Regional Summary on the key findings of the Baseline assessment with the use of the Annex 2 of the Multisectoral Accountability Framework to Accelerate Progress to End TB (MAF-TB) in Belarus, Kazakhstan, Moldova, Tajikistan, and Ukraine

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Lead Author: *Yuliya Chorna, expert on MAF-TB, regional team lead; Co-Authors*: *Amrita Daftary, expert on qualitative research methods, Professor in Global Health at York University; Ievgeniia Lukash, expert-sociologist; Natalia Kamenska, expert on technical support to civil society and affected communities.*
Contributors: *Yuliya Kalancha, TB Europe Coalition Executive Director; Mariia Chuprynska, TB Europe Coalition Program Manager; Dr. Sayohat Hasanova, WHO Regional Office for Europe*.

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List of Abbreviations

CCM - Country Coordinating Mechanisms for mitigating the impact caused by HIV/AIDS and TB

CLM - Community-based monitoring

COs - Community Organizations

CSOs - Civil Society Organizations

C19RM - COVID-19 Response Mechanism

EECA - Eastern Europe and Central Asia

Global Fund - The Global Fund to Fight Aids, Tuberculosis and Malaria

HIV - Human immunodeficiency virus

MAF-TB - Multisectoral accountability framework to accelerate progress to end the tuberculosis epidemic

MoH - Ministry of Health

MoSA - Ministry of Social Affairs

NTP - National TB Programme

SDGs - Sustainable Development Goals

TB - Tuberculosis

TBEC - TB Europe Coalition

TB-NSP - TB National Strategic Plan

ToR - Terms of References

UN - United Nations

UN HLM on TB - United Nations General Assembly High-level meeting on the fight against Tuberculosis

WHO - World Health Organization

I. Introduction

Importance of the multisectoral approach, has been a cross-cutting theme in the political commitments to end Tuberculosis (TB), ever since the WHO End TB Strategy ***(1)***, aligned with Sustainable Development Goals (SDGs) ***(2)*** has been developed to guide accelerated action from 2016. TB is known as a disease, which is highly impacted by social determinants. Poverty, malnutrition, poor living conditions, to name a few, affect how people get infected, develop TB disease, how they would cope with the hardships of treatment and what health outcomes they will eventually face. Access to care and opportunities is often being jeopardized by the structural barriers of care, which are excluding certain groups of people, usually those being already the most affected by health disparities, thus widening health inequalities.

A multisectoral approach is a key to galvanize implementation of political commitments to end TB, made by global leaders, that address social determinants of health, including barriers to TB care and support services, human rights violations, stigma, harmful gender norms, and strengthening multistakeholder response, beyond the health sector. To advance multisectoral collaborations in TB response, the Multisectoral accountability framework ***(3), (4)*** to accelerate progress to end the tuberculosis epidemic (MAF-TB) has been developed by WHO, upon request from Member States, following the 1st WHO Global Ministerial Conference on "Ending TB: A Multisectoral response" in November 2017 ***(5)*** and the United Nations General Assembly High-level meeting on the fight against Tuberculosis (UN HLM on TB) "United to End TB: An Urgent Global Response to a Global Epidemic" ***(6)*** in 2018.

The MAF-TB approach foresees conducting a Baseline Assessment with the use of a MAF-TB Checklist. The MAF-TB Baseline Assessment Checklist ***(7)*** is complemented by three Annexes ***(8)***; with each having its own value to bring in evidence needed for strengthening multisectoral collaboration and accountability processes. Annex 1 aims for assessment of the roles, activities and budgets of the various Ministries and Bodies, as well as other stakeholders, engaged with Ministry of Health in Ending TB. Annex 3 helps to assess the situation for adoption and implementation of WHO Tuberculosis Guidelines at the country level. Annex 2 of the MAF-TB Baseline Assessment Checklist provides guidance for assessing the engagement of civil society and TB-affected communities, both in multisectoral accountability processes in general and in the response to end TB, in particular.

Figure 1

has been adopted from WHO's guide "Multisectoral Accountability Framework to Accelerate Progress to End Tuberculosis by 2030" https://www.who.int/tb/WHO_Multisectoral_Framework_web.pdf?ua=1

As illustrated in the Figure 1, there are four elements of MAF-TB – commitments, actions, monitoring & reporting, and review. In practice, commitments should be followed by the actions needed to keep or achieve them. Monitoring and reporting are then used to track progress related to commitments and actions. Review is used to assess the results from monitoring that are documented in reports and associated products, and to make recommendations for future actions. Four elements of MAF-TB have been used as a framework of the countries' analytical reports resulting from the baseline assessments with the use of the MAF-TB Baseline Assessment Checklist/Annex 2.

Assessment findings obtained with the use of the MAF-TB Annex 2 and auxiliary data collection tools are summarized based on the experiences of five pilot countries in Eastern Europe and Central Asia (EECA) and documented in this paper. Additionally, the paper includes insights as for operationalization and interpretation of the MAF-TB Annex 2 and interpretation of the MAF-TB four core elements as relates to meaningful engagement of civil society and affected community in the TB response.

In 2020 a new report has been released by the United Nations Secretary-General António Guterres, titled "Progress towards achieving global tuberculosis targets and implementation of the UN Political Declaration on TB" ***(9)***. This report suggests the set of 10 priority recommendations for the Member States on how to put the world on track for reaching

agreed targets, which have been set in the political commitments of the UN HLM on TB which (among others) inform MAF-TB processes by 2022 and beyond.

Recommendation # 7, of the United Nations Secretary General report, specifically calls for ensuring meaningful engagement of civil society, communities and people affected by tuberculosis. This includes calling on the Member States to urgently invest in building capacity to ensure meaningful engagement in all aspects of the TB response, including with regard **to policymaking forums, planning, care delivery, monitoring and review**.

Furthermore, in November 2020, Stop TB Partnership TB Affected Community and NGO Delegations, in collaboration with over 150 community partners from over 60 countries, produced a community-led report ***"A Deadly Divide: TB Commitments vs. TB Realities. A Communities Report on Progress Toward the UN Political Declaration on the Fight Against TB and a Call to Action to Close the Gaps in TB Targets" (Deadly Divide) (10).*** A Deadly Divide report aims to complement the Global TB Report 2020 by providing a complementary view of the status of the Political Declaration of UN HLM on TB targets and commitments, specifically through the lens of civil society and TB affected communities. The report provides for six asks, alongside with defined areas for action, which require immediate attention and urgent measures, including through enhancement of multisectoral collaborations and accountability and meaningful engagement of civil society and TB affected community. Data analysis resulting from the assessment, supplies additional evidence to support the identified six asks and where possible, inform as well practical steps on the following priority areas for action:

Area for action 1:	Reaching all people through TB diagnosis, treatment, care and prevention
Area for action 2:	Making the TB response rights-based, equitable and stigma-free, with communities at the center
Area for action 3:	Accelerating the development of essential new tools to end TB
Area for action 4:	Investing the funds necessary to end TB
Area for action 5:	Committing to accountability, multisectorality and leadership on TB
Area for action 6:	Leveraging COVID-19 as a strategic opportunity to end TB

Assessment objective: to identify what makes the engagement of civil society organizations and TB affected communities in the TB response meaningful, and what is the role of the multisectoral collaboration and accountability for meaningful engagement.

Guiding principle: Multisectoral collaboration and accountability can be understood, practiced, and experienced in diverse ways depending on the perceptions, attitudes, experiences, and social contexts of implementing partners.

Affiliations: At the regional level, TB Europe Coalition (Secretariat and the Regional research support expert team) provides technical support to partners from civil society and TB-affected communities in the pilot countries to complete the Annex 2 of the MAF-TB Baseline Assessment Checklist. WHO Regional Office for Europe provides overall technical cooperation in countries to complete the MAF-TB Baseline Assessment Checklist and all related Annexes ***(7), (8)***. At the country level, civil society and TB affected community organizations, in collaboration with National TB Programs (NTP) at the Ministry of Health, Country Coordinating Mechanisms (CCMs) under the Global Fund, have been involved in data collection to complete Annex 2 of the MAF-TB Baseline Assessment Checklist. The project has been funded by the Stop TB Partnership in the framework of the "Challenge Facility for Civil Society" EECA grant, "Long term capacity strengthening of Community Networks and Organizations of People Affected by TB" Community, Rights, and Gender grant funded by the Global Fund and Eurasian Harm Reduction Association (EHRA) grant.

II. Methodology

Design: Mixed methods study related to Annex 2 of the MAF-TB Baseline Assessment Checklist, with emphasis on qualitative methods and findings. Annex 2 has been complemented with a quantitative tool (standardized survey). Concurrent qualitative methods, while not a prerequisite, ensured the capture of more in-depth data and a contextualized analysis of Annex 2.
Sites: Belarus, Kazakhstan, Moldova, Tajikistan, and Ukraine.
Setting: National level/regions where CSOs/COs work.
Recruitment: purposeful sampling to gather diverse and information-rich data.
Data sources: In-depth, semi-structured interviews with 5-7 heads of organizations/project manager per site; focus-group with project coordinators; focus-group with grassroot workers; focus-group with TB survivors – in Belarus, Kazakhstan, Moldova, Tajikistan, and Ukraine; and a survey - in Kazakhstan, Moldova, Tajikistan and Ukraine.
Analysis:
Quantitative (survey). Survey data were collected through e-mail outreach in accordance with the defined sampling to civil society and TB affected communities' organizations with an aim to complete relevant sections of the MAF-TB Baseline Assessment Checklist/Annex 2 and additional items corresponding with the perception of meaningful engagement of civil society and TB affected communities in the TB response. A 3-item Likert scale was used whereby survey respondents were presented with statements followed by response choices to indicate whether they - Completely disagree or strongly disagree; Somewhat or sometimes agree; Completely agree or strongly agree. An additional response choice was "I don't know", in the event a respondent had no access to information or did not understand the statement.
Measures of central tendency and frequencies (percentage of responses to each statement) were used to analyze the survey data ***(11)***. The results of the survey were illustrated with a graph showing the distribution of responses. Results were used to describe the respondents' perception of statements and helped to navigate the qualitative analysis. Survey responses were aligned with the completed MAF-TB Baseline Assessment Checklist/Annex 2, focus-group and interview data.
Qualitative (Interviews and focus-groups). The framework method ***(12)*** was used which included transcription; data familiarization; coding; development of a working analytic framework; application of the analytic framework to finalize themes; charting the data into a framework matrix; and interpreting the data. Coding was inductive (open) as well as deductive (informed by elements of the MAF-TB framework – see Fig 1).
Desk review was used for analysis of MAF-TB "Commitments".
Ethical issues and confidentiality Prior to each field procedure, potential participants went through an informed consent process and data was only collected from persons who provided informed consent. Consenting participants were given non-identifiable research codes to protect their personal information and anonymity. Findings were reported in aggregate, and not linked to individual participants.

III. Discussion and findings

This baseline assessment was grounded in mixed methods of data collection, including a survey associated with the **"Action", "Monitoring and Reporting"** and **"Review"** sections of the MAF-TB/Annex 2 Checklist. The **"Commitments"** section has been analyzed as a desk review. Statements included in the MAF-TB/Annex 2 informed a survey design ***(Please see Annex 1 for the survey questions)*** which had been administered through the available CSOs/COs National platforms (i.e. National Stop TB Partnership platforms).

3.1. Commitments

"Commitments inform the policy and strategic directions for TB response, and for CSOs/COs it is important to have a comprehensive understanding of the policy context at the international and national level as it is a practical way for civil society to speak "the same language" with policy and decision-makers." ***(13)***

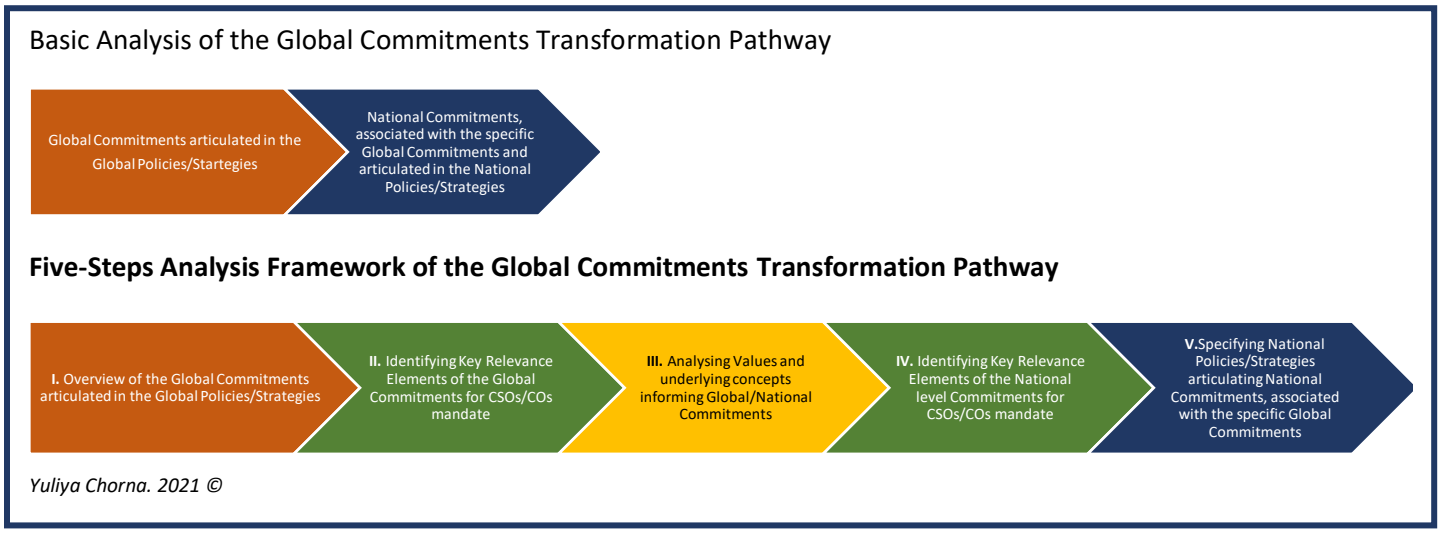
As observed by the regional research support expert team, interpretation of the ***"Commitments"*** section of the MAF-TB Annex2 Checklist, tracking of its value from the "global" to the "local" context meanings had been the most challenging part within the MAF-TB Annex 2 baseline assessment. In most cases, when completing the MAF-TB Annex 2 "Commitments" sections, participants made the links between Global Commitments and National documents, articulating National commitments which they found to be relevant to Global ones. However, it was less clear what specific elements should be in place, in order to consider that there is a real match between "Global" and "National" commitments; these missing pieces became apparent in interview and focus group discussions as well. Findings were accordingly triangulated for further use during scale up of MAF-TB baseline assessments in other countries in the current section of the report.

Entries of the National CSOs/COs assessment teams into the MAF-TB Annex 2 "Commitments" section were analyzed and the core documents referred as those associated with the alignment of National level commitments and Global commitments are presented in **Table 1** *(please refer to annex 2).* Respondents' responses received during interviews and focus-groups' discussions helped to add another level of inquiry from the lens of what ***meaningful engagement*** really means for civil society and affected communities and what elements need to be in place at the system level to enable sustainable meaningful engagement. As a apart of the data analysis and a bridge between Global Commitments and National Level commitments, **Values and Concepts** which should inform both sub-sets of Global and National commitments have been identified**.**

Conceptualizing process described above, helped to document a pilot approach for unpacking and operationalization of the Global commitments **"Basic Analysis of the Global Commitments' Transformation Pathway"** and to develop **"Five-Steps Analysis Framework of the Global Commitments Transformation Pathway"**, please see the ***Figure 2*** below.

Examples drawn from the pilot baseline assessments presented in Table 2 and developed "Five-Steps Analysis Framework of the Global Commitments Transformation Pathway" will be of help for further roll-out of the MAF-TB Baseline assessment 2 to inform the rational for answer choices under the Annex 2, as well as in other contexts, related to policy analysis.

Figure 2



Besides analysis of the "Commitments", the survey, and qualitative components of the Baseline assessment MAF-TB/Annex 2 in five pilot countries, helped to examine perspectives of civil society and affected communities relevant for **"Actions", "Monitoring and Reporting"** and **"Review"** elements of multisectoral accountability to end TB at country level. The concepts of ***"meaningful engagement", "multisectoral collaboration", "accountability"*** were especially heavily discussed in interviews and focus-group discussions with civil society, including TB survivors, and community organizations leaders, project coordinators and field workers. These perspectives and related implications are now discussed.

3.2. Meaningful engagement

Core elements seen to be fundamental to "**meaningful engagement"** were unpacked by the participants. They intersected with public participation, power, financing, service delivery and advocacy:

1) A safe environment for CSOs/COs to "voice" any suggestions and concerns to authorities and decision-makers to address barriers in access to care on behalf of the people they serve.
2) CSO/COs engagement throughout the associated process, beginning from the planning and conceptualization phase.
3) An impact on the decisions and policies made by CSOs/COs through their engagement in the associated process.
4) Sustainable public financing to support operational activities and deliver services to the people CSOs/COs serve.

Participating TB survivors and CSOs/COs representatives shared a host of challenges commonly experienced by TB survivors which were seen to inform future service delivery and advocacy efforts (Table 1). Despite a certain division in grouping these factors ("social", "clinical" and "structural"), in practice there are close links in how they flow, interact, reinforce each other and lead to health inequities. Participants emphasized that these challenges cannot be addressed by the healthcare sector alone and should be used to inform the planning and implementation of multisectoral collaboration models. While the frequency and intensity with which particular issues were raised and emphasized varied across sites, in general the three sets of challenges were seen to be relevant to all five pilot sites. The examples are provided as an illustration of how particular challenges manifested in some sites, though they varied substantially across sites.

Table 2: Challenges experienced by TB survivors

Social factors on the TB pathway	Clinical factors of disease	Structural factors in access to care
Stigma: Domestic/community violence (including towards family members). Social exclusion from the community. Lack of social support and/or loss of social (incl. family) support. **Discrimination:** Expulsion from work, school, housing. **Poverty:** Food insecurity. No housing/lost housing (also tied to long-term hospitalization and inability to pay utilities/rent). No financial means to pay for transportation to healthcare facility. No financial means to pay for auxiliary health services, medicines. **Unemployment:** Lost job. Lack of job opportunities.	Treatment' **side affects**, toxicity. **Treatment of other health** (comorbid) conditions: (TB/HIV; alcohol addiction; injection drug use).	**Mandatory documentation:** No access to diagnostics and care for people without identity papers or records, for example: *Residence registration.* *Citizenship proof.* *Employment record.* *Signed service-provision declaration with the family doctor.* *Social medical insurance.* *People who do not have medical social insurance face harshest barriers.* **Conflicting policies:** **Diagnostic services may entail** out-of-pocket payment and leads to delayed health care seeking. TB services are free-of-charge only once a diagnosis is confirmed.

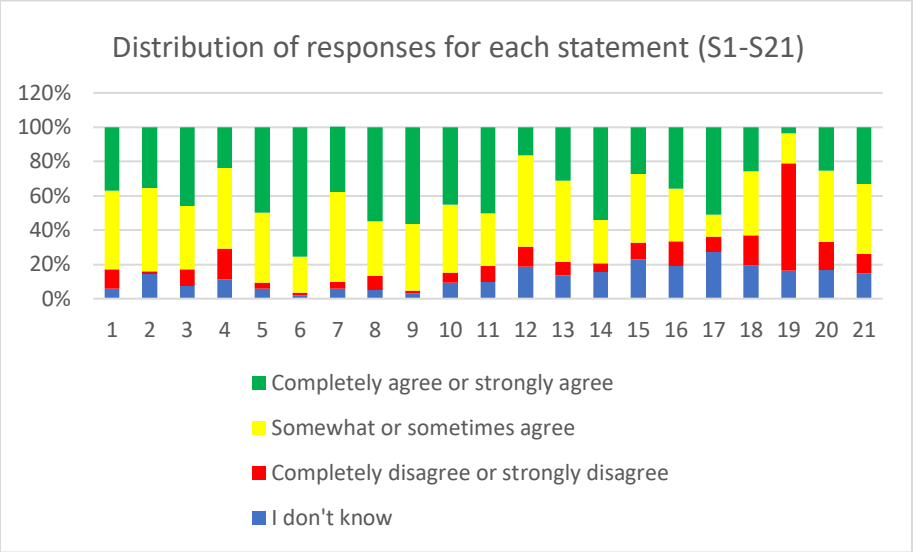
Lost profession (forbidden to work in certain areas). **<u>Lack of awareness about social entitlements:</u>** Social protection (pensions, disability payments). Social welfare (subsidizes). **<u>Gender biases:</u>** Patriarchy norms – women generally reported as experiencing more stigma; in some contexts, they have to ask permission of husbands /mothers-in-laws to access medical care; women's perceived roles as caregivers and housework burden may lead them to deprioritize accessing/treatment. Masculinity norms – men's perceived role as "breadwinners" may lead them to prioritize earnings over health.		**<u>Drug shortages:</u>** Lack of sustainable procurement and supply. **<u>Lack of referral mechanisms</u>**: No case management to ease patient navigation between multiple services/providers (eg, for comorbid conditions or social services). **<u>Poor infrastructure:</u>** Especially for people living in remote areas, outside of the capitals: - Poor quality of roads - Lack of public transportation - No laboratory networks - No specialized health facilities

Social and structural risk factors outlined in the Table 1, cast a light on the health disparities in TB and guide CSOs/COs' activities to address the needs of the most vulnerable people and communities to achieve equity by addressing disparities. These factors were seen to be exacerbated by the COVID-19 pandemic. For example, COVID-19 generated lockdowns have shrunk opportunities to earn income, and increased food insecurity for families already struggling with the poverty. Under such conditions, individual health needs have become even less of priority for affected people and communities. Moreover, access to social and medical care, especially in villages and remote areas has become even more hindered with the interruptions of work of the public transportation and closures or restricted access to the medical facilities.

CSOs/COs have been for a long time engaged in TB prevention, including awareness-building and helping to reach out to people who have been in contact with people with active TB disease, and care support activities throughout the whole continuum of TB pathway from symptoms to post-treatment adaptation. In the times of COVID-19, they have become even a more crucial linkage between TB-affected community and medical/social facilities, substituting facility-based directly observed therapy for TB with the community care based on video-supported interventions and delivery of medicines and social support. Emerging need to define the procedures and ways of working under the COVID-19 context has also become an entry point for increased multisectoral collaboration between CSOs/COs, health and state social care facilities. CSOs/COs provide services to address social and structural factors experienced by TB-affected people mostly through Global Fund grants, including through the recent COVID-19 Response Mechanism (C19RM) to support countries to respond to COVID-19 and mitigate its impact on the TB program; besides, there are also other streams of external funding, like USAID etc. allocated to support project activities of CSOs/COs.

Despite critical importance of CSOs/COs in advancing health equity and providing support to vulnerable people and communities affected by TB, there are short-term and long-term risks for maintaining service provision by CSOs/COs. Short-term risks relate to the gaps between project funding which negatively affects CSOs/COs staff retention and continuity of services, and long-term risks relate to countries' phasing into donor funding withdrawal from the region. This leads us into the next discussion point, about **sustainability of financing** which was also identified as an indicator of CSOs/COs' **meaningful engagement** and vital to trouble-free service delivery and operational capacity of civil society and community organizations. Four of five pilot sites administered the surveys, and responses on both peak statements (statement #6 and statement #19) demonstrated a high level of consistency in all participating countries. CSOs/COs **absolutely agreed** that "*they have a significant role in provision of TB service delivery/community-based TB care services to a patient / affected household support"* (#6), while at the same time they **absolutely disagreed** that "*there is a dedicated yearly operational budget exists to support work of civil society and TB affected communities"* (#19).

Figure 3: Distribution of Survey Analysis by countries, participating in the survey.



Peak Statement # 6

Civil society organizations and TB affected communities participate in TB service delivery/community-based TB care to provide services to a patient / affected household support.

Peak Statement # 19

There is a dedicated yearly operational budget exists to support work of civil society and TB affected communities.

These survey responses converged with interview and focus-group discussions of the pressures of donor transitions, and ongoing reforms including decentralization, which have shifted the priorities for allocation of budgets for social contracting/procurement of services from CSOs/COs from the centralized National to the local levels. As well, decisions about social/health issues and priorities, were viewed as being shifted to the local levels; hence work with municipal authorities was gaining heightened importance.

In general, all pilot countries are currently moving in the direction of allocating budgets and procurement of services from CSOs/COs – Ukraine has strong examples of allocations of financing from the municipal and regional budgets for procurement of services from CSOs for TB care; Moldova has started procurement of CSOs/COs services for active finding of people affected by TB from the medical social insurance fund; Kazakhstan has examples of social contracting mechanisms used to engagement of CSOs/COs in provision of TB care; and Belarus and Tajikistan have planned implementation of social contracting/procurement of TB services from CSOs/COs in the new GF country grants and TB strategies for 2021-2025. Despite these commendable advances, it was mentioned that to enable a social contracting or other types of state-budget procurement of CSOs/COs services in a sustainable way, there should be clear and transparent procedures on the process, as well as Nationally adopted standards of community-based care with essential quality benchmarks and cost estimations. So far standards of community-based care have not yet been adopted in most pilot countries.

3.3. Multisectoral collaboration

In sharing their experiences on existing multisectoral collaborations, participants referred to the Ministry of Health and related bodies, and the Ministry of Social Policy and the related bodies. They mentioned collaborations with Penitentiary services on support programs for inmates and ex-prisoners, and Internal Affairs when it concerned work on renewal of official papers, including for people without passports and other ID papers/documentation. Participants also shared examples of working with private sector, mass-media, opinion leaders, like religious leaders and famous actors and singers to raise awareness on TB and fight stigma. Although participants highlighted the importance of working with other CSOs/COs, in practice this mostly constituted collaboration with HIV-servicing organizations, rather than with CSOs working on other health and social issues.

Country Coordinating Mechanism (CCM) in charge of overseeing the implementation of the Global Fund grants and coordinating other aspects of developmental aid, include representatives of different sectors, beyond health, was often mentioned by participants as the existing platform for multisectoral collaboration and accountability. However, they reported that the degree of meaningfulness of their engagement through CCM depended on a number of factors. One such factor was linked to the level of participation and decision-making that CCM engagement could offer. The importance of not only being a member of the CCM, but additionally a member of its working groups and committees, which are really issue-based, was noted. Another factor was the level of representation of CCM members, as there was some discrepancy noted between official members and delegated members. If for example, a certain Ministry is represented by a high-ranked official, one could expect the follow up and oversight on CCM decisions by this member when it comes to the implementation in the associated Ministry. However, in practice it was noted that official members tend to delegate for participations their lower-ranked subordinates resulting is a lower degree of influence and actionability on CCM decisions. Therefore, CCM has often been regarded as the suitable mechanism for coordination of MAF-TB activities, but necessarily as a mechanism for MAF-TB high-level review, foreseen by the MAF-TB concept ***(3), (4).***

Besides cooperation with other sectors at the CCM level, one of the tools to support multisectoral collaboration processes often used by participants is an official memorandum of cooperation signed with governmental organizations. However, participants highlighted that formal memorandum do not work unless investments in social networks and informal relations are made, as these are most effective in driving the agenda. Hence, relations-building was acknowledged to have a key value. Working together at issue-based taskforces and working groups (i.e., on development of legislation, joint reporting); joint organization of events and activities were some examples of relations-building activities recommended to support multisectoral collaboration.

Building rapport with the National TB Program, policymakers, health, and social service providers in the public and private sector was also viewed as critical for understanding their positions and needs, and to identify entry points and opportunities for collaboration and joint solutions. At the same time, underlining the value of relations built on trust and empathy towards the common goal, participants struggled with ideas of effectively combining collaboration with advocacy actions. A feasible and promising intervention which could bridge the advocacy and collaboration points of interaction with NTP, and other stakeholders is the OneImpact community-led monitoring app, which at the time of data collection was being used in three pilot countries (Kazakhstan, Tajikistan, and Ukraine) to monitor quality, availability and accessibility of TB services. This intervention has a potential to serve as a channel for multisectoral collaboration with NTP and other stakeholders to jointly work on the challenges in access to care and other issues reported by the TB patients. It is particularly important that countries include objectives to sustain OneImpact after the end of the donor-funded projects in their strategic documents and funding applications. The OneImpact tool, as such, can be viewed as relevant for governmental and non-governmental stakeholders' (according to their mandates and roles) means of delivering accountability for ensuring quality, affordable and available services for people affected by TB.

3.4. Accountability

The meaning and practice of **accountability** was in general referred by participants as the CSOs/COs' obligation to report on financing and activities to the government and donors following vertical subordination lines. Accountability towards the Board, clients, its own members (for membership-based organizations), broader community have been mentioned as well, but the focus on its added-value has not become central in the discussions. This finding suggests that there is some hierarchy in accountability actions; possibly a greater level of responsibility to show accountability to persons outside the organization who may drive funding, as compared to service users or persons within/among whom accountability may simply be assumed (ie taken for granted).

That being said, several ideas were voiced that unpacked the complexity of accountability. Even as CSOs were understood to be externally funded and accountable to external (non-government) donors, they were still perceived to be working in the broader domain of international financial aid, given to countries through the channels of governmental international agreements. Hence, in fulfilling their activities, they understood to be contributing to overall efforts to end TB alongside governmental stakeholders, and as such they could be viewed as accountability bearers to citizens alongside the government. Other ideas were voiced, in particular that being accountable for reporting on active finding of people with TB, who are missed by healthcare system, and the impact of psychosocial support on adherence and well-being, among other issues, should be viewed as an opportunity rather than as a burden. These reports, as a reflection of the work CSOs do, could open more opportunities for collaboration with NTP and other sector stakeholders, and boost recognition of the CSOs/COs' value in the TB response.

In terms of the accountability of the governmental counterparts, participants stated that in many cases they did not have a clear picture about accountability from governmental organizations. Though there is an understanding of the accountability of government as duty-holders for the fulfilment of political commitments and program implementation, the process and means of government accountability was unclear. For example, they had limited access to disease statistics, programs, entitlements, etc. In this regard, CSOs/COs mentioned the importance of open access to public information on statistics, budget spending, program effectiveness in open sources, which would also facilitate evidence-based planning of their own activities. and commented on certain challenges of open access on the disease statistics, programs, entitlements etc. Usually, CSOs/COs received such information from their governmental counterparts through official inquiries, and sometimes this was a lengthy process resulting in basic information. They were keen to have opportunity to receive comprehensive answers particularly to support CSO/CO programming.

IV. Conclusions and potential contributions of the baseline assessment:

4.1. Conclusions

1. CSOs/COs address most of the social needs and part of the structural barriers in access to care experienced by TB affected people, through externally funded donor support.
2. Countries are gradually introducing social contracting and procurement schemes to sustain CSOs/COs services after donor transition, however there are no approved National standards of community-based care which would inform the approach to procurement; there is no sustainable budget from public sources to support operational and programmatic activities by CSOs/COs.
3. Ongoing de-centralization reforms shift finance allocation to the local budget; decisions on priorities of the procurement of social services have also shifted from the National to local levels.
4. People affected by TB are starting to experience additional structural barriers in access to care in the course of the ongoing reforms. In most countries the absence of personal documents (i.d., place of registration, identity documents) are reported as a major barrier to accessing medical services and social support. Current solutions rely on ad hoc and case-by-case negotiations with authorities; systematic solutions have not been fully established.
5. CSOs/COs role has become instrumental during COVID-19 when difficulties in access to care have been exacerbated by lockdowns and restrictions; the ongoing shift in service digitalization needs to be sustained.
6. CSOs/COs perceive CCMs as a platform to build on multisectoral collaboration and accountability efforts; however, meaningful engagement through CCMs platforms will depends on CSOs/COs' active participation in associated working groups and the level of high-level representation of CCMs members.
7. CSOs/COs are struggling to find a balance between collaboration and advocacy elements in their relations with governmental officials; sometimes these activities are perceived as mutually exclusive.
8. Behinds the memorandums and official inquiries are often an informal collaboration between the CSO and other actors, mostly healthcare workers. The collaboration is invaluable in positioning actors as people rather than institutions.

9. CSOs/COs perceive their accountability mostly as the obligation to report to government and donors; although some horizontal types of accountability towards members, clients, the general public and their Board have also been in place, its value has not become apparent in current discussions.
10. Governmental accountability is perceived in terms of access to public information in the open sources; there are certain difficulties in access, and lack of awareness/information in general on what makes the governmental accountable, the associated processes and channels.
11. There is a lack of awareness on theoretical concepts informing gender-sensitive approaches; however, CSOs/COs reported that they strive to use an individualized approach for their clients.

4.2. Potential contributions of the baseline assessment

The MAF-TB Baseline assessment/Annex 2 responds directly to Action Area 5 of the recent "Deadly Divide Report: TB Commitments and TB realities" produced by the Stop TB partnership **(10)**.

> Action area 5: Commit to accountability, multisectorality, and leadership on TB. By addressing the current weaknesses in accountability for TB, through urgently implementing an independent National Multisectoral Accountability Framework for TB in every country (as committed to by 2019), with high-level leadership and supported by a strong, national monitoring and review system. Using the results to strengthen accountability action, including the production of annual country and global progress reports on the Political Declaration and the holding of a United Nations High-Level Meeting on TB in 2023 **(10).**

There is potential for the MAF-TB Baseline Assessment/Annex 2 to support the Deadly Divide Report's areas as well. For example:

1. ***Action 1: reach all people through TB diagnosis, treatment, care, and prevention***
- Provide critical insights on the social and structural challenges experienced by people and communities affected by TB which influence their health outcomes and limit equitable access to care.
- Integrate people-centered approaches into TB service provision, which takes into account psycho-social needs of the patient, not only biomedical and technical/operational considerations.

2. ***Action 2: accelerate the development of essential new tools to end TB***
- Build capacity of CSOs/COs for service-provision, partnership-building and multisectoral collaboration.

3. ***Action 3: Make the TB response rights-based, equitable and stigma-free, with communities at the center***
- Define elements which may be adopted or strengthened for more equitable access to care and health outcomes for people affected by TB through multisectoral collaboration and accountability in the TB response.

4. ***Action 4: Promote investment of the funds necessary to end TB***
- Lend voice to CSOs/COs' perspectives about integral elements of their meaningful engagement in the TB response; and conditions which need to be in place to ensure their financial, operational, and programmatic sustainability.

5. ***Action 5: Leverage decision-makers commitment to accountability, multisectorality and leadership on TB***
- Inform policy analysis through pathway akin to the transformation of global political commitments to local practice.
- Identify ways to increase mutual accountability and collaboration among CSO and other sectors, beyond health, to help fulfill political commitments and pursue collective goals and actions.

6. ***Action 6: Leverage COVID-19 as strategic opportunity to end TB***
- Define elements which need to be addressed to sustain TB services by CSOs/COs during parallel health emergencies such as COVID-19, government/ structural reforms, and donor transition.

V. Recommendations

To enable operationalization by CSOs/COs, facilitate support from NTPs and other relevant government sector stakeholders, and enable monitoring, recommendations derived from findings of the MAF-TB Baseline Assessment/Annex 2 have been translated into an action-oriented framework (Table 3).

The entire framework is centered around the objectives of MAF-TB: Commitments; Actions, Monitoring & Reporting and Review, as well as action areas of the Deadly Divide Report as they apply to community stakeholders. Recommended actions, accountability partners, and capacity building areas are directly informed by the quantitative and qualitative findings of the Baseline Assessment with the use of the MAF-TB Checklist Annex 2 in five EECA countries, recommendations within country-level reports, and stakeholder input that was actively sought during the TBEC regional workshop on transforming research evidence into actional recommendations (July 30, 2021).

Principles taken into account while developing recommendations have been identified as actionability from the perspective of CSOs/COs; feasibility and equity-based approach as the core for all recommendations. Government sectors accountability partners have been identified as the primary partners to facilitate support and ensure sustainability of the recommendations. However, CSOs/COs should also consolidate their efforts within CSO/COs field and use their outreach and communication channels with donor agencies, technical partners, private sector to get their support and facilitate implementation of the recommendations.

Table 3. Action-oriented framework *for CSOs/COs across MAF-TB four core components: Commitments; Actions, Monitoring & Reporting and Review*

Objectives	Actions that might be undertaken by CSOs/COs	Governmental accountability partners (depending on the country context)	CSOs/COs capacity building[1] areas
I.COMMITMENTS			
1.1. Create a favorable environment for meaningful engagement of a civil society and TB affected community in TB response	1.1.1. Build advocacy coalition with other health CSOs/COs and advocate for: - Sustainable mechanisms of service procurements from CSOs/COs and support of their operational activities (legislation, budget, procedures) being put in place. - Formalized standards of community-based care and costed operational procedures. - Sustainable budget allocations from public sources at the national and local levels to support operational and programmatic activities by CSOs/COs. - Sustainable mechanism/funding for capacity building of CSOs/COs.	MoH; NTP; MoSA, National Health Services managing compulsory health insurance fund Municipal governments in charge of local budget and setting priorities for the public procurement of social services	Core elements of the End TB Strategy; Sustainable Development Goals. National legal documents regulating health strategies; National TB Strategic Plans; compulsory social insurance fund. Legal documents on social services/social contracting. Knowledge base on the budget advocacy, and decentralization reforms.
1.2. Advance towards universal access to quality, affordable and equitable TB prevention,	1.2.1. Advocate for policies in support of universal access: -Intersectoral policies and coordination mechanisms to reduce health disparities for the poor and most vulnerable, marginalized people[2];	Cabinet of Ministers MoH; NTP; MoSA and other relevant Ministries and Bodies Municipal governments/ bodies	Economic and social determinants of TB and TB-related risk factors affecting people health outcomes. Universal Health Coverage; Human rights frameworks.

[1] Please refer to the capacity-building areas needs to inform development of the capacity-building plans within the funding applications and submitting the requests for technical support to the technical agencies

[2] I.e., people without identity paper, citizenship or residence permits, people who are not entitled for compulsory state medical insurance, homeless people, and other groups affected by health disparities. Please refer to the Table 2 of the Report for more information

diagnosis, treatment, care, and education	-Developing/supporting specific legislation to promote health equity/reduce health disparities for key and vulnerable groups. - Revision and update of a current legislation to remove barriers to equity/reduce health disparities. 1.2.2 Prepare targeted information about TB and importance of the multisectoral action to address social determinants of TB to use in the outreach to sector-specific stakeholders responsible for addressing the identified social determinants[3] within their functions. 1.2.3 Join/or initiate creation and actively contribute to the work of the relevant issue-specific National working groups (i.e., aligned to CCM, NTP and other platforms) to identify priority issues which could be solved through the response from different societal and governmental sectors under the broader framework of health and well-being.	Parliamentary Health and Social Affairs Committees	Targets of the UNHLM on TB political declaration 2018. People-centered model of TB care; concepts of the social determinants of health and a social justice.
1.3. Strengthen national multisectoral mechanisms to monitor and review progress achieved towards ending the tuberculosis epidemic.	1.3.1. In consultation with NTP and a relevant country coordination body or mechanism initiate MAF-TB at the country level. 1.3.2. Engage in MAF-TB discussions and planning at the country level from the very beginning and throughout all stages of MAF-TB implementation. 1.3.3. Engage in MAF-TB baseline assessment and lead on assessing the role of TB civil society and affected community in TB response. 1.3.4. Advocate for creation/formalization (for example through CCM) of the MAF-TB coordination and high-level review mechanisms with adequate representation of the civil society and TB affected communities in both structures. 1.3.5. Advocate for MAF-TB High-level review mechanism to be led under the leadership of a Head of State/Government and actively seek membership and representation in both.	Cabinet of Ministers. CCM or other country coordination bodies and mechanisms; NTP; MoH; Ministry of Economics and other relevant Ministries and Bodies. Parliamentary Health and Social Affairs Committees	Health as whole-of-the governance and whole-of-the society approach; public participation. Multisectoral accountability framework to accelerate efforts to end TB.
II. ACTIONS			
2.1. Lend voice to CSOs/COs' perspectives about integral elements of their meaningful engagement in the TB response; and conditions which need to be in place to ensure their financial, operational, and programmatic sustainability.	2.1.1. Establish a TB civil society and affected community's forum for sharing information and building unified position on what are the major problems to tackle. 2.1.2. Identify National strategic and operational planning processes and platforms and seek opportunities to join the process in the national strategic planning and budgeting, as well as yearly operational planning and budgeting of the end TB response. 2.1.3. Ask NTP to assign a focal point for engagement with CSOs/COs and build partnership and a regular communication with a NTP focal point.	NTP, CCM or other country coordination bodies and mechanisms	Budget cycles and financing of health/social services.
2.2. Ensure TB care services reach those who need them equitably and, in a	2.2.1. Map available TB care services which exist at the National and regional levels and develop an inventory of relevant CSOs/COs engaged in TB service provision to support future service referral and collaboration system.	NTP, CCM or other country coordination bodies and mechanisms	

[3] Examples of social determinants: income and social protection, education, food security, housing etc. For more information, please refer to https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

people-centered way.	2.2.2. In collaboration with NTP, develop relevant mechanism and initiate keeping a regular track of evidence on the social determinants and risk factors experienced by people and communities affected by TB which influence their health outcomes and limit equitable access to care.	NTP, CCM or other country coordination bodies and mechanisms	Gender-sensitive approaches; people-centered TB care. Health equity, social determinants of health.
	2.2.3. Initiate the process and contribute towards development of the mechanism for estimation of a number of people who do not have identity papers and cannot receive services. Advocate for budget allocations and formalization of a service delivery model for people without identity papers/formal status in the country. 2.2.4. Advocate for local budget's allocations to finance diagnostics and care for people with no identity papers in the countries undergoing decentralization reforms.	NTP, CCM, Statistics service. Ministry of Finance and/or relevant regional structures	Budget cycles and financing of health/social services. Community, rights, and gender assessment tools.
	2.2.5. Document evidence through periodic stigma assessments and build awareness on the detrimental effect of stigma in TB response among general population, TB affected communities and increase healthcare workers' capacity to tackle stigma.	MoH, NTP primary healthcare network; CCM or other country coordination bodies and mechanisms; MoSA, state social services. Ministry of Education, Ministry of Information; Members of Parliament and elected officials of local self-governments	Intersectionality and health-related stigma frameworks; anti oppression frameworks.
	2.2.6. Document CSOs/COs effective interventions during COVID-19 and advocate for the effective practice to be sustained.	NTP, CCM or other country coordination bodies and mechanisms	Mixed methods research; analysis and report-writing.
	2.2.7. Systemize field evidence and advocate to participate in the working groups on development of national guidance and operational manuals/tools to make sure affected people experience and voices on how the quality TB care should look like is considered.	MoH, NTP, CCM, MoSA, Ministry of Justice and Penitentiary Service	Mixed methods research; analysis and report-writing. Group development and conflict management.
	2.2.8. Build strategic service-focused coalitions with other entities (i.e. governmental health and social services, private providers, other non-governmental service providers) to complement each other's different foci, strengths, and gaps to build a future service referral and collaboration system.	MoH; NTP; primary healthcare network; MoSA, state social services	People-centered TB care. biopsychosocial needs assessments theory, peer-support, and social work practice theories. Ethical standards in TB care provision.
III. MONITORING AND REPORTING			
3.1. Increase mutual accountability of multisectoral governmental stakeholders and CSOs/COs to help fulfill political commitments and pursue collective goals and actions.	3.1.1. Initiate multistakeholder National dialogues to identify indicators and channels of accountability to all stakeholders in TB response to ensure access to public information in the open sources, ways of effective public participation, transparency of governance and budget spending. 3.1.2. Agree targeted accountability channels and communication means for CSOs/COs to report on their progress and operational activities, as well as to solicit feedback from the clients of organization. 3.1.3. Develop indicators of CSOs/COs engagement in TB response and advocate for the inclusion of the section on the civil society and affected communities' input in the TB response to the annual National TB report.	MoH, NTP, CCM, and other relevant Ministries and Bodies	Accountability types and channels related to the functions and spheres of control of governmental and non-governmental stakeholders; best practices of accountability in the multisectoral response action. MAF-TB background documents.

3.2. Ensure that civil society and affected communities have a safe and nurturing environment to conduct community-led monitoring of access to TB services.	3.2.1. Advocate for sustainability of the community-led monitoring (i.e., OneImpact app) as a platform of common engagement with NTP to work on finding solutions and taking the actions within one's sphere of control to tackle challenges experienced and reported by people with TB. 3.2.2. Be involved in design and conduct gender, stigma, and legal environment assessments within CRG frameworks to advance health equity and address needs of key and vulnerable populations.	MoH, NTP, CCM, and other relevant Ministries and Bodies	Soft skills and emotional intelligence with the focus on mindfulness, interpersonal communication and building trust; conflict management and models of conflict behavior; negotiation, networking and partnership building. Litigation measures. Community, rights, and gender frameworks. Community-led monitoring.
IV. REVIEW			
4.1. Ensure that civil society and affected communities are members of a high-level review body/mechanism regularly reviewing the TB response, with associated terms of reference.	4.1.1. Advocate for specifying roles of the CSOs/COs in the National High-level Review Mechanism and participate in the development of its associated ToRs. 4.1.2. Advocate for having annual Parliamentary hearings on TB and support the implementation of its recommendations. 4.1.3. Advocate for developing and making publicly available TB annual multisectoral reports on progress in TB response.	Cabinet of Ministers, Administration; Ministry of Economic and Development; MoH, CCM, NTP, State Parliamentary Committee on Health and Social Affairs.	Functions of the governmental stakeholders, public administration, and public policy processes.
4.2. Ensure that TB civil society and affected community representatives participate in the full process of Joint Monitoring/Review Missions.	4.2.2. In collaboration with NTP initiate development of a procedure to ensure CSOs/COs engagement in the joint monitoring review missions of the National TB programme.	NTP	National TB Program review approach

Annex 1. List of statements to the Survey

1.There is an effective and representative TB civil society and community's forum or equivalent.

2 There is a transparent and formalized process to nominate representatives of civil society and affected communities to serve on any multisectoral and multi-stakeholder coordination and review bodies/mechanisms addressing the TB response (e.g., CCM etc.).

3. Civil society organizations and TB affected communities' organizations participate in yearly strategic planning and budgeting.

4. Civil society organizations and TB affected communities' organizations participate in yearly operational planning and budgeting.

5. Civil society organizations and TB affected communities participate in development of TB national guidance and operational manuals/tools.

6. Civil society organizations and TB affected communities participate in TB service delivery/community-based TB care to provide services to a patient / affected household support.

7. Civil society organizations and TB affected communities participate in relevant capacity-building of health workers.

8. Civil society organizations and TB affected communities participate in any national TB/health research forum or network and national research agenda-setting, including clinical and operational research.

9. Civil society organizations and TB affected communities collaborate with civil society fora/coalitions addressing other health priorities & sectors.

10. Civil society organizations and TB affected communities are involved in regular monitoring meetings of the National TB Programme.

11. Civil society and affected communities are involved in design and conduct of gender, stigma and/or legal environment assessment.

12. Recommendations, developed because of CRG assessments lead to revisiting of polies and programs, and are accounted there.

13.Community-led monitoring of access to TB care by CSOs/COs impact program and political changes in order to improve TB prevention and care.

14. Roles and activities of civil society and affected communities are addressed in annual national TB Report.

15. Specific indicators on civil society engagement are measured at the National level and accounted for in the process of monitoring and TB progress review.

16. Indicators are set with or by civil society and affected communities for assessing their own accountability in the TB response.

17. Representatives of civil society and affected communities are members of any high-level review body/mechanism regularly reviewing the TB response, with associated terms of reference.

18. Civil society and affected community representatives from within and beyond participate in the full process of Joint Monitoring/Review Missions.

19. There is a dedicated yearly operational budget exists to support work of civil society and TB affected communities.

20. There is a policy and practical guidance on engagement of CSOs/COs in provision of TB services.

21. Governmental organizations ask CSOs/COs for technical collaboration, if there is a need in CSO/CO associated expert knowledge and skills.

Annex 2

Table 2. Operationalization of "Commitments" relevant to the mandate of the CSOs/COs *(included in the Annex 2 of the MAF-TB Baseline Assessment Checklist)*

Column 1	Column 2	Column 3	Column 4[4]
Key Relevance Elements of the **Global Commitments** for CSOs/COs mandate	**Key Relevance Elements** of the **National level Commitments** for CSOs/COs mandate	**National Policies/Strategies articulating National Commitments,** associated with the specific **Global Commitments**	**Underlying Values/ Concepts** informing Global/National Commitments
1. World Health Assembly			
a) Commitment to the overarching principle in the End TB Strategy of *"a strong coalition with civil society organizations and communities*" as well as the 2nd Pillar of the End TB Strategy on Bold Policies and Systems including *"Engagement of communities, civil society organizations, and public and private care providers"* (**WHA67 resolution** adopting the Global Strategy and targets for tuberculosis prevention, care and control after 2015 - **The End TB Strategy**)			
A strong coalition with civil society organizations and communities. Engagement of communities, civil society organizations & public/private care providers.	*Sustainable mechanisms of service procurements from CSOs/COs in place (legislation, budget, procedures):* Social contracting (National and local mechanisms); -Mechanisms of procurement from medical social insurance funds; -Adopted standards of care (people-centered dimensions) and operational procedures/costed; -Quality and specification requirements for service provision; -Legislation on public participation, secured seats for CSOs/COs in the decision-making bodies; - Safe environment for community-led monitoring on access to TB care.	Long term national social and economic development strategies which include provisions for intersectoral coordination (government, private sector and civil society); National strategies or policy documents to achieve Sustainable Development Goals (SDGs), which include provisions for multisectoral collaboration and underline importance of civil society engagement; National Population Health Strategy (Long-term and short-term, supported by action plans), which include provisions for CSOs/COs engagement of CSOs for TB care and awareness raising; National TB care reforms strategy; National TB Strategic Plans (TB-NSP) or other relevant plans, where TB is specified; Country application to the GF; Laws and related legal documents on the infectious diseases, including TB and HIV/AIDS (may include provisions for social contracting); Legal documents on social services/social contracting.	Public Participation; Empowerment/voice; Public-private partnership; Cost-effectiveness; Access, affordability, and availability of care.
2. Political Declaration of the UN High-level meeting on TB			
Key Relevance Elements of the **Global Commitments** for CSOs/COs mandate	**Key Relevance Elements** of the National level Commitments for CSOs/COs mandate	**National Policies/Strategies articulating National Commitments,** associated with the specific **Global Commitments**	**Values and Underlying Concepts** informing Global/National Commitments
b)Commit to protect and promote the right to the enjoyment of the highest attainable standard of physical and mental health, in order to advance towards universal access to quality, affordable and equitable prevention, diagnosis, treatment, care and education related to tuberculosis and multidrug-resistant tuberculosis and support for those who become disabled due to tuberculosis, integrated within health systems towards achieving universal health coverage and removing barriers to care; to address the economic and social determinants of the disease; and to promote and support an end to stigma and all forms of discrimination, including by removing discriminatory laws, policies and programs against people with tuberculosis, and through the protection *and promotion of human rights and dignity, as well as policies and practices which improve outreach, education and care.*			
b) Universal Health Coverage & removing barriers to care;	**I. Equity-based lens in health benefit packages** under universal health coverage (what are the provisions to enable access to care to the most vulnerable people i.e. people with no documents/health insurance; people-	Constitution as a guarantee for citizens' rights for a health care; National Population Health strategy (Long-term and short-term, supported by action plans); National TB guidance/standards packages;	Right to health; Collective responsibility for pooled health risks/social medical insurance; Structural barriers;

[4] Column 4 "Underlying Values/Concepts" has been interpreted as the part of the analysis, whereas Columns 1-3 represent the commitments and their key elements found to be relevant by respondents during interviews, focus-groups and surveys.

Address economic and social determinants of disease; Promotion of human rights and dignity;	centered dimensions of care v. cost-effectiveness); **II. Social protection** and welfare (disability pension, unemployment, sick-leave coverage): **Financial protection** for people affected by disease/availability of subsidizes; **Right to housing** (how to enable access to temporary housing during/after treatment; safeguarding existing housing/subsidized rents/utilities for the time of treatment); **Right to education:** provisions for professional training during treatment as a part of post-treatment adaptation strategy; **Right** to have a social, psychological and legal support. **III. De-institutionalization provisions:** ceasing involuntary TB hospitalization; ceasing institutionalization of children into the long-term boarding schools/sanatoriums in a case when a single caregiver is subjected to hospitalization; development of probation services versus incarceration to reduce TB in congregated settings. **IV. Transborder cooperation** on migrants' health (enabling diagnostics and continuity of treatment in the recipient countries). *Sustainable mechanisms of service procurements from CSOs/COs in place*	National health reforms packages; National TB care reforms strategy; National TB Strategic Plans (TB-NSP) or other relevant plans, where TB is specified; Country application to the GF; National Laws and guidance on the social services and social welfare.	Social determinants of health; Health equity; Limitations of the biomedical approach to health; Social justice.
c) Commit to provide special attention *to the poor, those who are vulnerable, including infants, young* children and adolescents, as well as elderly people and communities especially at risk of and affected by tuberculosis, in accordance with the principle of social inclusion, *especially through ensuring strong and meaningful engagement of civil society and affected communities in the planning, implementation, monitoring and evaluation of the tuberculosis response, within and beyond the health sector.*			
c) Special attention **to the poor, those who are vulnerable through ensuring strong & meaningful engagement of civil society & affected communities** in the planning, implementation, monitoring & evaluation of TB response; **within and beyond health care**	**Intersectoral policies** and coordination mechanisms in support of the poor and most vulnerable, disenfranchised people; **Integrated services** (TB/HIV; TB and methadone therapy; TB and alcohol/drugs harm reduction; TB and mental health etc.); **Specific legislation** to promote health equity/reduce health disparities for key and vulnerable groups (i.e. migrants; people living in remote and rural areas etc.); Policies for provision of **psychosocial, including material and legal** support. *Sustainable mechanisms of service procurements from CSOs/COs in place*	National Population health strategy (Long-term and short-term, supported by action plans); National Laws on infectious diseases, including TB (covering prevention, health promotion, prevention check-ups for vulnerable people which experience increased risks of getting TB; issues of transborder TB cooperation); National guidance and standards on TB diagnostics and treatment, with the universal health coverage agenda; National health reforms packages; National TB care reforms strategy; National Strategic Plans for TB, which include provisions for community systems strengthening through the continuum of TB care and development of the research capacities; Country application to GF; National Laws and guidance on the social services and social welfare.	Right to Health; Public participation; Meaningful engagement; Social justice; Social welfare; Social determinants of health; Limitations of the biomedical approach to health;
d) Commit to develop or strengthen, as appropriate, national tuberculosis strategic plans to include all necessary measures to deliver the commitments in the present political declaration, including through national multisectoral mechanisms to monitor and review progress achieved towards ending the tuberculosis epidemic, with high-level leadership, preferably under the direction of the Head of State or Government, and with the active involvement of civil society and affected communities, as well as parliamentarians, local governments, academia, private sector and other stakeholders within and beyond the health sector, and promote tuberculosis as part of national strategic planning and budgeting for health,			

recognizing existing legislative frameworks and constitutional arrangements, so as to ensure that each Member State is on track to achieve the Sustainable Development Goals target to end the tuberculosis epidemic.			
d) **National multisectoral mechanism to monitor and review progress** achieved towards ending TB Epidemics, with **high-level leadership**, preferably under the direction of Head of State or Government, **and with active involvement of civil society and affected communities** as well as other stakeholders	Legislation which enables **health lens in all other sectors** (i.e., health impact policy assessment); **Formalized MAF-TB mechanism for multisectoral coordination** (coordination and enforceability dimensions; sustainability of the mechanism; transparent processes of election and representation; seats available for civil society and communities); **Formalized multisectoral action plan** (costed, indicators) and channels for communication and accountability; **Formalized High-level review** mechanism (decision making; actionability on the raised concerns and enforceability dimensions). *Sustainable mechanisms of service procurements from CSOs/COs in place*	National strategies or policy documents to achieve Sustainable Development Goals (SDGs); National Population health strategy; Long-term TB strategies and/or socially-important diseases supported by action plans); National TB care reforms strategy; National TB care reforms strategy; Terms of References for the Country's Coordinating Mechanism under the GF grants and collaboration with other donors Terms of References for other multisectoral bodies at the level of Presidential Administration, Cabinet of Ministers, Parliament.	Multisectoral collaboration; Health as whole-of-the governance and whole-of-the society approach; Empowerment and citizens' voice; Public participation; Accountability;

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