health

	disparities experienced by people with TB and inform interventions to end TB stigma. The Political Declaration of the UNHLM on TB commits to removing legal and social barriers in order to eliminate stigma and discrimination and promote TB responses guided by human rights principles. Overcoming the legal and policy barriers that exacerbate the stigma associated with TB and the people affected by it will reduce a key barrier to services and will enable access to quality, affordable and timely TB care, as well as a return to normal life. There is a need to scale up interventions aimed at reducing stigma that promote enabling legal environments, identify and overcome legal barriers to TB services, and build comprehensive social protection systems. In 2021, the Stop TB Partnership assessed practices related to governance of TB programs in 22 countries including policy frameworks to reduce TB stigma. An important next step is the design and implementation of both policy and programmatic interventions to address stigma, along with monitoring of the response to such interventions.
Data use	This indicator measures whether TB stigma reduction is featured and measured in the NTP Annual Plan and/or NSP highlighting the following three elements: Interventions, Indicators, and Assigned budget line. This is a companion indicator to 32B. Indicator 32B measures whether a stigma assessment or gap analysis has been conducted that would provide information for critical activities that need to be included and addressed in the NTP Annual Plan or NSP.

Indicator name and number	**SN_STGMA_ASSESS: TB stigma assessment/gap analysis available** *Previously [SN-32B]*
Definition	Stigma assessment/gap analysis conducted; the NTP Annual Plan or NSP mentions the findings of stigma assessment and clearly aligns the findings to TB stigma reduction activities and communication strategy.
Numerator	Use the following scoring system: 0 = No assessment conducted 1= Assessment conducted 2= Assessment conducted and Annual Plan/NSP mentions the findings of stigma assessment; communication strategy/interventions align with the NTP Annual Plan or NSP and specifically mention stigma as one of the objectives of communication
Denominator	NA
Category	Sustain
Indicator type	Output
PBMEF level	Project level
Unit of measure	Score 0-2
Data type	Integer
Disaggregate by	NA

Reporting level	Though project level indicators are expected to be reported at the subnational level for subnational units where the partner is operating, these assessments are generally done at national level and reporting should reflect the availability of results nationally.
Reporting frequency	This indicator should be reported on an annual basis at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended.
Data source(s)	The data sources for this indicator may include extracting information from a country's National Strategic Plan for TB, NTP Annual Plan or Stigma Assessment Report. The Stop TB Partnership also conducts an annual survey and publishes data relevant to this indicator in their report *"Governance of TB Programmes: An assessment of practices in 18 countries"*.
Importance	Research highlights that stigma and discrimination limit access to TB services and have a negative impact on the quality of life for people with TB. It is essential for countries to understand the levels and dimensions of TB stigma in order to address the health disparities experienced by people with TB to inform interventions to end TB stigma. The Political Declaration of the UNHLM on TB commits to removing legal and social barriers in order to eliminate stigma and discrimination and promote TB responses guided by human rights principles. Overcoming the stigma associated with TB will reduce a key barrier to services and enable access to quality, affordable and timely TB care, as well as a return to normal life. The need to scale up interventions aimed at reducing stigma is a priority. In 2021, the Stop TB Partnership assessed practices related to governance of TB programs in 22 countries including policy frameworks to reduce TB stigma. An important next step is the design and implementation of both policy and programmatic interventions to address stigma, along with monitoring of the response to such interventions. The TB Stigma Measurement Guidance is a resource developed by KNCV Tuberculosis Foundation with USAID support that can be utilized in the design, implementation and monitoring and evaluation of these activities.
Data use	This indicator measures whether a stigma assessment/gap analysis has been conducted and whether it is mentioned in the NTP Annual Plan or NSP. These analyses are important to highlight critical activities that need to be included and addressed in these documents.