THE REPUBLIC OF UGANDA

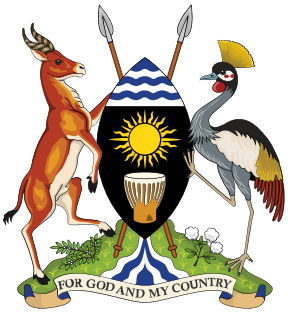
MINISTRY OF HEALTH

NATIONAL TUBERCULOSIS AND LEPROSY STRATEGY

2025/26–2029/30

NOVEMBER 2025

NATIONAL TUBERCULOSIS AND LEPROSY CONTROL PROGRAMME



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NTLP

Vision

A healthy and productive population that contributes to socio-economic growth and national development.

Mission

To provide high quality and accessible health services to all people in Uganda, including addressing broader determinants of health.

Citation

Ministry of Health. (2026). National Tuberculosis And Leprosy Strategy 2025/26–2029/30.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACSM	Advocacy, Communication and Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
BCG	Bacillus Calmette-Guérin
CAD	Computer-Aided Detection
CBO	Community-Based Organization
CHW	Community Health Worker
CPD	Continuing Professional Development
CRP	C-Reactive Protein
CRPs	Community Resource Persons
CSO	Civil Society Organization
CXR	Chest X-Ray
DHIS2	District Health Information System 2
DHO	District Health Officer
DLFP	District Leprosy Focal Person
DLTs	District Laboratory Technicians
DOT	Directly Observed Therapy
DR-TB	Drug-Resistant Tuberculosis
DST	Drug Susceptibility Testing
DTLS	District TB and Leprosy Supervisor
eCBSS	Electronic Case-Based Surveillance System
eCHIS	Electronic Community Health
EMR	Electronic Medical Records
EOC	Emergency Operations Center
EQA	External Quality Assessment
ETR	End-Term Review
FBO	Faith-Based Organization
GIS	Geographic Information System

HCDP	Human Capital Development Program
HCII	Health Centre II
HCIII	Health Centre III
HCIV	Health Centre IV
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSD	Health Sub-District
iHRIS	Information System Integrated Human Resource Information System
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
KAP	Knowledge, Attitudes and Practices
KOICA	Korean International Cooperation Agency
LMIC	Low- and Middle-Income Countries
LMIS	Logistics Management Information System
LPEP	Leprosy Post Exposure Prophylaxis
M&E	Monitoring and Evaluation
MAF-TB	Multisectoral Accountability Framework for Tuberculosis
MDR-TB	Multidrug-Resistant Tuberculosis
MD	Multidrug Therapy (for Leprosy)
METS	The Monitoring and Evaluation Technical Support
MoH	Ministry of Health
MoLG	Ministry of Local Government
NCD	Non-Communicable Disease
NDA	National Drug Authority
NDP	National Development Plan
NDP IV	National Development Plan IV
NMS	National Medical Stores
NPHC	National Population and Housing Census
NSP	National Strategic Plan

NTLP	National TB and Leprosy Programme
OOP	Out-of-Pocket (Expenditure)
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PFP	Private-for-Profit
PHC	Primary Health Care
PLHIV	People Living with HIV
PNFP	Private Not-for-Profit
PPM	Public–Private Mix
PTLD	Post-TB Lung Disease
QI	Quality Improvement
RR-TB	Rifampicin-Resistant Tuberculosis
RTLS	Real-Time Locating System
SDG	Sustainable Development Goals
SOP	Standard Operating Procedure
SPARS	Supervision, Performance Assessment and Recognition Strategy
TASO	The Aids Support Organisation
TB	Tuberculosis
TPT	Tuberculosis Preventive Treatment
TSR	Treatment Success Rate
TWOS	Threats, Weaknesses, Opportunities and Strengths (Analysis)
UCMB	Uganda Catholic Medical Bureau
UHC	Universal Health Coverage
UMMB	Uganda Muslim Medical Bureau
UMPB	Uganda Protestant Medical Bureau
USTP	Uganda Stop TB Partnership
VHT	Village Health Team
WALIMU	World Alliance for Lung and Intensive Care Medicine in Uganda
WHO	World Health Organization
WRD	WHO-Recommended Rapid Diagnostics
XDR-TB	Extensively Drug-Resistant Tuberculosis

GLOSSARY

Active tuberculosis (TB) disease. A clinical condition caused by Mycobacterium tuberculosis in which the bacteria are multiplying and causing illness. It may affect the lungs (pulmonary TB) or other organs (extrapulmonary TB). Pulmonary TB can be infectious, while extrapulmonary TB is generally not.

Contact. A person who has spent time with a person with infectious TB.

Close contact. A person who has had prolonged, frequent, or intense contact with a person with infectious TB. This group includes people who live together or spend a great deal of time together in close proximity. Close contacts, or household contacts, are more likely to become infected with tuberculosis than contacts who see the person with TB less often.

Community-Resource Persons (CRPs). Categories of staff and volunteers recognized as Community Resource Persons (CRPs) are individuals who play a critical role in mobilizing communities, delivering health services, and linking households with the formal health system. These include Village Health Teams (VHTs), Community Extension Workers (CHEWs), Health Assistants and Public Health Nurses, Local Governance structures (Village Health Committees, Local Councils), Tradition and Complimentary Medicine Practitioners (TCMPs) and Household and Family Caretakers (Uganda MoH's National Community Health Strategy (2022)

Community systems. Structures, mechanisms, processes and actors through which communities act on the challenges and needs that they face. They are made up of different types of entities: community members, formal and informal community organizations and networks, and other civil society organizations. Such systems are usually less formalized and less clearly defined than health systems. Entities that make up community systems have close links with communities; therefore, they are in a position to better understand the issues faced by those who are most affected and to find smart solutions.

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

Culture. A laboratory method used to detect and confirm Mycobacterium tuberculosis by growing the organism in solid or liquid media. Culture is considered the reference (gold standard) for TB diagnosis because of its high sensitivity and specificity. It can detect TB even when the bacterial load is low and allows for subsequent drug-

susceptibility testing.

Drug-resistant tuberculosis (DR-TB). Tuberculosis caused by Mycobacterium tuberculosis strains that are resistant to one or more anti-TB drugs. Drug resistance occurs when TB bacteria survive and multiply despite the use of standard medicines. WHO classifies drug-resistant TB into different categories:

- **Mono-resistant TB**: resistance to one first-line anti-TB drug only.
- **Poly-resistant TB**: resistance to more than one first-line drug (but not both isoniazid and rifampicin together).
- **Rifampicin-resistant TB (RR-TB):** resistance to rifampicin detected with or without resistance to other drugs
- Multidrug-resistant TB (MDR-TB): resistance to at least both isoniazid and rifampicin, the two most powerful first-line drugs
- **Extensive drug-resistant TB (XDR-TB):** MDR-TB with additional resistance to any fluoroquinolone and to at least one of the Group A drugs (bedaquiline or linezolid)

Extrapulmonary TB. TB diseases in any part of the body other than the lungs (for example the kidney, spine, brain, lymph nodes)

Gender sensitive. Policies and programs that recognize that both women and men are actors within a society, that they are constrained in different and often unequal ways, and that consequently they may have divergent and needs, interests, and priorities.

Intermediary Organization. An agency, often non-governmental in nature working on behalf of the NTLP, to engage, monitor and support the scale-up of quality TB services in the private sector.

Latent TB infection. A condition in which TB bacteria are alive but inactive in the body. People with latent TB infection have no symptoms; they do not feel sick, cannot spread TB bacteria to others, and usually test positive for infection, positive to a tuberculin skin test or a special test called IGRA test.

Nutritional support. Ensuring adequate nutrition status and food security of the individual or household and includes assessment of dietary intake.

Patient-centered approach to TB care. A patient-centered approach considers the needs, perspectives, and individual experiences of people affected by TB, while respecting their rights to be informed and receive the best quality care based on individual needs. It requires the establishment of mutual trust and partnership in the patient–care provider relationship and creates opportunities for people to provide input into and participate in the planning and management of their own care. A patient-centred approach improves treatment outcomes, while respecting human dignity.

Person lost to follow-up. A TB patient who did not start treatment or whose treatment was interrupted for two consecutive months or more.

Preventive Therapy. Medicines that prevent TB infection from progressing to active TB disease.

Smear Microscopy. A laboratory test used to examine for the presence of TB bacteria in sputum using a microscope.

Stigma. Stigma refers to negative attitudes, beliefs, and behaviors directed towards people affected by TB. It arises when individuals are discredited, excluded, or discriminated against because of their real or perceived TB status. TB stigma can occur at multiple levels individual, family, community, workplace, and health-care settings and may lead to delays in care-seeking, reduced treatment adherence, social isolation, and violation of human rights.

TB prevention and Care. TB prevention and care refer to a comprehensive set of interventions aimed at reducing the risk of Mycobacterium tuberculosis infection, preventing progression from infection to disease, and ensuring timely diagnosis, treatment, and support for people with TB. It encompasses:

- **Prevention**: early detection and treatment of latent TB infection, vaccination (e.g., BCG), infection prevention and control measures, and social protection to reduce vulnerability.
- **Care:** prompt diagnosis of all forms of TB (drug-susceptible and drug-resistant), access to appropriate treatment regimens, adherence support, management of comorbidities (such as HIV and diabetes), and psychosocial and social support to enable treatment completion and quality of life.

FOREWORD

The Uganda National Tuberculosis and Leprosy Strategic Plan (NSP) 2025/26–2029/30 builds on the achievements of the previous plan (2020/21–2024/25), which registered notable progress in TB case notifications, treatment success, preventive treatment coverage, and laboratory capacity. However, significant gaps remain. About 20,000 TB cases go undiagnosed annually, with children and other vulnerable groups disproportionately affected. Drug-resistant TB outcomes remain suboptimal, and leprosy continues to cause disability and stigma, particularly in high-burden districts. These challenges underscore the urgent need for innovative, people-centered and multisectoral approaches.

This NSP sets bold targets aligned with the World Health Organization's End TB Strategy, the 2023 UN High-Level Meeting Political Declaration on TB, Global Leprosy (Hansen's disease) Strategy 2021 – 2030, Uganda's Fourth National Development Plan (NDP IV), and the Ministry of Health Strategic Plan (2025/26–2029/30). By 2029/30, Uganda aims to reduce TB incidence by 6.5% (from 198 to 185 per 100,000 population), cut child leprosy notifications from 17% to below 3%, achieve TB treatment coverage above 95%, and increase treatment success for all forms of TB to at least 95%.

The plan is organized around the three pillars of the WHO End TB Strategy and adopts the WHO People-Centered Framework for TB Programme Planning: Pillar 1: Integrated, patient-centered TB care and prevention; Pillar 2: Bold policies and supportive systems and Pillar 3: Intensified research and innovation

The development process was participatory and evidence-driven, involving government ministries, departments and agencies, local governments, civil society organizations, development partners, academia, and affected communities. It prioritizes high-impact interventions, including scaling up access to rapid molecular diagnostics, expanding preventive treatment, optimizing shorter TB treatment regimens, strengthening community-based services, integrating digital health systems, and linking patients to social protection.

Ending TB and leprosy requires sustained political commitment, stronger domestic financing, efficient procurement and supply chains, and robust multisectoral accountability. Communities, survivors, and civil society remain at the heart of this response. Together, through a whole-of-government and whole-of-society approach, Uganda can accelerate progress toward ending TB and eliminating leprosy as public health threats by 2030.

I invite all stakeholders to join us in this collective effort. For God and my country.

Dr. Olaro Charles
Director General of Health Services
Ministry of Health

ACKNOWLEDGEMENT

The development of the National Tuberculosis and Leprosy Strategic Plan (2025/26–2029/30) represents a major milestone in Uganda's public health response. This achievement has been made possible through the collective effort and dedication of many stakeholders at international, national, subnational, and community levels.

On behalf of the Ministry of Health, I extend my sincere appreciation to all stakeholders who contributed their expertise, time, and experience to this process. Special thanks go to the World Health Organization (WHO) at the global, regional, and country levels for their consistent technical guidance throughout the End-Term Review and strategic planning process. The Ministry also acknowledges the CDC Foundation, METS, and KNCV Tuberculosis Foundation for supporting consultancy services during the development of the NSP. We are equally grateful to CDC-Uganda, Global Fund, Cepheid, TASO, WALIMU, USTP, KOICA and the Stop TB Partnership/ UNOPS for their invaluable support throughout the planning and development of the NSP. Finally, the Ministry appreciates the leadership of the National TB and Leprosy Programme (NTLP), whose stewardship ensured that evidence, consultations, and national priorities were effectively translated into this strategic plan.

We acknowledge the valuable contributions of government ministries, departments and agencies, local governments, development partners, civil society organizations, academia, health workers, survivor networks, and community champions. Their input has ensured that this plan is scientifically sound, people-centered, context-specific and aligned with Uganda's broader development and health sector goals.

This Strategic Plan sets forth our commitment towards ending TB and achieving zero Leprosy transmission by 2030 through collaboration, sustainable financing, accountability, and a whole-of-society approach.

To all partners, stakeholders, and communities affected by TB and leprosy thank you for your continued commitment and collaboration. Together, we will accelerate progress towards a Uganda free of tuberculosis and leprosy.

Dr. Diana Atwine
Permanent Secretary
Ministry of Health

EXECUTIVE SUMMARY

Uganda continues to face a high burden of tuberculosis (TB) and leprosy, with an estimated 96,000 new TB cases annually and significant levels of TB/HIV co-infection. While the implementation of the previous National TB and Leprosy Strategic Plan (NSP) 2020/21–2024/25 achieved notable progress—including increased TB notifications, improved treatment success rates, expanded preventive therapy coverage, and strengthened laboratory capacity critical gaps persist. Approximately 20,000 TB cases remain undiagnosed each year, with children and other vulnerable groups disproportionately affected. Detection and treatment outcomes for drug-resistant TB (DR-TB) remain suboptimal, and leprosy continues to cause disability and stigma, particularly in high-burden regions.

The NSP 2025/26–2029/30 builds on these achievements while addressing systemic and programmatic challenges highlighted in the End-Term Review, Epidemiological Review, TB Diagnostic Network Assessment, and other evaluations. Persistent bottlenecks include limited access to diagnostics in rural areas, weak integration of digital health systems, insufficient private-sector engagement, underfunded community interventions, and weak linkages to social protection. Addressing these gaps requires bold, targeted, and people-centered approaches.

The new NSP is fully aligned with Uganda's Fourth National Development Plan (NDP IV), the Ministry of Health Strategic Plan (2025/26–2029/30), and global commitments including the Sustainable Development Goals (SDGs), the UN High-Level Meeting Political Declaration on TB, and the WHO End TB Strategy. It is structured around the three pillars of the WHO End TB strategy and applies the WHO People-Centered Framework for TB Programme Planning to prioritize investments and optimize resource allocation.

By 2029/30, Uganda aims to reduce TB incidence by 6.5% (from 198 to 185 per 100,000 population), cut child leprosy notifications from 17% to below 3%, achieve TB treatment coverage from 90% to above 95%, and increase treatment success rate for all forms of TB from 91.3% to at least 95%.

The strategic objectives include:

1) To increase TB and leprosy awareness and increase care-seeking from health facilities from 61% to 90% by 2029/30.
2) To increase TB preventive treatment coverage among eligible people to 95% by 2029/30.
3) To increase TB treatment coverage from 90% to 95% by 2029/30.
4) To increase TB treatment success from 91.3% to 95% by 2029/30.

5) To reduce leprosy notifications in children from 14% to 3% by 2029/30.

6) To build effective and efficient systems that ensure quality, equitable access, and timely TB and leprosy services.

The NSP also prioritizes operational and implementation research, investments in digital health, optimized supply chains, and robust monitoring and evaluation systems to track progress and inform adaptive programming.

Finally, the NSP emphasizes a whole-of-government and whole-of-society approach, mobilizing communities, civil society, the private sector, and development partners. Sustained domestic financing, efficient procurement, and strengthened multisectoral accountability will be essential. By investing strategically, scaling innovations, and ensuring equitable access, Uganda is positioned to accelerate progress toward ending TB and leprosy as public health threats by 2030.

SECTION ONE.
INTRODUCTION

Uganda remains among the 30 high TB and TB/HIV burden countries globally. Current estimates indicate an incidence of about 198 cases per 100,000 population, translating to about 96,000 people falling ill with TB annually, and a substantial proportion (37%) co-infected with HIV. While the burden of TB remains high, programme performance has improved markedly over the last strategic plan period, creating a solid platform for accelerated impact in the next five years. The 2020/21–2024/25 National TB and Leprosy Strategic Plan catalyzed important gains. Case notifications rose from 152 to 192 per 100,000; treatment success improved from 72% to 92.3%; and treatment success among people with TB/HIV reached nearly 90%. Bacteriological confirmation among pulmonary TB cases increased from 53% to 67%, and the proportion of patients diagnosed using WHO-recommended rapid diagnostics reached 82%, coverage of contact investigation expanded substantially, and TB Preventive Treatment (TPT) coverage increased for children, adult contacts and people living with HIV. These achievements demonstrate the value of investments in laboratory capacity, surveillance and integrated models of care.

At the same time, persistent system bottlenecks constrain impact. For instance, the 2024 TB Diagnostic Network Assessment (DNA) identified gaps in supplies, equipment maintenance, digital X-ray access, and specimen referral timelines, all of which are crucial in shortening time to diagnosis and treatment and sustaining quality.

The TB Epidemiological Review noted a 2% decline in incidence in recent years alongside meaningful reductions of 54% in mortality and improvements across the care cascade, though these trends remain unvalidated given that the latest TB prevalence survey was conducted over 10 years ago. The review also highlights persistent gaps in pediatric and DR-TB case detection, private-sector engagement, and sub-national variability in performance. These findings underscore the need to deepen community-centered case

finding, increased use of rapid diagnostics for DST, maintain high-quality integrated TB/HIV services, and scale up preventive treatment and infection prevention and control.

Leprosy remains a public health concern in several districts. Implementing the Zero Leprosy Roadmap has strengthened contact tracing, preventive therapy, and treatment outcomes. A sustained effort is required to reduce disability and stigma through earlier diagnosis, continuous availability of Multi Drug Therapy (MDT), and decentralized rehabilitation services.

Against this backdrop, the National Tuberculosis and Leprosy Strategic Plan (NSP) 2025/26–2029/30 was developed through a participatory, people-centered, evidence-informed process. It aligns with the Ministry of Health Strategic Plan 2025/26–2029/30, the fourth National Development Plan, the WHO End TB Strategy, and Global Leprosy (Hansen's disease) Strategy 2021 – 2030.

The success of this NSP will depend on sustained domestic commitment and partner support, efficient procurement and supply chain management, empowered communities people with diseases and private providers; and rapid adoption of innovations. This strategic plan is therefore a call to action grounded in equity, resilience, and accountability for progress towards ending TB and eliminating leprosy by 2030.

Alignment of the NSP with Global and National targets

Building on the achievements and lessons of the 2020/21 – 2024/25 NSP, the new strategic plan sets targets that are aligned with global milestones. (Figure 1)

The NSP also contributes directly to Objective 4 of the NDP IV — enhancing the productivity and social well-being of the population and operationalizes priorities within the Human Capital Development Programme and the Health Sector Strategic Plan. (i). Reduce the burden of communicable diseases and related mortality and morbidity, (ii) Address health inequalities by expanding access to quality diagnostics, treatment, and preventive services nationwide, (iii). Build resilient, inclusive health systems with effective governance, financing, supply chains, and information systems, and (iv). Strengthen financial protection to reduce catastrophic costs for people affected by TB and leprosy. The plan further advances Universal Health Coverage (UHC) through a patient-centered, data-driven, and equity-focused approach.

VISION A Uganda free of Tuberculosis and Leprosy

GOAL To reduce the incidence of TB by 6.5% from 198/100,000 population in 2024/25 to 185/100,000, and the proportion of Leprosy notification that are children from 17% to less than 3% by 2029/30.

SO1. To increase TB & Leprosy awareness and increase care seeking from health facilities from 61% to 90% by 2029/30	SO2. To increase TB preventive treatment coverage among eligible people to 95% by 2029/30	SO3. To increase TB treatment coverage from 90% in 2023/24 to 95% by 2029/30	SO4. To increase TB treatment success from 91.3% in 2024/25 to 95% by 2029/30	SO5. To reduce the proportion of Leprosy notification that are children from 14% to 3% by 2029/30	SO6. To build effec and efficient systems that ens quality, equitable and timely TB an Leprosy services
					
SO1.1 People with knowledge about TB symptoms increased from 46% to 90% **SO1.2** People with TB symptoms seeking appropriate care increased from 61% to 95% **SO1.3** Stigma and discrimination among TB patients reduced from 53.7% to 10%	**SO2.1** TB contact tracing increased from 59.4% to 95% **SO2.2** TB contact screening coverage increased from 91% to 95% **SO2.3** TB preventive treatment coverage increased among eligible individuals to 95% **SO2.4** TB notification rate among healthcare workers reduced from 316/100,000 to 250/100,000 **SO2.5** The Proportion of TB patients screened for comorbidities increased to 80% **SO2.6** The proportion of chronic care clients & substance users screened for TB increased to 80%	**SO3.1** TB treatment coverage increased from 90% to 95% **SO3.2** Notified new and relapse TB cases with bacteriological confirmation increased from 66% to 90% **SO3.3** Notified new and relapse TB patients tested using WHO recommended TB rapid diagnostic tests (WRD) increased from 82% to 90% **SO3.4** DST coverage among bacteriologically Confirmed cases increased from 72% to 90% **SO3.5** MDR-TB treatment coverage increased from 58% to 80% **SO3.6** Child treatment coverage increased from 62% to 95%	**SO4.1** TB patients diagnosed and not started on treatment reduced from 2.8% to <1% **SO4.2** TSR of Notified Drug-Susceptible TB patients increased from 91.3 % to 95% SO4.3 TSR for DR-TB increased from 88% to >92% **SO4.4** TSR for TB/HIV increased from 89% to 95% **SO4.5** TB related mortality reduced from 4.5% to <3%	**SO5.1** The number of districts reporting zero new autochthonous leprosy patients from 116 (79%) to 132 (90%) **SO5.2** The number of new and relapse leprosy patients detected annually reduced from 273 to 30 **SO5.3** The proportion of child leprosy patients reduced from 14% to 3% **SO5.4** The proportion Leprosy treatment completion increased from 91% to 95% **SO5.5** The new Leprosy cases with Grade 2 disability reduced from 18% to 5% **SO5.6** Leprosy patients in need of protective wear who are provided with footwear increased from 72% to 90%	**SO6.1** Improved Coordination of th TB and Leprosy response **SO6.2.** Improved Capacity for servi delivery at nationa and subnational levels **SO6.3** Improved availability and access to Resourc for Delivery of qua TB and Leprosy services

Figure 1. Global targets and Uganda status 2024/25 for Elimination of TB and Leprosy

1.0 BACKGROUND AND CONTEXT

1.1 Geography and Demographics

Uganda's population is estimated at 46 million, growing at an annual rate of 2.9%, with nearly 48% of the population under the age of 15. Approximately 75-80% of the population lives in rural areas, underscoring the country's predominantly agrarian economy. Life expectancy stands at 70.1 years for females and 66.9 years for males. Of the 10,698,913 million households, 33.4% are headed by women. These demographic trends have significant implications for the planning and delivery of health, education, and social protection services. Uganda's expanding urban centers, climate shifts, and periodic disease outbreaks pose risks to TB service delivery and health system resilience.

1.2 Socio-economics and economic development agenda

The country has continued to register steady economic growth, with a GDP of 5.3% in FY2022/23 driven by sectors such as construction, manufacturing, ICT, and financial services. Despite these improvements, poverty and inequality remain as critical challenges. Over, 20% of Ugandans live below the poverty line, and 39% remain vulnerable to economic shocks and food insecurity, especially in rural and climate-affected regions.

Access to social services has improved, particularly in health, education, transport, and water and sanitation. The government continues to offer free essential services at the point of care to reduce barriers to access. However, disparities remain due to financial, geographic and sociocultural barriers, particularly for women and marginalized groups or those in hard-to-reach areas. Men are disproportionately affected by TB yet underrepresented across the TB care cascade due to systemic and behavioural barriers. Although TB is four times more prevalent among men, they are less likely than women to seek care when symptomatic (53.9% vs 67%) and are underrepresented among those presumed to have TB. Men also had a higher prevalence-to-notification (P:N) ratio (3.5 compared to 1.4 for women), suggesting that many TB cases among men go undiagnosed and untreated. A rights-based, gender-responsive approach is therefore essential to address these gaps and promote equitable access to health services.

The NDP IV emphasize inclusive growth, equity in service delivery, and empowerment of marginalized groups. In alignment with these priorities, the Ministry of Health has mainstreamed human rights and gender considerations into health sector planning, capacity building and program implementation, in collaboration with Civil Society Organizations (CSO) and development partners. These efforts reflect

Uganda's broader commitment to achieving the Sustainable Development Goals (SDGs), particularly SDG1 (No poverty), SDG3 (Good Health and Well-being), and SDG5 (Gender Equality).

1.3 The National health system

Uganda's national health system is a mixed public-private model, each contributing approximately 50% of health service delivery. The public sector, led by the Ministry of Health (MoH), includes health services provided under other ministries such as Defense, Education, Internal Affairs (Police and Prisons), and Local Government. Services are provided through networks of 6,404 facilities 48% public and 37% private-for-profit, and 15% private-for-profit. The health system is structured into National Referral Hospitals (NRHs), Regional Referral Hospitals, General Hospitals, Health Center levels II-IV, and Village health Teams (VHTs) also referred to as HC Is. Figure 2.

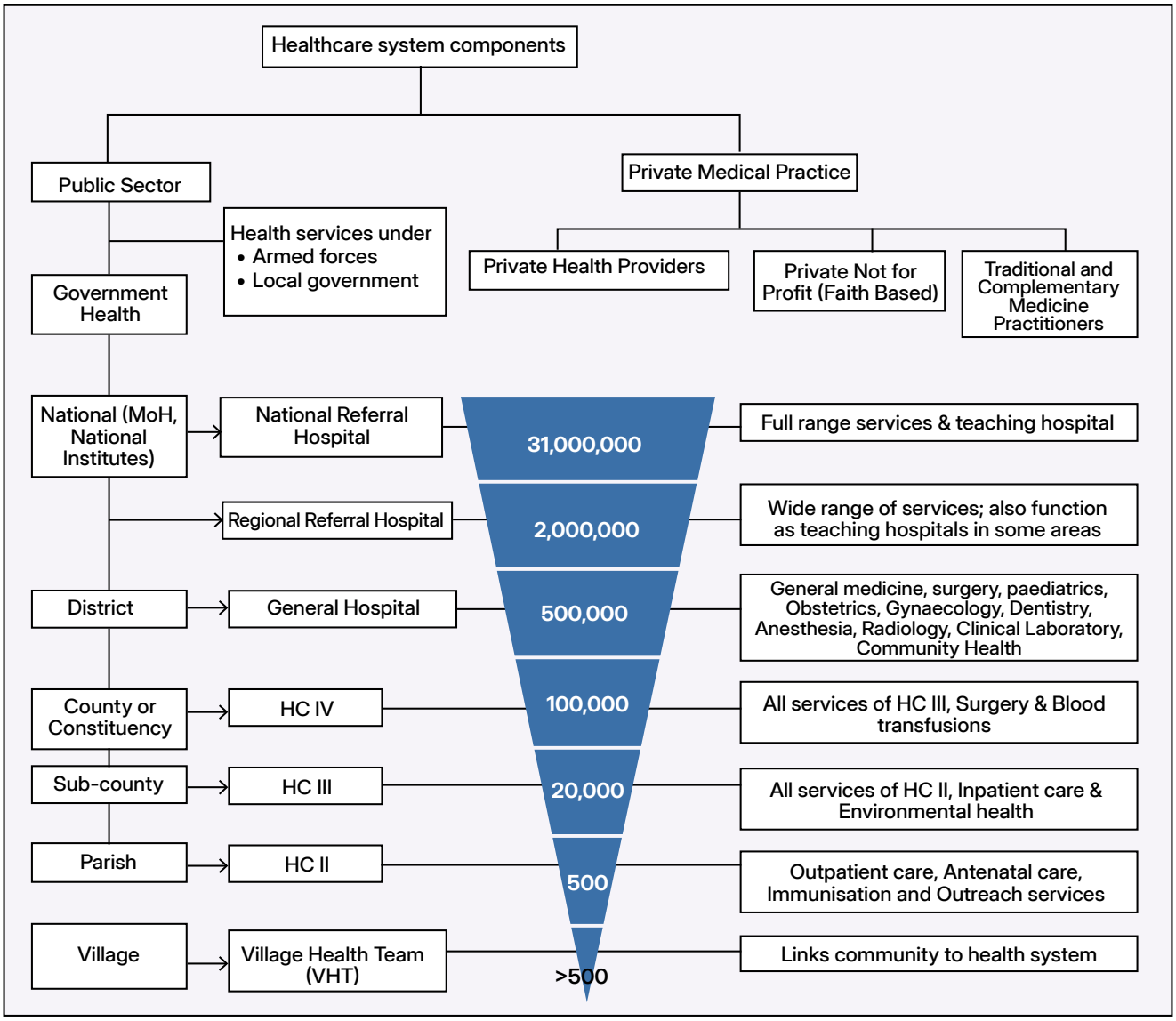


Figure 2. The Uganda Health system

Though 75% of the population lives within5 kms of a health facility, high out-of-pocket costs (about 40% of health spending) limit access, especially for rural and low-income communities.

Efforts are ongoing to strengthen the health system through increased investments, human resources, digitization and public-private partnerships.

Key message

About 75% of the Ugandan population lives within 5 km of a health facility but access to health services is still limited by negative cultural beliefs and practices and financial hardships suffered by most patients involving out-of-pocket payments as high as 40%

Ministry of Health, 2015; The National Planning Authority, 2019

1.3.1 Health leadership and governance

Health leadership and governance in Uganda operate within a decentralized system. The MoH provides overall policy and strategic oversight, while local governments manage service delivery, through districts and health sub-districts (HSDs). Health centers and general hospitals provide promotive, preventive, curative, and rehabilitative services, coordinated by health facility in-charges and local health management teams.

The NTLP, under the Communicable Disease Prevention and Control within the MoH, leads the TB and Leprosy response efforts aligned with national priorities and global strategies. The NTLP mobilizes resources and ensures access to quality diagnosis, treatment, prevention, and care services for TB and Leprosy across the country.

Core functions of the NTLP include

i) Mobilize resources from domestic and international partners to ensure sustainable financing for TB and Leprosy Prevention, care and control

ii) Establishing and maintaining a nationwide network of TB and Leprosy diagnostic and treatment services

iii) Coordinating the implementation of TB and Leprosy prevention and care programs in collaboration with stakeholders across government, civil society, and international partners

iv) Providing technical oversight for the prevention and management of TB and Leprosy related complications and disabilities and

v) Facilitating the integration of multisectoral needs of persons affected by TB and leprosy, such as mental health, nutritional support, cash assistance and other social protection services, particularly for vulnerable populations.

Management of TB and Leprosy services at regional, district and facility level

TB and Leprosy services are managed through a decentralized structure. Regional TB and Leprosy Supervisors (RTLS) provide technical oversight, coordination and technical support to districts, while District Health Officers (DHOs) oversee implementation at the district level through District TB and Leprosy Supervisors (DTLSs). Health Sub-Districts coordinate service delivery under Medical Officer or designated senior health personnel, with focal persons assigned to TB and leprosy. Services are integrated into all levels of care from hospitals and health centers to community outreach. Nurses and clinical officers manage services in public facilities, while private sector care includes doctors. Laboratory staff and radiographers are vital for TB diagnosis.

Community Health Workers, including Community Health Extension Workers (CHEWs), Village Health Teams (VHTs), support case finding, referrals, and treatment follow-up. However, community support for leprosy remains limited and needs strengthening. Persistent barriers to TB and Leprosy treatment include poor transportation infrastructure, which delays access to diagnosis and care; gender disparities that contribute to delayed health-seeking behavior among women; and cultural and economic challenges that limit TB services, particularly among marginalized populations. Addressing these systemic issues will be key to ensuring equitable access and improving treatment outcomes.

1.3.2 Health workforce

Despite progress in expanding the health workforce, absorption and retention remain major challenges. This highlights the need for integrated service delivery to optimize the limited workforce.

1.3.3 Health Financing

Health financing in the country operates as a mixed system comprising government allocations, contributions from development partners, private sector involvement, social health insurance schemes, individuals out-of-pocket (OOP) expenditures, and limited community-based health insurance arrangements. Public health facilities primarily depend on government grants, concessional loans, and development partner support, while private not-for-profit (PNFP) facilities also benefit significantly from government subsidies and human resource secondments.

Despite this, health sector funding remains insufficient—only 6.8% of the national budget was allocated to health (FY2023/24), far below the 15% Abuja Declaration

target. OOP payments exceed 38%, leading to financial hardship for households. with over 4% fall into poverty annually due to health costs, and more than 50% of TB-affected households face catastrophic expenses.

The TB and Leprosy program is underfunded, with only 5% domestic financing, over 55% donor-funded, and over 30% needs unmet. To strengthen health financing, the Government of Uganda has initiated reforms, including the development of the National Health Insurance Scheme (NHIS), implementation of program-based budgeting, and exploration of innovative domestic resource mobilization strategies such as earmarked taxes. However, the full implementation of the NHIS remains pending due to regulatory, political, and operational challenges.

Closing the health financing gap will require sustained political commitment, increased domestic investment in health, alignment of partner support with national priorities, and acceleration of health financing reforms that ensure efficiency, equity, and sustainability.

1.3.4 Health information system

The MoH has strengthened the national Health Information system (HIS), with the District Health Information System version 2 (DHIS2) as the primary platform for health data collection including TB. However, DHSI2 data capture on Leprosy remains weak and requires strengthening. Additional data sources like surveys and surveillance reports support planning and service delivery. Investments in digital health infrastructure are increasingly recognized as essential enablers for Uganda's socio-economic development as underscored in NDP IV. Digital tools such as electronic medical records (EMRs), LabXpert, electronic Case Based Surveillance System (eCBSS), electronic Community Health information systems (eCHIS) and logistics management information system (LMIS) are expanding, but challenges remain with data quality, system fragmentation, and limited ICT capacity, especially at subnational levels. The iHRIS system for workforce planning is in place but underutilized.

Strengthening data systems remains a key priority for improved planning, accountability, and service delivery.

Key messages

- Uganda's health information system has been strengthened, with DHIS2 as the main platform, complemented by digital tools (EMRs, eCBSS, eCHIS, LabXpert, logistics systems, iHRIS) and guided by an eHealth Strategy and national technical working group
- Leprosy data capture remains weak within DHIS2 and requires targeted strengthening to ensure comprehensive disease surveillance and reporting
- Challenges such as data quality gaps, system fragmentation, and limited ICT capacity at subnational levels highlight the need for greater investment in digital health systems to improve planning, accountability, and service delivery

Ministry of Health, 2017; 2023

1.3.5 Health Products and technologies

The MoH, through its Department of Pharmaceuticals and Natural Medicines, oversees procurement supply chain management. Public facilities are served by the National Medical Stores (NMS), while PNFP facilities receive supplies via Joint Medical Stores (JMS).

The national procurement of TB medicines

The procurement and supply of TB and Leprosy medicines and diagnostics are financed through a blended mechanism involving the Government of Uganda (GoU), the Global Fund, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

The TB Medicines Web-Based Ordering System (TWOS), integrated into DHIS2, allows facilities to order from NMS. While the LMIS has improved the supply chain, especially at lower levels, gaps remain at higher-level facilities, highlighting the need for a fully integrated e-LMIS for better efficiency and real-time stock tracking.

For Leprosy, the GoU in collaboration with the WHO, ensures the procurement and availability of MDT, which is distributed through NMS. However, challenges remain with timely distribution, quantification, and reporting, which can result in periodic stock imbalances at service delivery points.

1.3.6 Health sector achievement

The health sector has achieved notable progress in improving health outcomes, like a decline in maternal, infant, and under-five mortality; an increase in institutional deliveries; and an improvement in coverage of essential health interventions. This has been supported by enhanced availability of essential medicines and supplies, significant infrastructure expansion, and strengthening of referral systems. The sector has also strengthened disease surveillance and epidemic preparedness through the Emergency Operational Center (EOC) and improved integration of digital health systems.

Persistent challenges hinder optimal sector performance. These include procurement delays under the Uganda Intergovernmental Fiscal Transfers Programme (UGIFT), weak communication and coordination between District Local Governments and the Ministry of Health, misalignment of plans and budgets, and stock-outs of medicines caused by rising service demand against limited budget ceilings.

To sustain progress, Uganda needs to consolidate these gains, including through increasing domestic financing for essential services to achieve Universal Health Coverage (UHC) and health-related Sustainable Development Goals (SDGs).

1.3.7 Universal health coverage and social protection

Uganda's health sector aims to accelerate progress towards UHC, ensuring access to essential health services without financial hardship. However, healthcare remains unaffordable for many, pushing households—especially the poor and vulnerable—into poverty. Service delivery is uneven, with significant disparities between urban and rural areas. The country has developed a UHC Roadmap to guide the implementation of the National Health Insurance Scheme (NHIS), which is yet to be enacted. Social protection coverage remains weak, with less than 4% of TB-affected individuals receiving limited support, largely due to the absence of mechanisms to assess and address social welfare needs. While a nationally representative survey on catastrophic costs was conducted in 2017, no recent nationally representative data are available, creating a critical gap that hinders progress toward targets set in the National Strategic Plan. Social determinants such as undernutrition, poverty, and inadequate housing significantly contribute to TB and Leprosy burdens. Key priorities for Uganda include operationalizing the NHIS, expanding social protection for TB-affected households, strengthening nutrition support, enhancing multisectoral collaboration, and establishing robust data systems to monitor catastrophic costs and social protection coverage.

2.0 SECTION TWO.
SITUATION ANALYSIS AND PROGRESS UNDER NSP 2020/21-2024/25

During the implementation of the NSP 2020/21–2024/25, Uganda made significant progress in the response towards TB and Leprosy. The program narrowed the gap between estimated and detected TB cases, with case notifications increasing from 152 to 192 per 100,000 population, achieving over 100% of the target. Diagnostic capacity expanded substantially, with 82% of TB patients diagnosed using WHO-recommended rapid diagnostic tools, while bacteriological confirmation among pulmonary TB cases improved from 53% to 67%. Coverage of contact investigation rose dramatically from 33% to 90%, and TB Preventive Treatment (TPT) expanded to reach 79% of eligible children under 5, 80% of eligible contacts over 5 years, and 94% of eligible people living with HIV.

Treatment outcomes also improved, with the overall TB treatment success rate rising from 72% to 92%, and DR-TB treatment success increasing from 64% to 88%. These achievements demonstrate the value of investments in diagnostic capacity, surveillance, and integrated models of care.

However, challenges persisted: Uganda met only 80% of its target for DR-TB case detection, childhood TB detection lagged (particularly among younger children), and Grade 2 disability at diagnosis for leprosy patients rose to 24%, reflecting delayed diagnosis and ongoing transmission.

Number of Incident TB Cases Notified

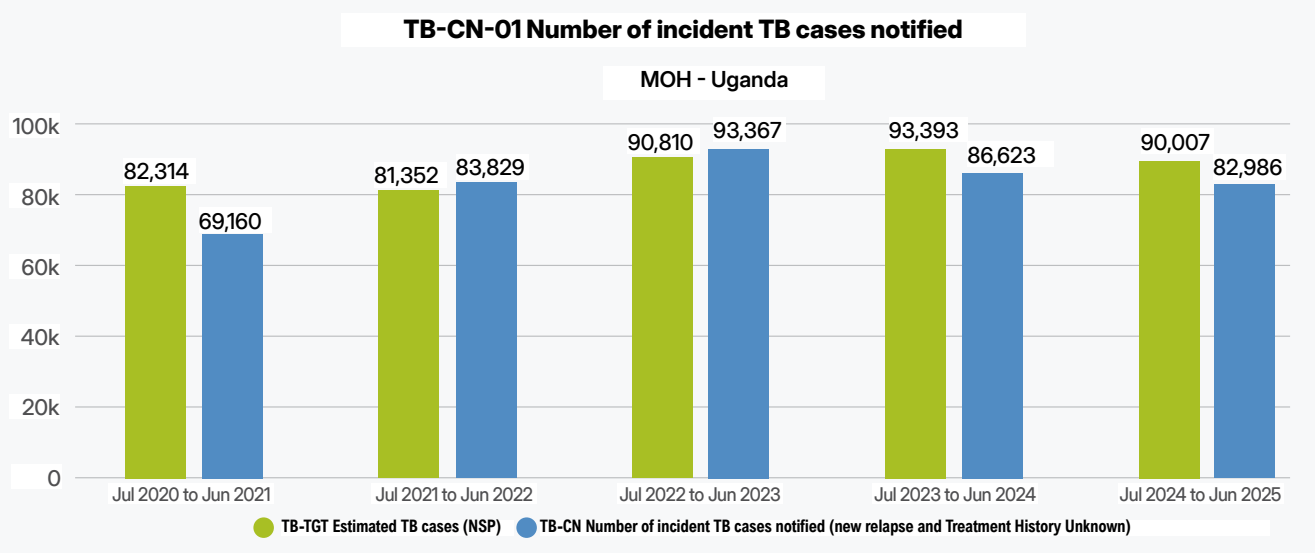


Figure 3. Number of TB Cases Notified

2.1 TB incidence and Case notifications

According to the WHO Global TB Report 2024, an estimated 96,000 people developed TB in 2023, representing an incidence rate of 198 per 100,000 population. Men accounted for approximately 64% of cases, and children constituted 12%. The estimated number of TB-related deaths was 15,000, including deaths among people living with HIV. Despite improved treatment coverage, an estimated 20,000 cases remain undiagnosed annually, with children and people with DRTB disproportionately affected, necessitating more targeted screening and improved linkage to care. Over 85% of TB notifications were from public health facilities, while PNFP and PFP facilities contributed 11% and 2%, respectively. This highlights the need for better private sector engagement.

2.2 TB/HIV

The estimated TB/HIV co-infection rate in 2023 was high at 37%. Anti-Retroviral Therapy (ART) coverage among TB/HIV patients reached 98% by 2023. TPT coverage for PLHIV also improved rising from 21% in 2020 to 89% in 2023, with a 96% completion rate.

2.3 Childhood and adolescent TB

Children aged 0-14 years contributed 13.8% of TB notifications in 2023 (~11,700 cases), marking a modest increase from the 12.5% reported in FY 2018/19. This reflects improved detection through decentralized childhood TB management, expanded diagnostics including the use of stool as an alternative specimen, contact tracing, and integration with maternal and child health services. Clinically

diagnosed TB remains predominant (62%), followed by bacteriologically confirmed TB (28%) and extra-pulmonary TB (10%). Uganda has laid a strong foundation for a comprehensive child and adolescent TB response through scale-up of child-friendly formulations, integration of TB screening into child health programs like school health, immunization, nutrition programs, and adolescent friendly services; adoption of the shorter 4 - months treatment regimen for non-severe TB; and contact tracing strategies that prioritize children under 5 years. Despite these gains, key challenges persist, including limited capacity among health workers to effectively screen, diagnose, and collect appropriate samples from children. Preventive interventions also remain inadequate TPT coverage for eligible child contacts remains suboptimal and contact tracing efforts are inconsistent. Addressing these gaps will require strengthening pediatric TB diagnostic capacity, expanding TPT coverage, enhancing household contact tracing, and integrating pediatric TB services more effectively into routine child health programs.

2.4 Drug susceptible TB: Treatment coverage and treatment outcomes

Treatment coverage for drug-susceptible tuberculosis (DS-TB) improved significantly but fell short of 90% national and global targets. In 2024, 82% of estimated incident TB cases were diagnosed and started on treatment, an increase from 65% in 2022. The TSR for the 2022 cohort rose to 92.3%, surpassing the national target of 85%. However, regional disparities persist. Arua maintained a strong performance at 84%, while Moroto remained low at 49%. Urban areas such as Kampala, Gulu, and Masaka continued to show suboptimal outcomes. Among TB/HIV co-infected patients, TSR was 89.8%, with ongoing challenges from loss to follow-up (11%) and mortality (7%). Pediatric TSR improved to 83%. These findings underscore the continued need to strengthen adherence support and community-based directly observed therapy, decentralize TB services further to reach underserved populations, scale-up Advocacy Communication and Social Mobilization (ACSM) to improve health seeking behaviour and reduce loss to follow-up, and enhance surveillance, monitoring, and feedback mechanisms to ensure that every TB patient successfully completes treatment.

2.5 Drug resistant TB

In 2024, Uganda had an estimated 1,500 RR/MDR-TB cases, of which 66.5% were detected, an improvement from 43%in 2023, though still below the NTLP target. The treatment outcomes for DR-TB have improved markedly. The treatment success rate (TSR) for the 2021 DR-TB cohort reached 88%, surpassing the earlier 71.4% reported in 2021. Mortality dropped to 7.9%, while loss to follow-up declined to 3.5%, reflecting progress in patient support and adherence systems.

The country currently operates 20 MDR-TB treatment centers, with additional

decentralization through district hospitals and community-based models of care. However, screening for rifampicin resistance remains suboptimal, with only 77% of presumptive TB patients accessing GeneXpert services, and 74% of bacteriologically confirmed TB patients receiving DST for rifampicin resistance. Delayed turnaround times for results, stock-outs of cartridges, and limited access to second-line DST continue to undermine early detection.

Persistent programmatic challenges include gaps in timely sample referral and reporting due to weak transport and connectivity systems, underutilization of newer diagnostics platforms such as Xpert MTB/XDR, high patient costs and stigma, which hinder health-seeking and retention in care. To consolidate gains and accelerate progress, this NSP prioritizes Universal access to molecular WHO-recommended diagnostics (mWRDs) as first-line test, expanding beyond the current 20 MDR-TB treatment centers, expansion of shorter, all-oral DR-TB regimes alongside robust pharmacovigilance, strengthened specimen transport and connectivity systems to reduce turnaround times, enhance ACSM interventions to reduce stigma, improve community awareness, and support adherence, and continuous capacity building for health workers at decentralized DR-TB care sites.

2.6 Progress with high-risk populations

TB prevention and care efforts have prioritized people living with HIV (PLHIV), household contacts of PTB patients, and people in prisons. Recent data show that TB prevalence in prisons remains alarmingly high – 1,904 per 100,000, nearly 8 times the national average, with 48% TB infection prevalence among inmates. While entry screening coverage improved to 72%, gaps remain as only 13 of 57 DTUs are equipped with GeneXpert, and courier access for timely sample transport is limited. Scaling up mobile diagnostic innovations (e.g. digital chest X-ray vans, CAD, GeneXpert) alongside environmental measures (UV light, negative pressure fans) and strengthening prison health services and social protection remain urgent priorities.

Other underserved high-risk groups include men, adolescents, health care workers, people with diabetes, those affected by undernutrition, tobacco users, refugees, migrants, miners, pastoralists, and older adults (65+). Urban slum dwellers and internally displaced populations continue to face disproportionately high TB risks due to overcrowding, poor ventilation, and limited access to health services. Miners and pastoralists are particularly vulnerable due to occupational exposure and mobility challenges. Furthermore, rural women and girls face persistent gender and economic barriers that restrict access to TB services, despite ongoing empowerment initiatives

This NSP therefore emphasizes systematic identification of high-risk groups and disaggregated surveillance to guide tailored interventions, expansion of TPT coverage to household contacts and at-risk populations (including children, PLHIV),

strengthening ACSM to address stigma, build demand for services, and foster community engagement among vulnerable groups, integration of TB services into NCD clinics, maternal and child health services, refugee health services, schools, and workplaces to improve reach and continuity of care and leveraging mobile diagnostics and digital health tools to improve access in hard-to-reach and high-risk settings.

2.7 Leprosy

Leprosy remains endemic in Uganda, though with a relatively low burden compared to TB. In 2024, 275 new cases were reported, equivalent to 6 per 1,000,000 population. Cases remain concentrated in the West Nile Region, which continues to report the highest incidence ranging from 56 to 280 per 1,000,000, while 49% of districts (72/146) recorded at least one new case between 2020 and 2024. The demographic and clinical profile of cases underscores continued transmission and late detection, 17% of new cases occurred in children, indicating ongoing transmission, 86% were multibacillary, carrying a higher risk of spread, Grade 2 Disability (G2D) at diagnosis stood at 24% in 2024, an increase from earlier years and well above the elimination target (<5%), highlighting late diagnosis.

Treatment completion has improved but remains below target. In 2022, the treatment completion rate (TCR) reached 78%, rising to 91% by 2024 following intensified programmatic efforts, though still fragile due to resource constraints. Persistent challenges include low community and health worker awareness, stigma, weak integration of leprosy into district health services, and poor data capture in DHIS2.

In response, the country has taken important steps that include assignment of a national focal person for leprosy under NTLP, integration of leprosy into DHIS2 and district health services to strengthen surveillance, implementation of the Zero Leprosy Roadmap (2022–2030), which has accelerated progress in contact tracing (67%), preventive therapy (55%), and TCR (91%) and ongoing efforts to deploy new diagnostics, expand community engagement and ACSM, and address stigma as part of the national strategy.

The country's goal remains aligned with the 2030 global target of zero leprosy, but this will require sustained funding, early detection, stronger community engagement, and integration of social protection measures for affected households.

2.8. Strengthening systems for TB and Leprosy control

Uganda has made notable progress in strengthening foundational systems for TB and leprosy control during the implementation of the previous National Strategic Plan (2020/21–2024/25). This progress was fueled by increased political commitment, improved resource mobilization, and strong stakeholder collaboration. Key achievements included prioritizing TB in national health plans, expanding access

to diagnostics and treatment, recruiting additional technical staff, and training healthcare workers. Partnerships with civil society supported case detection and adherence, while M&E systems were improved through recruitment of dedicated officers, integration of routine data into DHIS2, and deployment of electronic DR-TB surveillance. Regular performance reviews and data quality assessments have been institutionalized, with digital tools being introduced to enhance accountability and decision-making.

2.8.1 Monitoring and evaluation for TB and Leprosy Programming

The NTLP has made substantial progress in strengthening its M&E system through recruitment of M&E personnel, enhancement of data systems, and capacity-building. The program leverages both DHIS2 and eCBSS, which now cover 100% of DR-TB and over 80% of DS-TB cases. Quarterly data reviews, DQAs, and partner collaboration have contributed to improved data quality and program oversight. Additionally, extensive evidence has been generated through program reviews, surveys, and operational studies to inform the 2025/26 – 2029/30 NSP. However, key challenges persist. Multiple unlinked digital systems at community and facility levels hinder integration; laboratory and case management data remain disconnected due to absence of unique identifiers; and the community M&E system is weak, limiting effective monitoring of community interventions. Additionally, underreporting remains unquantified due to absence of inventory studies, and the vital registration system covers only about 40% of deaths. The NTLP should transition toward a unified digital M&E platform, integrating laboratory and surveillance data, conducting inventory studies to assess underreporting, and scaling up community-level data systems to support TB and Leprosy service delivery.

2.8.2 The TB diagnostic network

The TB diagnostic network has significantly expanded, with 389 GeneXpert machines deployed across 272 facilities, covering 98% of districts. GeneXpert remains the primary diagnostic tool, supported by a robust sample referral system with over 280 hubs and more than 400 riders ensuring nationwide coverage. Access to WRDs continues to improve, with 70 – 75% of bacteriologically confirmed TB patients receiving drug susceptibility testing (DST) for at least rifampicin resistance (RR-TB). However, DST for isoniazid (INH) resistance among rifampicin susceptible TB cases is not routinely included in the current diagnostic algorithm, representing a critical gap in early detection of pre-MDR cases. Expansion of Xpert MTB/XDR testing is recommended to cover both RR and INH resistance.

Other diagnostics face challenges: LF-LAM testing for PLHIV with advanced disease remains limited, available in only 31% of targeted facilities. Microscopy is still widely available in 1,610 of 1,612 sites, but is now mainly used for follow-up or in areas

without WRDs. Quality assurance systems are in place, but delays in corrective action remain.

NSP priorities include expanding TB molecular diagnosis coverage and integrating INH resistance testing into the diagnostic algorithm, decentralizing second-line DST beyond the National TB Reference Laboratory, strengthening sample transport, tracking, and digital connectivity systems (LabXpert, eCBSS), scaling up the use of alternative specimens (e.g., stool, urine LAM) and mobile digital CXR with CAD support and enhancing external quality assurance (EQA) and biosafety systems. These improvements are essential for timely, accurate, and equitable TB diagnosis, particularly for drug-resistant TB and TB/HIV co-infection, and to accelerate progress toward End TB targets.

The National Sample Referral System (NSRS)

The NSRS plays a vital role in transporting TB samples from lower-level facilities to GeneXpert sites and the NTRL. Despite expanded diagnostic platforms and coordination efforts, challenges persist—limited rider capacity, long turnaround times (2–14 days), and under 60% of samples reaching NTRL within 3 days. Private sector engagement and digital tracking remain weak, and radiology services are underused.

The 2025/26– 2029/30 NSP prioritizes optimizing sample transport, expanding digital tracking, decentralizing diagnostics (e.g., GeneXpert Edge, TrueNat, digital chest X-ray with AI), and engaging private labs. Key actions include scaling rider coverage, piloting drones/CHW delivery, setting national turnaround benchmarks, and linking e-tracking to DHIS2. Strengthened coordination, regional oversight, and integration into national accountability frameworks will support a more efficient, equitable, and digitally enabled NSRS.

2.8.3 The Afro TB Supranational Reference Laboratory - Uganda (SRL-Uganda)

Uganda is the host for the SRL Network to support Integrated Laboratory Systems Strengthening in Africa. As part of the WHO-designated TB Supranational Reference Laboratory Network (SRLN), Uganda's SRL plays a central role in improving the quality, reliability, and performance of integrated laboratory services across the WHO AFRO region. The SRLN comprises 37 specialized laboratories mandated to provide technical assistance, external quality assurance, diagnostic stewardship, capacity building, operational research, and support for the adoption of WHO-endorsed diagnostic technologies. Although the network was historically dominated by laboratories based outside Africa, the continent has seen significant expansion in recent years, with Uganda among the key SRLs providing leadership and support to countries in the region.

Uganda's SRL is instrumental in strengthening regional diagnostic capacity through optimization, innovation, and coordination of integrated laboratory systems. Its contributions include advancing universal access to high-quality diagnostics, supporting the development and adaptation of locally relevant diagnostic solutions, and accelerating the uptake of WHO-endorsed tools and guidelines. These functions reinforce the resilience, efficiency, and sustainability of laboratory systems across the AFRO region.

Uganda's position as host of the SRL provides several strategic advantages. It enhances the country's national diagnostic capabilities and positions Uganda as a continental leader in advanced TB and integrated laboratory diagnostics. It also promotes south-to-south collaboration, increases Uganda's influence in shaping regional diagnostic policies, and ensures faster adoption of innovations within the National TB and Leprosy Programme. In addition, the SRL attracts technical partnerships, investment opportunities, and capacity-building initiatives that further strengthen the national and regional laboratory ecosystem. Collectively, these advantages underscore Uganda's critical role in advancing integrated laboratory systems strengthening across Africa.

2.8.4 Supply chain management

During the implementation of the previous NSP, substantial progress was made including introduction of new anti-TB regimen, including optimized child-friendly pediatric formulations, improved stock management through SPARS in 20 districts, and consistent TB medicine availability above 80%. The introduction of the TB Web-based Ordering and Reporting System (TWOS) improved digital ordering, though gaps remain at lower-level facilities lacking IT infrastructure.

For 2025/26– 2029/30, priorities include nationwide SPARS expansion, full digitization of the LMIS, stronger last-mile delivery, integration of private sector data, and increased domestic financing. These efforts aim to ensure reliable, equitable access to TB and leprosy commodities.

2.8.5 Community engagement

Under the previous NSP period, community health actors including Village Health Teams (VHTs), community health extension workers, expert clients, and TB survivors played a pivotal role in contact tracing, health education, treatment support, sputum collection, and referrals. Their effectiveness was strengthened through training, job aids, integration into differentiated service delivery (DSD) models, and community dialogues. Community-led monitoring (CLM) pilots were initiated in selected districts to improve accountability and responsiveness to patient needs.

Notwithstanding these achievements, challenges remained, including weak coordination with formal health systems, inadequate facilitation and supervision,

persistent stigma, limited IEC and ACSM materials, and weak integration of community-generated data into DHIS2/eCBSS. These issues limited the scale and impact of community interventions.

The new NSP aligns with the National Community Health Strategy (2021/22–2025/26) and focuses on scaling up community-led monitoring (CLM) across all regions, Integrating community data into national health information systems (DHIS2/eCHIS, eCBSS) for real-time feedback, expanding culturally relevant ACSM interventions to reduce stigma, increase demand for TB services, and promote TPT and treatment adherence, strengthening multi-sectoral collaboration with CSOs, CBOs, and faith-based actors to reach underserved and vulnerable populations and institutionalizing a harmonized and adequately financed community TB care model, anchored in the Parish Development Model, to ensure sustainability. These measures are intended to create a resilient, people-centered community health platform that accelerates case finding, improves adherence, and enhances social accountability in the TB and leprosy response.

2.8.6 Expansion of public-private mix for TB control

The public-private mix (PPM) for TB control in Uganda has seen gradual expansion over the NSP 2020/21–2024/25 period. While the private sector remains the first point of care for over 50% of individuals with symptoms, its contribution to TB notifications is only about 20%. The MoH has built capacity of selected private-not-for-profit (PNFP) and private-for-profit (PFP) health facilities in high-burden areas through training of quality improvement mentors and coaches, facility-based capacity building of private health providers on TB and Leprosy, accreditation of high volume PFPs as TB Diagnostic and Treatment Units (DTUs) and also equipped selected PNFP and PFP facilities with TB screening and diagnostic tools. PNFP facilities also continue to benefit from Primary Health Care (PHC) grants and seconded human resources. A PPM technical Working Group was established to enhance coordination and supervision.

Persistent gaps include limited provider capacity, inconsistent commodity supply, and weak reporting. The new NSP will prioritize expanding accreditation, integrating supply chains, strengthening supervision and mentorship, and engaging a broader range of private actors—including pharmacies, workplaces, and informal providers—to improve TB case detection and outcomes nationwide.

2.8.7 Advocacy and multi-sectoral collaboration

Significant progress was made in strengthening advocacy and multi-sectoral collaboration for TB and leprosy control during the previous NSP period. Key achievements included the establishment of the National TB Coordination Committee, formation of the TB Parliamentary Caucus, issuance of the TB Implementation Letter, and the appointment of a National TB Ambassador. Regular World TB Day commemorations, media campaigns, and Uganda's participation in UN High-Level

Meetings on TB elevated political commitment at the highest level. The Uganda Stop TB Partnership coordinated ACSM efforts across more than 60 partners, while engagement with sectors such as education, prisons, and refugee services enabled joint interventions including TB outbreak responses, biannual prison screenings, and a joint refugee health strategy.

The NTLP further strengthened collaboration with ministries (education, defense, internal affairs), IGAD, UNICEF, and civil society organizations, leading to important outcomes such as the October 2024 national TB prevalence survey in prisons and enhanced cross-border TB initiatives. Civil society actors, including TB survivors, have increasingly contributed to advocacy, stigma reduction, and community-led monitoring. These steps reflect Uganda's alignment with the WHO Multisectoral Accountability Framework (MAF-TB) which calls for clear commitments, monitoring, and review mechanisms across government and non-health sectors.

Nonetheless, significant challenges persist. Engagement of non-health sectors remains inconsistent, civil society roles are often underfunded or insufficiently defined, and high-level advocacy tends to fluctuate with political cycles. In addition, coordination and financing for ACSM are inadequate, while accountability mechanisms for multi-sectoral action remain weak.

The new NSP (2025/26–2029/30) prioritizes institutionalizing multi-sectoral accountability through full implementation of the MAF-TB framework, strengthening functionality of the National TB Coordination Committee and TB Caucus, and ensuring a well-financed ACSM strategy that includes social protection advocacy. This approach will expand engagement beyond the health sector to ministries of finance, gender, labor, education, justice, and local government, alongside private sector, faith-based actors, and CSOs. It will also draw on the WHO–ILO 2024 joint guidance on social protection for TB-affected households to advocate for integration of TB-sensitive social protection into Uganda's national systems.

The integration of TB into broader development and social protection agendas, alongside sustained advocacy at community, national, regional, and global levels, is central to advancing a whole-of-society approach. This will strengthen political commitment, secure adequate domestic and partner resources, reduce stigma and discrimination, and accelerate progress toward ending TB and leprosy in line with the End TB Strategy and the SDGs.

2.9 Summary of Performance against targets for key indicators

The TB and Leprosy Strategic Plan 2020/21-2024/25 had four TB objectives, and five (5) Leprosy objectives that aimed to reduce TB incidence by 20% i.e. from 200/100,000 population to 160/100,000 and reduce the incidence of advanced disabilities among new leprosy cases from 8% population to <3% population. Table 1 below summarizes the progress on key indicators.

Table 1. Performance against targets for key indicators for key indicators for the NSP 2020/21 – 2024/25

#	NSP Objective	Baseline (2020)	Target (2024/25)	Actual Achievement (2025)	Status
1	Proportion of people with TB symptoms seeking appropriate care from health facilities	61%	90%	Not directly measured in country profile	Unable to assess
2	TB preventive treatment coverage among eligible people	Not specified	>90%	PLHIV newly enrolled in care: 6.9%	Partially achieved
				Household contacts: 100%	
3	TB treatment coverage	76%	>90%	90% (range: 40–130%)	Target achieved
4	TB treatment success rate	72%	>90%	New/relapse cases: 92.3%	Partially achieved
				Previously treated: 79%	
				TB/HIV co-infection: 88%	
				MDR/RR-TB: 89%	
				XDR-TB: 50%	
5	Leprosy notifications that are children	8%	<3%	Proportion of leprosy patients that are children: 17%	Not achieved
6	Build effective and efficient systems for TB and Leprosy services	Not specified	Not specified	Rapid diagnostics use: 69%	Progress made
				HIV status known: 100%	
				Bacteriologically confirmed:68%	
				Rifampicin susceptibility testing (new cases): 88%	
				Rifampicin susceptibility testing (previously treated): 95%	
				TB/HIV on ART: 97%	

2.10 Strategic Gaps and Challenges in Uganda's TB and Leprosy Response: Priorities for NSP 2025/26–2029/30

Uganda's TB and leprosy response made important strides under the 2020/21–2024/25 NSP, yet significant gaps persist across prevention, diagnosis, treatment, and system-wide enablers.

Case detection and treatment coverage

Despite progress, around 20,000 TB cases remain undiagnosed annually, with missed cases concentrated among children, adolescents, and drug-resistant TB patients. Case detection improved to 82% in 2024 but is still below the 90% End TB target. Gaps remain in engaging the private sector, which is often the first point of care for over half of Ugandans, yet contributes minimally to notifications.

TB/HIV co-infection

Co-infection continues to weigh heavily, with an estimated 33–37% of TB patients living with HIV. ART coverage is high (98%), but integration of pediatric TB/HIV services and preventive interventions remains weak. Mortality among TB/HIV co-infected patients is still high at 7–11%, largely due to late diagnosis and loss to follow-up.

Childhood and adolescent TB

Children accounted for 13.8% of TB Notifications in 2023, just below the global benchmark of 15%. Most childhood TB remains clinically diagnosed (62%) especially in rural districts despite improvements in stool-based diagnostics and child-friendly formulations. Preventive coverage for under-five contacts remains low due to several factors including cascade attrition, reduced operational intensity, funding and HR constraints, care-giver-level barriers, weak integration with child health services, and social protection gaps.

Treatment outcomes

National TSR for DS-TB improved to 92.3% for the 2022 cohort, but regional disparities are stark—Moroto reported outcomes as low as 49%, compared to 84% in Arua. Pediatric TSR (83%) remains below target, affected by delayed diagnosis and weak integration of pediatric TB services into routine health programs.

Drug-resistant TB

Drug-resistant TB (DR-TB) remains a major challenge. In 2024, Uganda had an estimated 1,500 RR/MDR-TB cases, of which 66.5% were detected. Treatment outcomes improved, with a treatment success rate of 88%, mortality at 7–9%, and loss to follow-up reduced to 3–5%. Despite these gains, gaps persist in universal access to WHO-recommended rapid diagnostics, second-line DST, timely result reporting, and referral systems. Expanding access to shorter, all-oral regimens and strengthening

community-based support remain critical to sustaining progress.

High-risk and vulnerable populations

TB prevalence in prisons remains disproportionately high at 1,904/100,000, with infection rates up to 48%, eight times higher than the general population. Screening gaps persist, with only 72% of prisons conducting entry screening. Refugees, migrants, miners, urban slum dwellers, men, and rural women also remain underserved, facing barriers of stigma, gender inequity, and poor access to diagnostic and treatment services.

Leprosy

Leprosy remains endemic, with 275 new cases reported in 2024 (6 per 1,000,000). Nearly 17% of cases were in children (ongoing transmission), 86% were multibacillary, and 23% presented with Grade 2 Disability (G2D)—a clear sign of delayed detection. Treatment completion (78%) is still below the 90% target. Integration into TB/NTLP systems and community-level awareness remain weak.

System and cross-cutting gaps

Diagnostics: While 389 GeneXpert machines cover 98% of districts, access to second-line DST remains centralized, and sample referral systems face delays.

Digital health and M&E: Fragmentation persists across DHIS2, eCBSS, EMRs, and eCHIS, limiting interoperability.

Supply chain: Stock-outs of medicines and commodities remain frequent due to underfunding and weak eLMIS integration.

Community engagement: Community-led monitoring (CLM) remains limited, with weak facilitation and data integration.

Advocacy and multi-sectoral collaboration: Engagement of non-health sectors, financing for ACSM, and accountability under the MAF-TB framework are still insufficient.

Social protection: The 2023 TB social protection baseline showed that most existing schemes are TB-sensitive but not TB-specific, with MDR-TB "Enablers packages" as the only dedicated support.

Human Resources Challenges: The NTLP continues to face significant human resource challenges, with heavy reliance on partner-supported staff at both national and subnational levels, raising sustainability concerns. Critical shortages of laboratory personnel, clinicians, and specialized DR-TB staff constrain service delivery, while high attrition, slow recruitment, and limited capacity for supervision and mentorship further weaken program performance.

Addressing these gaps will require a bold and transformative strategic focus for the NSP 2025/26 – 2029/30. Priorities must include scaling up case detection through expanded WRD coverage, private sector engagement (PPM), and community-driven strategies, integrating TB and HIV services, with stronger focus on pediatric and adolescent prevention and treatment, decentralizing DR-TB care and scaling up shorter regimens with patient-centered support, expanding interventions for high-risk populations (prisons, migrants, miners, urban poor, refugees, and women), strengthening leprosy surveillance, disability prevention, and stigma reduction efforts, investing in digital health integration, real-time data use, and eLMIS rollout, reinforcing supply chain resilience and sustainable domestic financing, institutionalizing community engagement and CLM, supported by adequate ACSM investments, operationalizing the MAF-TB to drive multisectoral accountability and social protection linkages and transitioning from donor-dependent staffing to sustainable government-funded positions while accelerating recruitment, retention, and capacity building of critical cadres, especially in rural and high-burden areas. Together, these actions, aligned with the End TB Strategy and NDP IV, are designed to accelerate progress towards ending TB and leprosy as public health threats in Uganda by 2030.

3.4 STRATEGIC FOCUS

3.4.1 Early diagnosis and universal DST

a) Scale up screening and diagnosis at health facilities and within high-risk communities, with a particular focus on vulnerable groups such as children, PLHIV, urban poor, miners, plantation workers, HWs, prisoners/incarcerated persons, undernourished, and men

b) Expand access to rapid molecular diagnostics (e.g., GeneXpert Ultra, TrueNat) at all PHC levels

c) Introduce point-of-care tests as they become available

d) Implement universal DST for first and second-line drugs

3.4.2 Treatment of all people with TB with patient support

a) Expand community-based DOT and adherence support models using digital adherence tools

b) Improve treatment literacy, especially for DR-TB patients

c) Strengthen patient-centered support including nutrition, transport, and psychosocial support

d) Optimize shorter, safer DR-TB regimens and expand decentralized DR-TB care sites including DRTB treatment initiation sites

e) Improve follow-up and longitudinal data capture for DS-TB and DR-TB patients

3.4.3 Collaborative TB/HIV activities and management of comorbidities

a) Improve joint planning, supervision, and M&E between TB and HIV programmes

b) Ensure bidirectional screening and integrated service delivery at all levels

3.4.4 Preventive treatment and infection prevention and control

a) Scale up TPT among eligible household contacts, PLHIV, and other high-risk groups

b) Integrate TPT delivery into routine HIV and maternal-child health services

c) Improve facility-based and community-level TB IPC

3.4.5 Mainstream leprosy services within PHC (service delivery)

a) Increase active case finding and early diagnosis

b) Expand availability of MDT drugs and disability-prevention services at decentralized levels

c) Train health workers to recognize and manage leprosy and associated stigma

3.4.6 Political commitment and sustainable financing

a) Mobilize domestic and international financing for priority interventions

b) Transition key donor-supported staff into government systems to safeguard continuity/sustainability purposes

c) Strengthen leadership, accountability, and programme-based budgeting at sub-national levels

3.4.7 Engagement of communities, CSOs and all providers

a) Strengthen functionality of community structures at parish, sub-county, and district levels

b) Expand engagement of TB survivors, CSOs, VHTs, and local leaders

3.4.8 UHC policy, regulatory frameworks and data systems

a) Strengthen TB/HIV and Leprosy data integration within HMIS

b) Strengthen real-time surveillance, e-health, and case-based digital reporting systems

c) Scale up use of digital adherence technologies, eLMIS, and analytics for decision-making

d) Mainstream leprosy into PHC policies and surveillance systems

3.4.9 Social protection and action on TB determinants

a) Link TB patients to existing social protection and nutritional schemes and multi-sectoral responses to reduce catastrophic costs

2.4.10 Discovery and rapid uptake / Implementation research

a) Invest in operational and implementation research for new diagnostics, treatment models and tools; generate evidence for rapid adoption

SECTION THREE.
TB AND LEPROSY STRATEGY 2025/26 – 2029/30

3.1 The NSP development process

The development of the NSP adopted the WHO people-centered framework, structured along the continuum of TB care. This framework identifies gaps in service delivery across three key population groups: (i) individuals who do not access the health system, (ii) those who access care but are not diagnosed or notified, and (iii) those who are diagnosed but not successfully treated.

Assessment of these gaps required the consolidation and interpretation of data drawn primarily from national TB and health systems surveys, as well as systematic assessments of TB and leprosy surveillance systems across the continuum of care. The consolidated evidence was further used to identify critical data and evidence gaps along the TB care cascade and in cross-cutting areas such as TB burden estimation, stigma, and vulnerable and key populations.

To address these gaps, the Framework for Prioritizing TB Data and Evidence-Related Tools was applied to identify and prioritize relevant TB data tools, assessments, and surveys. This process informed the sequencing, timelines, and implementation plan for deploying these tools during current NSP cycle, ensuring that programme planning and decision-making are guided by robust, timely, and people-centered evidence.

The development process began with a comprehensive review of recent evidence from the TB Epidemiological Review 2025, End -Term Review, and multiple data sources, including DHIS2, NTLP reports, and national surveys. These data were consolidated and analyzed to assess program performance, burden trends, and surveillance system capacity.

A multi-stakeholder national workshop was held to prioritize problems,

conduct root cause analysis, and identify high-impact interventions. Thematic working groups assessed programmatic gaps and mapped strategic interventions using a structured WHO-endorsed people-centered planning framework, guided by a consultant. (Figure 4) This was structured across three domains: people not accessing the health system, (2) people with TB seeking care but either not diagnosed or notified, and (3) people notified as a case but not successfully treated.

A triangulation of priorities was done across stakeholder groups putting into consideration the national and sub-national priorities. Root cause analysis was conducted for each of the priority areas yielding a prioritized set of socio-economic, health system and clinical determinants that contribute to the ongoing challenges. Lastly the groups assessed potential strategic interventions to address identified determinants and root causes. They mapped the feasibility and potential impact of the different interventions to generate optimized packages that will achieve the highest impact on the epidemic overall and for selected special populations especially those that may be driving the TB epidemic.

The result was a consensus driven, evidence informed strategic plan that aligns with the End TB strategy and national priorities.

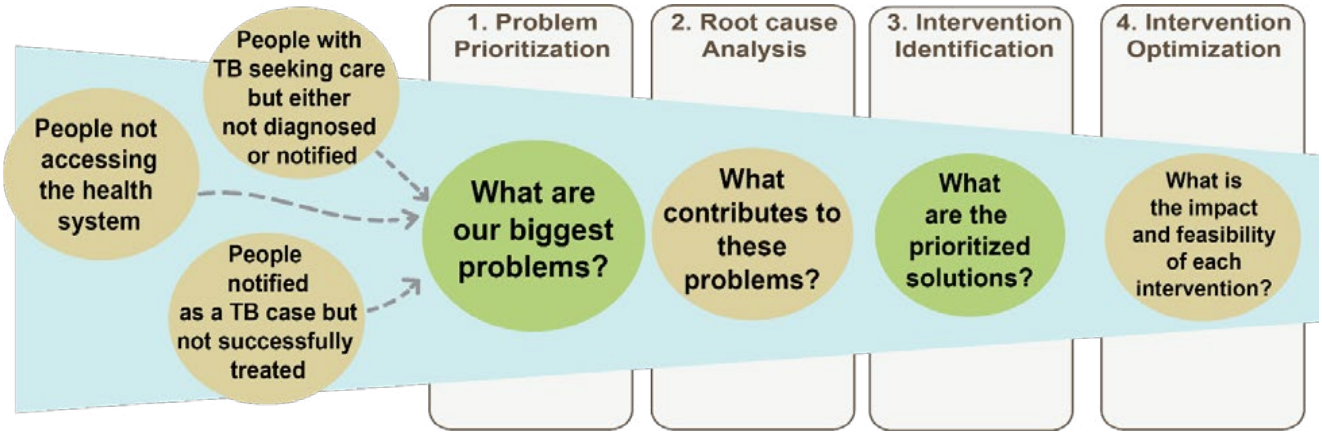


Figure 4. The people-centered planning framework

3.2 VISION AND MISSION OF THE NTLP

VISION

The vision of the National TB and leprosy Control Programme (NTLP) is a Uganda free of Tuberculosis and Leprosy

MISSION

The mission of the NTLP is to provide quality, accessible and affordable TB and Leprosy prevention and care services to all people in Uganda.

3.3 GOAL AND STRATEGIC OBJECTIVES OF THE NSP 2025/26 – 2029/30

GOAL

The goal of the NSP is to reduce the incidence of TB by **6.5**% from *198 per 100,000 population in 2024/25* to *185 per 100,000* by 2029/30 and the proportion of *leprosy cases notified among children* from 17*% to below 3%*

STRATEGIC OBJECTIVES

The national TB and Leprosy response aims to achieve the six broad strategic objectives below that are in line with the thematic areas of the TB and Leprosy care cascade, i.e. Promoting care seeking and prevention of TB and Leprosy in the community, accelerating appropriate and timely diagnosis of TB and Leprosy, and promoting appropriate treatment and ensuring cure.

SO1. To increase TB and Leprosy awareness and increase care seeking from health facilities from 61% to 90% by 2029/30

SO2. To increase TB preventive treatment coverage among eligible people to 95% by 2029/30

SO3. To increase TB treatment coverage from 90% to 95% by 2029/30

SO4. To increase TB treatment success from 91.3% to 95% by 2029/30

SO5. To reduce Leprosy notifications that are children from 14% to 3% by 2029/30

SO6. To build effective and efficient systems that ensure quality, equitable access and timely TB and Leprosy services

The framework below links the vision, goal, strategic objectives and outcome targets of the NSP 2025/26 – 2029/30

VISION A Uganda free of Tuberculosis and Leprosy

GOAL To reduce the incidence of TB by 6.5% from 198/100,000 population in 2024/25 to 185/100,000, and the proportion of Leprosy notification that are children from 17% to less than 3% by 2029/30.

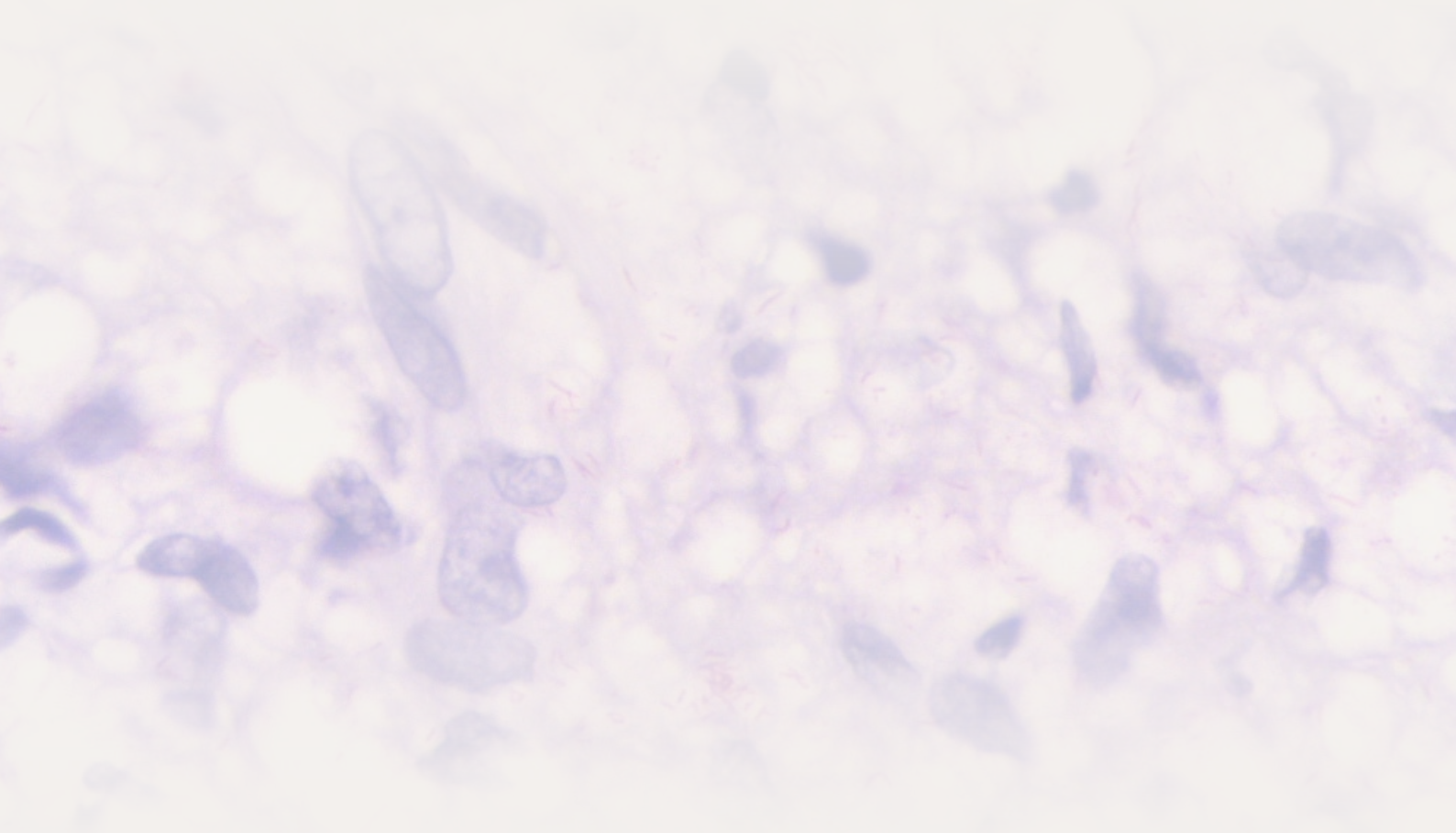
SO1. To increase TB & Leprosy awareness and increase care seeking from health facilities from 61% to 90% by 2029/30	SO2. To increase TB preventive treatment coverage among eligible people to 95% by 2029/30	SO3. To increase TB treatment coverage from 90% in 2023/24 to 95% by 2029/30	SO4. To increase TB treatment success from 91.3% in 2024/25 to 95% by 2029/30	SO5. To reduce the proportion of Leprosy notification that are children from 14% to 3% by 2029/30	SO6. To build effective and efficient systems that ensure quality, equitable and timely TB and Leprosy services
					
SO1.1 People with knowledge about TB symptoms increased from 46% to 90% **SO1.2** People with TB symptoms seeking appropriate care increased from 61% to 95% **SO1.3** Stigma and discrimination among TB patients reduced from 53.7% to 10%	**SO2.1** TB contact tracing increased from 59.4% to 95% **SO2.2** TB contact screening coverage increased from 91% to 95% **SO2.3** TB preventive treatment coverage increased among eligible individuals to 95% **SO2.4** TB notification rate among healthcare workers reduced from 316/100,000 to 250/100,000 **SO2.5** The Proportion of TB patients screened for comorbidities increased to 80% **SO2.6** The proportion of chronic care clients & substance users screened for TB increased to 80%	**SO3.1** TB treatment coverage increased from 90% to 95% **SO3.2** Notified new and relapse TB cases with bacteriological confirmation increased from 66% to 90% **SO3.3** Notified new and relapse TB patients tested using WHO recommended TB rapid diagnostic tests (WRD) increased from 82% to 90% **SO3.4** DST coverage among bacteriologically Confirmed cases increased from 72% to 90% **SO3.5** MDR-TB treatment coverage increased from 58% to 80% **SO3.6** Child treatment coverage increased from 62% to 95%	**SO4.1** TB patients diagnosed and not started on treatment reduced from 2.8% to <1% **SO4.2** TSR of Notified Drug-Susceptible TB patients increased from 91.3 % to 95% SO4.3 TSR for DR-TB increased from 88% to >92% **SO4.4** TSR for TB/HIV increased from 89% to 95% **SO4.5** TB related mortality reduced from 4.5% to <3%	**SO5.1** The number of districts reporting zero new autochthonous leprosy patients from 116 (79%) to 132 (90%) **SO5.2** The number of new and relapse leprosy patients detected annually reduced from 273 to 30 **SO5.3** The proportion of child leprosy patients reduced from 14% to 3% **SO5.4** The proportion Leprosy treatment completion increased from 91% to 95% **SO5.5** The new Leprosy cases with Grade 2 disability reduced from 18% to 5% **SO5.6** Leprosy patients in need of protective wear who are provided with footwear increased from 72% to 90%	**SO6.1** Improved Coordination of the TB and Leprosy response **SO6.2.** Improved Capacity for service delivery at national and subnational levels **SO6.3** Improved availability and access to Resources for Delivery of quality TB and Leprosy services

3.4 GUIDING PRINCIPLES

The NSP 2025/26- 2029/30 is guided by the following principles that are in line with the Key Asks for Universal Health Coverage.

Table 2. Principles guiding the National TB and Leprosy Strategic Plan 2025/26-2029/30

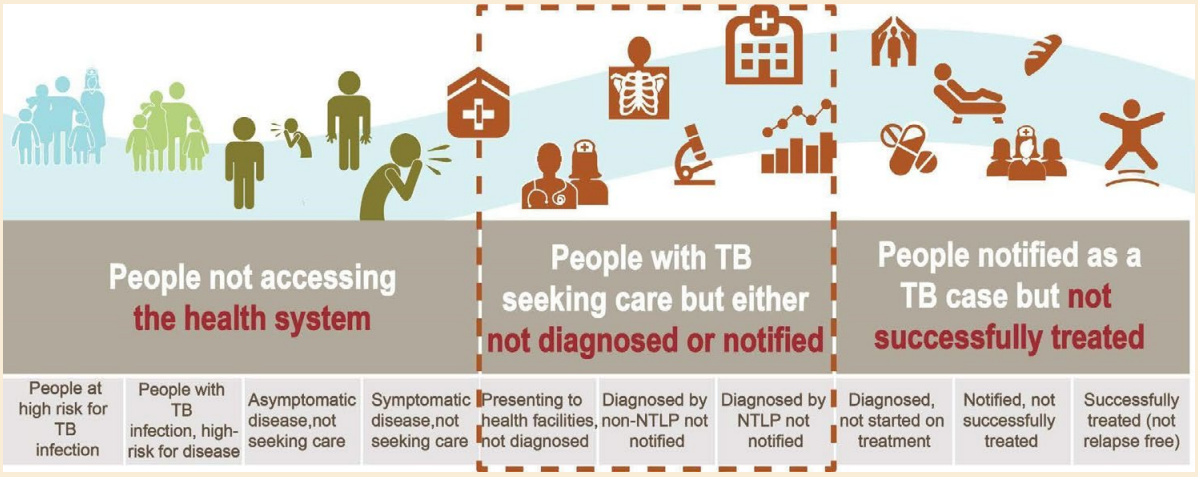
Guiding principle	NSP response
1. People-centred approach	This NSP has identified priority gaps and opportunities according to community and patient perspectives as a basis for designing and providing high quality services that are accessible to all who need them
2. Political Leadership and multi-sectoral collaboration	Embedded in this plan are targeted advocacy strategies at national and local government levels that aim to improve political commitment and funding for TB and Leprosy services. Multi-sectoral collaboration is one of the major facets of implementation of the three pillars of this NSP. This plan includes a multi-sectoral partnership accountability framework that demonstrates increased commitment to establish partnership and coordination mechanisms for a healthier population.
3. Upholding Quality of Care	Quality of care strategies proposed include, human resource development, infrastructure improvements, and monitoring and evaluation approaches including patient feedback. In built is the research agenda that will also continually inform the quality of care
4. Investing more, Investing better	The plan sets forth ambitious targets with interventions that have been optimized for better results. Its realization will need increased investment. Efforts to pool and harmonize investment have been laid out including advocacy, service and population mapping, stakeholder coordination, integration among others



SECTION FOUR.
STRATEGIC INTERVENTIONS

4.1 INTERVENTIONS FOR THE TB AND LEPROSY CARE CASCADE

4.1.1 Promoting care seeking and TB prevention in the community



Thematic gap. People not accessing the health system

1) **Only 46% of the population are knowledgeable about TB symptoms**
2) **61% of people with TB symptoms seek appropriate care, especially men**
3) **TB contact investigation coverage remains low at 33%**
4) **Stigma against TB patients persist, with over 53% reporting discrimination**

Strategic Objective SO1. To increase TB and Leprosy awareness and care seeking from health facilities from 61% to 90% by 2029/30

Table 3. Strategic Objective S01

Outcome Targets	Strategic interventions	Activities
SO1.1 People with knowledge about TB symptoms increased from 46% to 90% **SO1.2** People with TB symptoms seeking appropriate care increased from 61% to 90% **SO1.3** Stigma and discrimination among TB patients reduced from 53% to 10%	Implement community-led TB and Leprosy awareness and health education campaigns	• Develop and disseminate comprehensive IEC materials tailored to different literacy levels, age groups, and KVPs (e.g. men, prisons, mines, refugees, fisherfolk, mobile populations, adolescents) for TB and leprosy • Design and roll out targeted multi-channel TB and leprosy awareness campaigns using radio, TV, posters, social media, and community events in local languages • Conduct regular TB and leprosy health education sessions in schools, markets, places of worship, male-dominated spaces and other community settings • Engage and train community influencers, including religious leaders, traditional healers, male action groups, school clubs, and drama groups to disseminate accurate messages • Conduct targeted community mobilization to address stigma and myths about TB and leprosy among KVPs and children • Engage private sector clinicians, school health teams, and CSOs to raise awareness and improve referral for KVPs and pediatric TB • Community engagements and awareness campaigns at the border areas • Conduct baseline surveys and community consultations to assess knowledge, attitudes, and practices on TB/Leprosy • Organize targeted workplace sensitization sessions and tailored outreach campaigns for special groups (e.g. youth, migrants, PLHIV)

	Strengthen the role of community health workers (CHWs), TB & Leprosy survivors, and civil society in community mobilization	• Involve community stakeholders in planning, implementation, and monitoring of TB activities • Train CHWs and equip TB & Leprosy survivors for TB and leprosy communication, stigma reduction, and referral systems • Facilitate household visits and targeted outreach in high-burden and underserved areas to identify and refer symptomatic individuals • Establish partnerships with civil society organizations for community mobilization, peer support, and linking communities to care • Implement community-led monitoring for TB and Leprosy services
	Promote stigma reduction and social protection to improve care seeking	• Conduct stigma-reduction dialogues and community theatre sessions featuring TB survivors and local leaders • Integrate psychosocial support for TB and leprosy patients through community structures • Link TB and leprosy patients to available social protection services (e.g., transport vouchers, nutritional support) • Include anti-stigma training in community and facility capacity-building efforts
	Improve community-facility linkages and referral mechanisms	• Strengthen and monitor formal referral systems between CHWs and health facilities, with feedback loops • Introduce toll-free community hotlines and SMS reminders for symptom screening and follow-up

Strategic Objective SO2. To increase TB preventive treatment coverage among eligible people to 95% by 2029/30

Table 4. Strategic Objective SO2

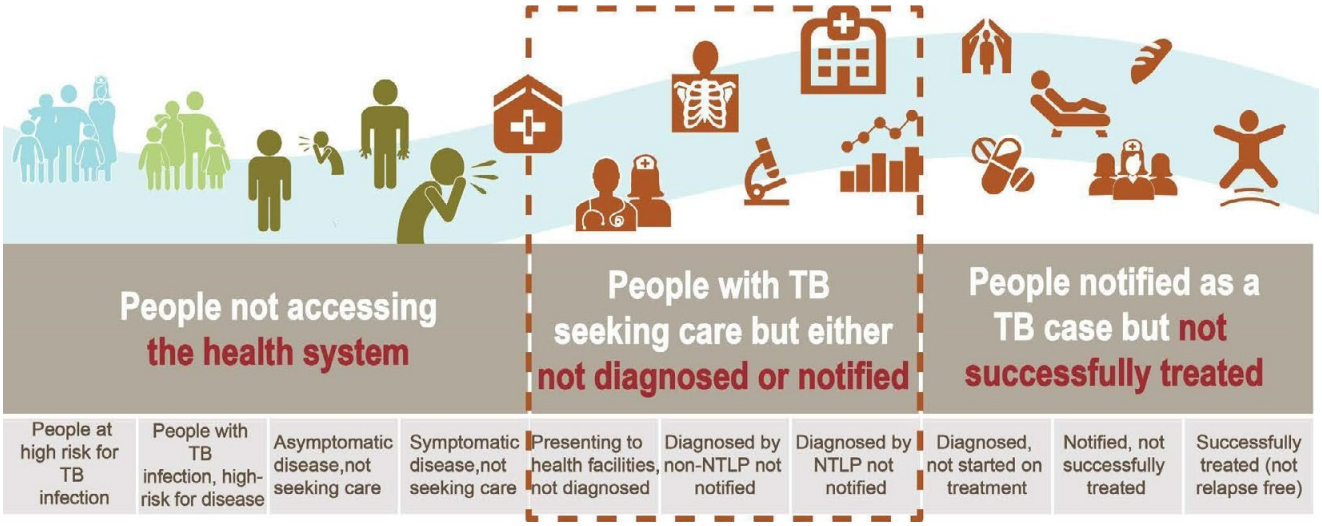
Outcome targets	Strategic interventions	Activities
SO2.1 TB contact tracing increased from 33% to 95%	Build capacity for contact investigation at the facility level	• Train health workers on standardized contact investigation SOPs and infection prevention measures • Disseminate updated contact investigation tools (guides, SOPs, forms) • Translate Intensified Case Finding (ICF) materials into major local languages for facility use • Develop and deploy mobile technology to support contact screening, mapping, real-time reporting, referral initiation, and patient self-reporting of symptoms • Strengthen monitoring, supervision, and mentorship for contact investigation at facility level
	Strengthen community contact investigation	• Train VHTs, CHWs, CHEWs, TB survivors and CSOs for community contact investigation protocols and tools • Work with CSOs and community groups to facilitate TB contact investigation and follow-up at household level • Provide logistical support (transport, airtime, e-registers) to community TB actors • Link community-level findings with facility care and feedback systems to ensure TPT initiation and adherence support
SO2.2 TB contact screening coverage increased from 92.9% to 95%	Strengthen systematic TB contact screening and evaluation at all levels	• Conduct systematic TB symptom screening for all household and close contacts of TB patients using standard national tools • Implement extended and reverse (targeting children) contact tracing • Implement differentiated approaches for screening and TPT among high-risk groups such as children under 5, PLHIV, and elderly contacts • Provide TPT to all eligible contacts in line with national guidelines

	Leverage digital innovations and community systems to enhance TB contact investigation	• Enhance utilization of digital tools (including eCBSS) for monitoring contact investigation • Deploy GIS-enabled tools and mobile data collection platforms to improve mapping and follow-up of contacts • Implement community-based adherence monitoring and support for contacts on TPT through community teams
SO2.3 TB preventive treatment (TPT) coverage increased among eligible individuals to 95%	Expand Access and Uptake of TPT through targeted and Integrated Approaches	• Scale-up TPT provision to private-for-profit (PFP) health facilities through a dedicated PPM engagement strategy • Strengthen the delivery of TPT at the health facility and community care points • Expand eligibility criteria to align with new WHO guidance, including older children and other high-risk groups (e.g., uniformed personnel, refugees, , migrants, persons in prisons, remand homes & police cells) • Conduct periodic targeted campaigns (e.g., "TPT weeks") to boost uptake in low-performing regions
	Strengthen Systems for Monitoring, Adherence, and Quality of TPT Services	• Establish and enhance TPT adherence monitoring frameworks using community health workers, digital adherence technologies (DAT), and family-supported models • Train health workers and VHTs & CRPs on new TPT regimens, adherence support, and side effect management

SO2.4 TB notification rate among healthcare workers reduced from 316/100,000 to 250/100,000	Improve TB prevention for healthcare workers through annual screening, policy implementation, and IPC integration in facilities	• Disseminate updated MoH IPC guidelines in collaboration with the Department of Clinical Services • Review, adapt, and distribute TB-specific IPC Standard Operating Procedures (SOPs) to health facilities • Ensure TB IPC plans are integrated into routine operations of facility IPC committees and provide adequate PPE • Conduct annual digital chest X-ray screening using CAD software for early TB detection among healthcare workers • Establish a system to track TB incidence and monitor occupational exposure among healthcare workers and other occupational groups and offer appropriate preventive interventions • Train facility-based IPC focal persons on TB IPC, screening, and surveillance • Advocate for psychosocial and occupational health support for healthcare workers diagnosed with TB and Leprosy • Advocate with the housing, transport and local government sectors for appropriate housing and public service vehicle designs. Work with the MoH infrastructure department to promote appropriate health facilities designs • TB and Leprosy outbreak investigation and response
SO2.5 The Proportion of TB patients screened for comorbidities increased to 80%	Strengthen integrated TB-comorbidity screening and management through SOPs, joint supervision, and health worker capacity building	• Develop and disseminate SOPs for integrated TB-comorbidity screening, diagnosis and case management • Orient health workers on TB-comorbidity integration and SOPs • Develop and roll out joint TB-comorbidity supervision tools • Conduct integrated support supervision and performance review visits at national and sub-national levels • Monitor and report TB-comorbidity screening coverage and outcomes through DHIS2 and eCBSS • Engage technical working groups to incorporate NCDs, HIV, and other comorbidities into TB planning and reviews

SO2.6 The proportion of chronic care clients & substance users screened for TB increased to 80%	Strengthen bidirectional TB screening for chronic care and substance use clients through policy implementation, health worker training, and stakeholder collaboration	• Conduct Training of Trainers (ToTs) and cascade trainings to frontline health workers at OPD entry points • Engage stakeholders across TB, NCD, SRH, and mental health programs for alignment • Monitor and review implementation progress through joint supervision

4.1.2 Accelerating appropriate and timely diagnosis for TB



Thematic gap. People with TB seeking care but either not diagnosed or not notified

1) Low investigation of chronic cough – Only 16% of patients with cough ≥2 weeks are evaluated with sputum and/or chest X-ray
2) Significant care-seeking in the private sector with low diagnostic capacity – 24% of symptomatic TB patients first seek care at private facilities, many lacking WRDs and X-ray capacity
3) Limited TB service coverage in public facilities – Only 35% of public facilities provide TB services; among these, 85% offer microscopy, 40% X-ray, and only 4% of HCIIIs have onsite GeneXpert testing
4) Inadequate screening in high-risk groups – Screening coverage remains suboptimal among TB contacts, under-5 children, PLHIV, people with diabetes, smokers, health workers, and refugees, with most groups screened at <60% coverage
5) Very low TB service availability in private sector – Only 3% of PFPs and 28% of PNFPs provide TB diagnostic and treatment services
6) Low reporting from peripheral health facilities – Only 22% (820/3,785) of PHF DTUs report into the national TB surveillance system

Strategic Objective SO3. To increase TB treatment coverage from 86% in 2024/25 to 95% by 2029/30

Table 5. Strategic Obective S03

Outcome targets	Strategic interventions	Activities
SO3.1 TB treatment coverage increased from 86% to 95%	Scale up systematic TB screening at health facilities	• Strengthen the capacity of health workers in TB screening and diagnosis • Disseminate and orient public and private facility teams, including community actors on the updated Active Case Finding (ACF) strategy • Scale up digital X-ray (dCXR) use for TB screening through equipping health facilities as well as training, and mentorship of health workers (including private sector) including interpretation of chest X-rays for children • Enhance TB screening among PLHIV using sensitive tools such as CXR/CAD and C-reactive protein (CRP) • Coordinate with MAAIF to develop a plan for Mycobacterium bovis surveillance
	Strengthen community TB case finding	• Establish and strengthen partnership with community actors including traditional healers, CSOs, and private providers for case finding • Pilot and scale-up self-screening using digital technology • Scale-up community TB case-finding using door to door and snowball approaches to reach closed and high-risk communities including CAST+ • Use GIS mapping to identify TB hotspots and prioritize community screening in those areas
	Intensify case finding among the high-risk groups through targeted screening in communities	• Accelerate adoption of updated TB diagnostic algorithms with targeted mentorship for compliance • Conduct targeted screening using dCXR among KVPs (prisons, mines, refugees, fisherfolk settlements, male dominated spaces, prisons, cross border, mobile and uniformed populations) to identify people with TB • Functionalize mobile TB screening and molecular testing (Tri-cycle with dCXR and TB LAMP) for TB testing during community outreach • Strengthen TB and Leprosy screening of travelers at all the designated Points of Entry and refugee reception/transition centers • Capacity building of staff at the POEs on TB screening, sample referral and tracking of patients across boarders

S03.1.1 The proportion of TB patients notified by the private sector increased from 20% to 35%	Build capacity of private health providers to deliver TB and Leprosy services	• Scale-up targeted training, supervision, and mentorship on TB/Leprosy diagnosis, case notification, data management, and supply chain for private health providers • Provide tools to facilitate TB screening and diagnosis in private health facilities (ICF guides, ICF Stamps, SOPs and diagnostic guidelines for clinicians to enable easy identification of patients with TB) • Scale up quality treatment services through inclusion of eligible private facilities on the Joint Medical Store commodity master list • Integrate AI software for CXR interpretation at high-burden private facilities with dCXR for improved TB screening • Provide incentives (financial and non-financial) to private health providers to boost TB service delivery
	Strengthen the availability/ accessibility of TB diagnostic tools and commodities within the private health sector	• Identify and build capacity of high-volume urban and peri-urban private facilities for targeted deployment of TB diagnostic equipment and supplies. • Integrate private health facilities into the sample transportation system for improved access to TB diagnostic services. • Link supported private facilities to quality control/assurance programs (EQA, proficiency testing).
S03.1.2 The proportion of PFPs and PNFPs diagnostic and treatment units reporting on TB in DHIS2 increased from 2% to 20% and from 42% to 90%	Scale up and formalize the engagement of private health providers at sub-national level	• Support the accreditation of high-volume facilities for TB service delivery (TB Diagnostic and Treatment Units). • Scale up private sector engagement models to also incorporate stand-alone laboratories, imaging centers, specialized clinics, pharmacies and traditional healers.

	Support/Ensure complete and timely reporting from the private sector	• Scale-up the updated HMIS tools and monitor their use in both PFP and PNFP facilities, including digital tools. • Engage private health providers in routine data review meetings to encourage data use for decision-making

SO3.2 Notified new and relapse TB cases with bacteriological confirmation increased from 63% to 80%	Expand availability and use of molecular-WHO recommended rapid diagnostic (mWRD) tools	• Develop and implement a mWRD implementation strategy to accommodate new tools and near-point of care diagnostic tools (including use of alternative samples such as tongue swabs, sputum swabs, stool) • Expand the number of mWRDs tools, including near-point of care diagnostic tools through needs-informed resource mobilization, procurement and maintenance as well as training and mentorship using a QI approach • Optimize access and utilisation of mWRDs through integrated mentorship using Continuous quality improvement (CQI) approach, such as GeneXpert for Every TB Patients (GET) • Strengthen monitoring of result turnaround time (TAT) to improve linkage to care, reduce loss to follow-up, and improve patient outcomes including through expanding integrated digital connectivity solutions (LabXpertDS) and Laboratory Information Systems (LIS) • Finalise and disseminate guidelines for muti-disease testing to accommodate all integrated platforms

SO3.2.1 Public health facilities (HC III and HC IV) offering mWRDs diagnostic services increased from 23% to 50%	3.2.2 Strengthen the Quality of TB laboratory services	• Strengthen and expand the national sample referral network to ensure timely transportation of specimens from lower-level facilities to WRD sites • Support 10 Laboratory personnel to provide support for PT production and scheme management for the network • Procurement of reagents, materials, and equipment for PT production and provision at NTRL Uganda • Strengthen decentralisation of TB EQA activities and Support Proficiency testing (PT) for all TB diagnostic tests
	3.2.3 Enhance management of laboratory supplies and equipment	• Maintenance of the PT data management system hosted at NTR • Strengthen the implementation of Biosafety and Biosecurity guidelines at all tiers • Centralize and digitize all policies, guidelines and tools within a document control system and ensure training and mentorship of health workers on their use • Develop a comprehensive training plan for all health workers on TB diagnostic procedures and continue updating the health workers through the CME • Strengthen capacity for maintenance, service and repair of TB diagnostic equipment in the Network (microscopy, mWRD, Biosafety cabinets, mobile clinics) • Strengthen procurement of commodities for TB diagnostics through the National ware houses
SO3.3 Notified new and relapse TB patients tested using WHO recommended TB rapid diagnostic tests (WRD) increased from 82% to 90%	3.3.1 Strengthen culture and drug susceptibility testing for both phenotypic and genotypic assays	• Increase access to molecular testing for first line and second line drugs • Increase access to Culture, 1st and 2nd line phenotypic DST for eligible patients • Enhance national capacity for INH resistance surveillance • Increase access to targeted next generation sequencing (tNGS) for DR-TB diagnosis and surveillance • Improve Sample Transport and Result Turnaround:

SO3.4 DST coverage among bacteriologically confirmed cases increased from 72% to 90%	3.4.2 Enhance national capacity for INH resistance surveillance	
SO3.5 MDR-TB Treatment coverage increased from 58% to 80%	3.5.1 Strengthen Referral and Linkage Systems for MDR-TB	• Service and Maintenance contract of the HVAC system and BSL3 facilities at NTRL. • Service and Maintenance of laboratory equipment and the facilities at the NTRL laboratory • Support maintenance of the TB laboratory information management systems (PT, TBLIS, AMS & e- learning) at NTRL, including web hosting, internet connectivity, Zoom license, and server maintenance • Strengthen Drug Susceptibility Testing DST including universal rifampicin DST for all bacteriologically confirmed cases, simultaneous Rifampicin and Isoniazid DST, and access to second-line pDST and sequencing through sample referral to NTRL • Procurement of spare parts for the HVAC system and diagnostic equipment at NTRL • Procurement of equipment for Culture and DST for the NTRL • Procurement of reagents for phenotypic DST and sequencing at NTRL • Acquisition of a server for storage of genomic surveillance data from the sequencing platforms • Strengthening the inventory system for TB commodities at NTRL • Procurement of additional targeted NGS platforms to strengthen drug resistance surveillance • Introduce reflex DST algorithms in all GeneXpert sites using XDR cartridges • Establish robust referral mechanisms for timely linkage of MDR-TB patients from diagnostic points to treatment initiation sites, with real-time tracking of arrivals • Implement patient navigators or linkage coordinators at district and regional levels to reduce delays and loss to follow-up • Integrate MDR-TB referral tracking into the national DR-TB Management Information System (MIS)

	3.5.2 Expand and Equip MDR-TB-Initiating Hospitals	• Scale up the number of MDR-TB treatment initiation sites from the current baseline of 22 to all general hospitals, including PNFP facilities and upgrade infrastructure in high-burden facilities • Equip MDR-TB hospitals with adequate laboratory capacity for monitoring treatment, including procurement of necessary lab equipment, reagents, and biosafety material
	3.5.3 Engage and Build Capacity of PFP and PNFP Facilities for MDR-TB Care	• Conduct a national assessment of the capacity, readiness, and willingness of PFP and PNFP facilities to provide MDR-TB services • Develop and implement a phased accreditation program for capable PFP and PNFP facilities to initiate and manage MDR-TB treatment • Provide targeted capacity-building including training on clinical protocols, reporting, supply chain management, and infection prevention and control (IPC) measures.
	3.5.4 Enhance Patient-Centered Support Systems for MDR-TB	• Implement comprehensive adherence support programs including psychosocial counselling, community health worker follow-up, and nutritional support • Strengthen community-based MDR-TB treatment models to improve access for patients in remote and underserved areas • Integrate digital adherence technologies (DATs) for remote patient support
SO3.6 Childhood TB treatment coverage increased from 71% to 95%	3.6.1 Intensify Integrated and Targeted Active Case Finding (ACF) for Children and Adolescents	• Integrate TB screening into RMNCAH platforms (e.g. IMCI, iCCM, nutrition, school health, immunization, child health days) • Strengthen TB case finding among high risk groups including routine TB screening for all admitted children with severe acute malnutrition, HIV, severe pneumonia, or history of TB contact • Conduct school-based TB screening and termly awareness sessions in collaboration with education and environmental health sectors • Introduce adolescent-friendly TB screening at health facilities and communities including schools • Use innovative platforms (youth champions, social media, sports events, CHEWs, YAPS peer supporters) to reach adolescents and out-of-school youth • Implement family-centered TB care, ensuring household contact investigation and linkage to care • Adopt and scale up successful innovative approaches for child and adolescent TB case finding such as DETECT child TB, TB SPEED, Cap TB

	3.6.2 Strengthen Diagnostic Capacity for childhood TB	• Roll out the updated pediatric TB diagnostic algorithms and SOPs at all health facilities • Expand access to child-friendly diagnostic tools (alternative specimens such as stool) gastric aspirates, fine-needle aspiration) with necessary equipment at hospitals, including training and supervising health workers • Establish regional child and adolescent TB hubs/centres of excellence with referral and mentorship capacity including TB/HIV and DR TB • Implement the concurrent testing approach (stool and respiratory sample for all children, plus LF-LAM for children living with HIV) in higher level facilities
	3.6.3 Build and Sustain Health Worker Capacity	• Train (with CPD accreditation) and consistently mentor and supervise health workers on pediatric TB diagnosis, including interpretation of chest X-rays where available • Introduce and promote the WHO and Union online child and adolescent TB courses for continuous learning • Adopt/Adapt training materials for interpreting CXR to diagnose TB in children (Union atlas, TB SPEED CXR training materials) • Engage pediatricians in conducting region-based webinars, regional mentorship and clinical case review • Update curricula in pre-service training institutions to strengthen child and adolescent TB content
	3.6.4 Improve Access to and Quality of Treatment	• Scale up the use of shorter child-friendly regimens for DS-TB (4-month regimes) and DR-TB • Ensure uninterrupted supply of pediatric TB medicines and formulations • Provide adherence support through community-based follow-up, digital adherence tools, and linkage to social protection where feasible

4.1.3 Promoting appropriate TB treatment and ensuring cure

Strategic objective SO4 To increase TB treatment success from 91.3% in 2024/25 to 95% by 2029/30

Thematic gap. People notified as a TB case but not successfully treated

1) 2.8% of TB patients diagnosed were not started on treatment (2023/24)
2) 91% of Notified DS-TB patients were successfully treated (2023 cohort)
3) Treatment success rate for Drug resistant TB improved to 88% (2023 cohort)
4) The treatment success rate for the TB/HIV co-infected patients is 86% (2023 cohort)

Table 6. Strategic Objective S04

Outcome targets	Strategic interventions	Activities
SO4.1 TB patients diagnosed and not started on treatment reduced from 2.8% to 1.5%	Address stigma among patients and the community	• Implement community awareness interventions given under Strategic Objective SO1
	Improve coordination and integration of TB services at facility level	• Develop and disseminate guidance for improving the organization of TB services including implementation of TB clinic days • Initiate targeted education and counselling of presumptive and diagnosed TB and MDR-TB patients on TB care process and their roles to access treatment • Strengthen implementation of quality improvement approaches at the health facility including regular data audits • Strengthen the role of intermediary organizations to support and equip private health providers to ensure favorable treatment outcomes • Integrate tobacco cessation interventions into TB control • Engage community actors (CLFs, VHTs, CHEWs, TB Survivors) to link persons detected with TB to care (*covered under SO1*)
	Improve availability of TB supplies	• Procure adequate TB medicines (first and second line) • Provide mentorship in logistics management at both private and public health facilities, including MDR-TB logistics • Support the implementation of Supervision, Performance Assessment, and Recognition Strategy (SPARS) at all DTUs

	Increase access to TB treatment through the private sector (PNFPs and PFPs)	• Develop and roll out tools for accrediting DTUs in all districts • Accredit and mentor at least 40% of high-volume PFPs (including availing tools and logistics) • Facilitate complete referrals, linkage to treatment, and follow up for both DS and DR TB • Avail PHC funds to PHFs to improve TB care • Regular inclusion of PHF management and providers in quarterly and annual meetings • Collaborate with the private sector network to establish and strengthen regional PPM offices to improve TB care and support in private health facilities and by other private sector players • Collaborate with intermediary agencies and private sector networks to establish and strengthen regional PPM structures
	Strengthen referral and linkage mechanisms	• *Refer to Strategic Objective SO3.2.1 for activities geared towards strengthening the referral network*
	Increase reporting of private health facilities DTUs	• Enhance private sector engagement to ensure standardized TB treatment initiation and reporting across PFP and PNFP facilities, including performance review meetings
	Increase leadership engagement in planning to end TB	• Orient technical and political leaders at all levels to support advocacy, resource mobilization, implementation, accountability. • Develop and use monthly (real-time) performance dashboards to provide targeted support for achievement of the required results
	Support the development and dissemination of supportive TB Policies	• Include TB in the result-based financing models as part of incentives to improve staffing and performance levels in private facilities • Develop and disseminate policy and operational guidance and tools for routine surveillance for TB relapse and Zoonotic TB

	Improve linkage of people diagnosed with TB to care	• Physical handover of diagnosed patients to treatment initiation points • Offer patient literacy to diagnosed TB patients on the importance of prompt initiation and adherence • Scale up the use of lab Xpert and SMSs to relay timely results
	Increase number of DTUs	• Assess, accredit, equip, and train facilities as DTUs including private facilities, cross-border points
SO4.2 TSR of notified Drug-Susceptible TB patients increased from 91% to 95% by 2029/30	Strengthen community-based patient support and follow-up	• Scale up engagement of community health workers (CHWs), civil society organizations (CSOs), local councils (LCs), TB survivors, religious and traditional leaders for treatment education, adherence counselling, and rapid tracing of treatment interrupters • Offer patients a choice of preferred DSD model (use locator forms, appointment registers, home delivery of medicine) **Cross Reference:** *See detailed community engagement activities under SO1.1 in NSP*
	Address the socio-economic barriers adherence	• Provide treatment enablers (food, transport) to vulnerable patients such as patients in Karamoja, refugees, and urban poor • Expand integration of TB patients into existing (e.g., SAGE, PDM, refugee welfare programs) and future social protection schemes **Cross Reference**: *See additional activities under SO1.2 (enabling people to seek appropriate care)*

	Implement patient-centered Adherence with digital innovations	• Expand the use of DATs such as smart pill boxed and Video DOT (VDOT) to > 50% of DTUs, prioritizing districts with TSR <90% through dissemination of guidelines, procurement and capacity building • Diversify Differentiated Service Delivery (DSD) models for TB treatment (facility-based, community-based, Client-led TB drug delivery services, fast-track refill models) • Integrate TB care with management of comorbidities (HIV, diabetes, malnutrition) • Strengthen linkages between the facility and community **Cross Reference**: *Patient engagement approaches under SO4.1 in NSP*
	Enhance district and Health facility level accountability for treatment outcomes	• Institutionalize quarterly TSR performance reviews at district and monthly health facility levels with feedback (e.g. using dashboards) • Use eCBSS to line list with high risk for follow-up • Deploy targeted district mentorship teams to low-performing regions • Strengthen drug supply chain reliability for uninterrupted treatment, aligned with PSM strengthening activities under SO6
	Improve provider capacity in TB case management and CQI	• Conduct mentorship and coaching on adherence monitoring, sputum follow-up, and rapid management of side effects • Implement continuous quality improvement cycles (PDSA) to address TSR gaps
SO4.2.1 Reduce loss to follow among TB patients initiated on treatment from 3.5% to 2%	Strengthen enrolment of TB patients on DSD models	• Build capacity of health workers through mentorship and supervision and routinely monitor uptake and outcomes of TB DSD models • Support facility staff to systematically enroll and follow up patients onto DSD models as part of a patient-centered approach (facility- or community-based options) **Cross-reference:** *See detailed DSD and patient support activities under NSP SO4 (Promoting appropriate TB treatment and ensuring cure)*

	Strengthen facility-community linkages and tracking systems	• Map and collaborate with community actors (VHTs/CHEWs, CSOs/CBOs, TB survivors, local councils, community gatekeepers) through facilitating them and availing information (with consent) for target groups • Activate automated alerts from EMR/eCBSS/LabXpert where available for missed visits and sputum follow-up; escalate cases not found within 7 days **Cross-reference:** *Community engagement package under NSP SO1.1 and linkage/tracing functions under SO4.2*
	Integrate CQI to address loss to follow-up	• Use CQI principles to identify patient-level and system barriers and tailor adherence approaches • Design community-specific solutions (e.g., peer clubs, male-friendly services, refugee camp outreach, Karamoja nomadic routes) to retain patients in care ***Cross-reference:*** *CQI and data use activities under NSP M&E and SO4*
SO4.3 Treatment success rate for the TB/HIV co-infected increased from 70% to >95% by 29/30	Integrate TB/HIV services ("one-stop" model) and fast-track co-management	• Strengthen the provision of integrated TB/HIV services like diagnostics and linkage to care ***Cross reference:*** *SO 3.1 and 3.2* • Scale up provision of the AHD package including introduction of a triage/ severity tool, same day TB treatment initiation, and rapid ART start • Introduce and schedule TB/HIV case conferences for complex scenarios to enhance clinical management capacity

	Strengthen treatment tracking and adherence support	• Optimize clinical co-treatment and drug-drug interaction (DDI) management • Integrate management of comorbidities like mental-health and substance-use support (brief counselling and referral) within adherence counselling sessions • Scale Differentiated Service Delivery (DSD) models that integrate TB and HIV follow-up (facility Fast-Track, community refills, group models) including the use of DAT • Implement patient- centered Adherence with digital innovations • Address determinants and comorbidities that lower TSR • Continuous Quality Improvement (CQI) and dada use • Run monthly TB/HIV dashboards: TSR, LTFU, mortality, time-to-ART, VL suppression at 6–12 months, AHD package coverage; compare facilities with league tables • Conduct quarterly mortality and LTFU reviews (linked to SO4.2.1 & SO4.2.2); implement QI changes and re-measure within 60–90 days Maintain exception lists: TB/HIV patients without ART; RR-TB patients awaiting DR-TB regimen; patients with non-suppressed VL needing enhanced adherence counseling. Support the integration of HIV and TB services at health facilities *(cross-reference SO2–SO3 for diagnostic & linkage systems and SO6 for PSM/HR enablers)*

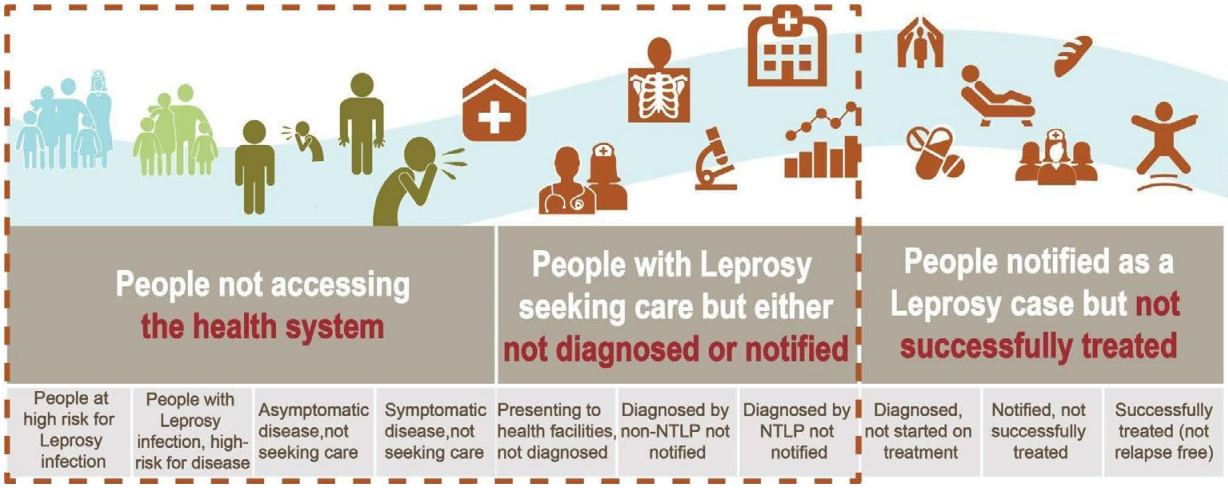
SO4.4 TB related mortality reduced from 4.5% to 3%	Fast track identification and stabilization of high-risk TB patients	• Introduce a simple TB severity/triage tool at OPD, HIV clinics, emergency units and wards (includes red-flags: very low SpO_2, severe under-nutrition, altered mental status, advanced HIV, severe anemia). Trigger same-day referral to oxygen/HDU • Optimize access to digital chest X-ray with CAD and Xpert/Truenat placement and uptime • Reduce late presentation from community and PPM channels ***Reference***: *community screening/CAST+, contact investigation, and same-day treatment start—see SO1 & SO3 in the NSP*
	High-dependence care for critically ill TB patients	• Establish and functionalize TB HDU 'bundles' at national/regional referral and phased district hubs (reliable oxygen supply, oximetry, suction, basic monitors, rapid labs, clear transfer pathways) • Annual competency-based training & mentorship for physicians, interns, nurses and clinical officers in TB critical care bundles (triage, oxygen/airway, fluids, advanced HIV disease package, nutrition, appropriate corticosteroid use per guidance) • Institutionalize monthly mortality and near-miss reviews with QI action loops; track risk-adjusted CFR, time-to-diagnosis, time-to-treatment and oxygen uptime on dashboards • Adopt and disseminate a simple prognostic/early warning score; embed in triage registers and EMR for automatic flags and fast-track management
	Fix the basics that drive deaths: diagnostics, oxygen and medicines	• Clear equipment service/maintenance backlog using funded regional workshops, KPI-based vendor contracts and spare-parts pools • Eliminate stock-outs (cartridges, LF-LAM, PPE, triple packaging) via national/regional buffer stocks (≥3 months), emergency order lanes at NMS/JMS, and facility stock-out alerts tied to supervisory action • Maintain oxygen uptime ≥95% with preventive maintenance, backup options and daily logs reviewed in mortality meetings

	Integration with HIV, DM/HTN, mental health, nutrition, and chronic lung disease	• Reference S.O. 4.3 for TB/HIV integration • Implement multimorbidity screening and timely linkage to care
SO4.5 Treatment success rate for Drug resistant TB increased from 85% to 90% by 2029/30	Increase access to DR-TB initiation	• Build health worker capacity for health workers including refresher trainings, mentorship (includes tele mentoring), • Decentralize services to high-burden districts focusing on General Hospitals, PNFPs, and HC IVs in districts without hospitals, including treatment initiation • Strengthen the scale up of shorter all-oral regimens (e.g., BPaLM/BPaL); select regimens using rapid and comprehensive DST (Xpert MTB/XDR, LPAs, culture-based DST as needed) • Institutionalize weekly tracking of time from RR-TB result to treatment start; target same-week initiation for ≥90% of patients • Strengthen aDSM, treatment response monitoring, and Cohort Event Monitoring (CEM): train regional teams; use a national PV database; routine analyses and feedback with NDA; annual supervisory visits • Provide buffer laboratory monitoring logistics to support aDSM among DR-TB patients • Update regimens, quantification and diagnostic algorithms using DRS results • Quarterly mortality audits within program reviews using a standard tool; implement QI actions with follow-up mentorship • Strengthen critical care management areas for admitted critically ill DR-TB patients • Increase engagement with CSOs at all levels • Strengthen the multidisciplinary approach to MDR-TB management • IPC package for DR-TB sites: triage and separation, ventilation, respirators; institutionalize annual TB screening for HCWs; periodic IPC audits; targeted mentorship for prisons and refugee settlements • Initiate mentorship of lower-level follow-up facilities to detect recurrence after successful treatment and to standardize post-treatment surveillance

	Strengthen DR-TB patient support mechanisms	• Provide enablers/incentives (food for patient's HHs, transport for the patients, vouchers where appropriate) prioritizing high-risk patients; • Deploy differentiated service delivery (DSD) for DR-TB with community-based models (CSOs/VHTs/CHEWs/CBOs); integrate community DOT, sample collection, and medicine refills for stable patients • Scale-up digital adherence technologies (DAT) including VDOT for DR-TB cohorts; integrate adherence dashboards into facility cohort reviews • Mental-health and psychosocial support; engage successfully treated DR-TB 'champions • Conduct cohort reviews to strengthen patient retention and improve treatment outcomes • Provide disability support/occupational therapy to patients • Evidence-based programming and continuous improvement of service delivery through operations research.
	Improve patient education and empowerment	• Ensure up-to-date multilingual IEC packs for DR-TB in public and private facilities; include timelines, side-effect red flags and emergency contacts • Train counsellors in DR-TB services and structured adherence counselling; leverage peer groups/hotlines • Make patient education a standard step in each visit (checklist in card/register) • Develop and implement a comprehensive nutritional and socio-economic literacy plan for DR-TB patients to support treatment adherence and overall well-being • Prevent cross-border loss of DR-TB patients

	Address System gaps with digital tolls and CQI	• Renovate and upgrade at least four DR-TB wards to enhance specialized care and infection control • Eliminate stock-outs of SLDs and diagnostics through ≥3-month buffer stocks, KPI-based service/maintenance contracts and rapid emergency order lanes (NMS/JMS) • Improve documentation and data harmonization (eCBSS/EMR, LabXpert connectivity); maintain cohort review dashboards and exception lists for RR-TB not yet initiated • Follow up all DR-TB contacts for 24 months; use available data to evaluate prophylactic treatment effectiveness
	Improve TB-associated disability (PTLD) care	• Strengthen the capacity of health workers to assess Quality of Life (QoL) at the end of treatment and 6–12 months post-treatment; • Link patients with post-TB lung disease to pulmonary rehabilitation/long-term care where available

4.1.4 Promoting care seeking and Leprosy prevention in the community and accelerating diagnosis



Thematic gap. People not accessing the health system

1) Grade-2 disability (G2D) at diagnosis remains high: 24% (2024/25)
2) Household contact tracing reaches only 67% of contacts
3) Single-dose rifampicin (SDR-PEP) given to just 55% of eligible contacts

Strategic objective SO5 To reduce the proportion of Leprosy notifications that are children from 17% to 3% by 2029/30

Table 7. Strategic Objective S05

Outcome targets	Strategic objectives	Activities
SO5.1 The number of districts reporting zero new autochthonous leprosy patients increased from 116 (79%) to 132 (90%)	Enhance Community awareness by integrating leprosy information in community interventions	• Conduct targeted community sensitization in hotspots, border districts, and learning institutions (link to CAST+ outreach); run periodic radio and TV talk shows in local languages; social media campaigns; provide referral hotlines • Commemorate World Leprosy Day with district-led campaigns that include testimonies from champions/survivors and CSOs • Design, print, and disseminate tailored IEC/BCC materials (including pictorial aids for early symptoms, self-care, and stigma reduction) • Engage persons affected by leprosy as change agents in stigma-reduction and peer support • Integrate anthropological expertise to address myths/misinformation and improve caregiver health-seeking; engage local influencers and people affected by leprosy as champions
	Maximize contact tracing and post-exposure prophylaxis (PEP)	• Implement systematic household and neighborhood contact screening for every index case; prioritize child contacts and neighbors in overcrowded settings • Provide single-dose rifampicin PEP (SDR-PEP) to all eligible contacts after exclusion of disease; maintain buffer stocks at district level
	Strengthen early detection, diagnosis and referral	• Refresh skills of frontline clinicians, dermatology/NTD focal persons and laboratory staff on recognition of cardinal signs, use of slit-skin smears where indicated, and differential diagnosis of common skin conditions • Establish fast-track referral pathways from private clinics, drug shops and traditional healers to DTUs/MDT sites • Provide simple photo-based decision aids and job aides at OPD, HIV, RMNCAH, and diabetes clinics • Expand early detection through integrated establishing or designating skin clinics in facilities in high-endemic districts (starting with RRHs and HCIVs), with clear standard operating procedures (SOPs) for triage, slit-skin smear where indicated, reaction management, and referral

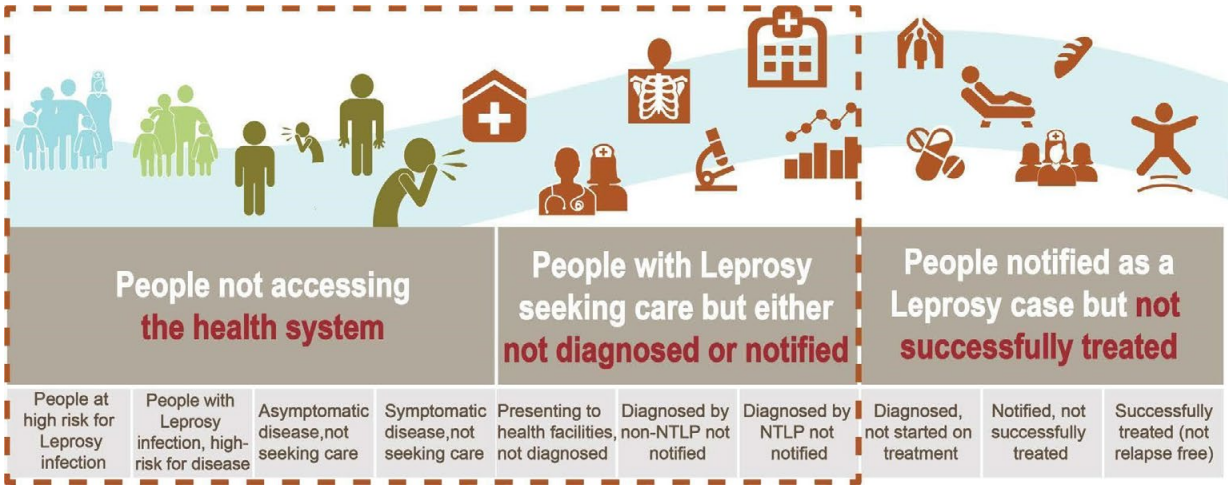
	Tighten surveillance, classification and zero-reporting	• Digitize all leprosy notifications in eCBSS and ensure linkage with DHIS2; capture contact screening and PEP completion fields • Map hotspots and cross-border corridors and use CAST+/community campaigns to saturate screening in those areas • Introduce simple event-based surveillance (e.g., cluster alerts in schools/prisons) with rapid investigation • Strengthen cross-border and special-setting surveillance
	Prevent disability and reduce stigma	• Scale up self-care training, provision of protective footwear and assistive devices; strengthen referral to reconstructive surgery, physiotherapy, and socioeconomic support schemes • Integrate mental health and psychosocial support;
	• Strengthen governance, financing and partnerships	• Adapt MAF-TB structures to include leprosy accountability at regional and district levels; assign clear roles to DHTs, DTLS and CSOs • Integrate leprosy screening/referral into private sector platforms through engaging PFP and PNFP providers • Mobilize domestic funds to sustain outreach, contact tracing, and footwear provision;
SO5.2 The number of new and relapse leprosy patients detected annually reduced from 242 to 50	Active case finding (ACF) with rigorous contact management and integration of leprosy detection in community health interventions	1. End-to-end contact management with chemoprophylaxis (SDR-PEP) including systematic identification, line-listing and screening of contacts 2. CAST+ campaigns with embedded leprosy modules 3. Community engagement involving the private sector, informal health providers, school health programs, and other programs targeting congregate settings

SO5.3 The proportion of child leprosy patients reduced from 17% to 3%	Child-focused active case finding (ACF) and verification	• Verify every child leprosy case (case audit within 2 weeks) and conduct rapid epidemiological investigation (home, school, congregation points) with mapping of exposure networks • Organize school health leprosy awareness and screening campaigns at start-of-term and mid-term in hotspot districts; train focal teachers and auto-refer positives • Bundle ACF with other skin NTD services and child health days; ensure same-day referral or tele-dermatology consult where available
	Child-focused active case finding (ACF) and verification	• Verify every child leprosy case (case audit within 2 weeks) and conduct rapid epidemiological investigation (home, school, congregation points) with mapping of exposure networks • Conduct house-to-house and hotspot screening in parishes/communities reporting child cases or clusters; line-list all contacts and symptomatic neighbors for evaluation • Organize School Health leprosy awareness and screening campaigns at start-of-term and mid-term in hotspot districts; train focal teachers and auto-refer positives • Bundle ACF with other skin NTD services and child health days; ensure same-day referral or tele-dermatology consult where available
	Ensure commodities, quality and safety	• Ensure uninterrupted MDT, rifampicin supplies, and ancillary medicines (for SDR-PEP under SO5.2) via integrate ordering into TWOS/DHIS2 logistics modules, quarterly quantification, last-mile tracking and rapid replenishment for campaign bursts • Embed pharmacovigilance for MDT/SDR-PEP and establish AMR testing pathways for relapses and selected multibacillary cases

SO5.3.1 The proportion of contacts of Leprosy patients given single dose Rifampicin preventive therapy increased from 55% to 90%	Enhanced contact management with chemoprophylaxis (SDR-PEP)	• Screen contacts and provide administer SDR-PEP to all eligible contacts on the same day (or within 7 days) where feasible • Set quarterly district targets for contacts identified, eligible, and receiving SDR-PEP; implement catch-up plans where coverage <90% ***References:*** *Leverage contact-tracing systems under SO5.2/SO5.3 and TB contact investigation platforms under SO2.1 and SO2.3.*
	Service readiness and uninterrupted supply for SDR-PEP	• Quantify SDR-PEP needs using contact line-lists; maintain minimum stock levels of rifampicin (adult/child dosing) and job-aids at DTUs, HC IV/III and outreach teams • Issue simple dosing charts and pre-packed dose kits; include tools for eligibility screening, consent, AE reporting, and recording in eCBSS/DHIS2 • Schedule integrated mentorship/supervision for DTLS/DTUs and outreach teams; track SDR-PEP wastage, stock-outs and last-mile delivery times ***References:*** *Refer to Supply Chain Management actions under SO6 and laboratory/ diagnostic logistics under SO3/PMDT sections of the NSP*
SO5.3.2 Leprosy household contact tracing increased from 67% to 90%	Universal, timely contact tracing for every new index case	• Conduct household visits for symptom screening, skin exams and patient education; provide on-site counselling and schedule follow-ups for contacts not found on first visit • *Implement* catch-up plans to close gaps
	Continuous quality improvement and learning	• Track tracing timeliness, coverage and yield by parish; implement monthly CQI huddles with corrective actions for low-performing areas • Commission operations research on optimal strategies (household-only vs. household + neighbors; ring vs. blanket tracing) and digital nudges (SMS reminders) ***References:*** *Research priorities and pharmacovigilance reporting — see SO6*

SO5.3.3 The proportion of leprosy patients presenting to health facilities with Grade 2 disability at the time of diagnosis reduced from 17% to 5%	Prevent and manage disability	• Early detection through integrated skin-NTD outreach and active surveillance • Expand rehabilitative services and self-care • Address social and behavioral drivers of diagnostic delay
	Streamline referral pathways and reduce access barriers	• Map and publicize regional referral points that can manage reactions, provide wound care, protective footwear and assistive devices, and arrange reconstructive surgery/physiotherapy where indicated • Adopt standard referral/feedback forms and clinician-to-specialist consultation digital platforms; monitor referral completion and turnaround time

4 1.5 Promoting appropriate Leprosy treatment and ensuring cure



Thematic gap. People notified as a Leprosy case but not successfully treated

1) Treatment Success Rate for MB leprosy patients is high at 91% (2024)
2) 72% of Leprosy patients in need of protective wear receive them (end 2024)
3) 3. Only 65% of persons affected by leprosy access self-care support (end 2024)

Outcome targets	Strategic intervention	Activities
SO5.4 The proportion Leprosy treatment completion increased from 91% to 95%	Strengthen patient tracking and differentiated follow-up to improve retention in care	• Implement an end-to-end patient tracking system using eCBSS/DTU registers (appointment reminders, missed-visit flags, and VHT-triggered home visits) • Conduct phone and home visits for all missed appointments and for patients at risk of loss to follow-up (e.g., reactions, migration, long distance) • Leverage community structures (VHTs, self-care groups) for adherence support, transport reimbursement where appropriate • Introduce simple defaulter tracing dashboards at district level and review monthly • Ensure uninterrupted supply of MDT and ancillary medicines
	Equip health workers with adherence counselling skills and early management of complications	• Provide modular training on intensive adherence counselling for all MDT providers and integrate job aids (treatment calendars, side-effect prompts) • Train on recognition and management/referral of reactions and neuritis to prevent treatment interruption • Provide brief mental health/psychosocial support modules and referral directories
	Improve documentation and quality assurance of treatment outcomes	• Conduct quarterly cohort reviews of enrolled patients and incorporate leprosy outcomes in triangulation meetings • Print and distribute updated HMIS/leprosy treatment cards; ensure outcomes are captured in eCBSS and DHIS2 • Introduce routine data quality audits for leprosy registers at DTUs
SO5.6 Leprosy patients in need of protective wear who are provided with footwear increased from 72% to 90%	Fix last-mile supply: quantification, procurement and timely distribution of MCR footwear	• Strreamline production and delivery system for MCR sandals/shoes with clear SLAs and turnaround-time targets

	Standardize eligibility, fitting and replacement	• Conduct foot assessments/foot-mapping at baseline and at scheduled follow-ups to determine need and size • Provide fitting and user education, plus a replacement schedule (e.g., every 12–18 months or earlier if worn) • Bundle gloves/assistive devices for those with hand neuropathy; provide basic repair kits where feasible
	Link footwear to self-care and rehabilitative services	• Make footwear provision contingent on enrolment/participation in self-care groups where available • Refer eligible clients to physiotherapy/eye care and reconstructive surgery as indicated
	Mobilize partnerships and resources	• Engage UNALEP, ILEP members, GLRA and district governments to co-finance footwear and self-care packages • Link self-care groups to IGAs and social protection schemes for sustainability ***Reference**: See SO5.3.3 (self-care), SO1–SO3 (community systems and ACSM), and SCM sections for cross-cutting supply chain actions*

4.2 POLICIES AND SUPPORT SYSTEMS

Strategic Objective SO6. **To build effective and efficient systems that ensure quality, equitable and timely TB and Leprosy services**

4.2.1 Achieving Universal Health Coverage and social protection including nutrition

Gap.

1) Catastrophic costs remain very high: 53.1% of TB-affected households spend ≥20% of annual income on TB care—well above the End TB target of 0% by 2030
2) Patient costs per episode remain substantial: about USD 396 for DS-TB and ~USD 3,722 for MDR-TB
3) Social protection coverage is negligible: under 4% of TB-affected people report receiving any TB-related social support
4) Non-medical expenses drive hardship: transport, nutrition and food account for the largest out-of-pocket costs despite free testing in public facilities

Table 8. Strategic Objective S06

Outcome target	Strategic interventions	Activities
The proportion of households facing catastrophic costs reduced from 53.1% in 2025/26 to 0% by 2029/30	Expand Social Protection & Financial Enablers for TB-Affected Households	• Extend food and transport support beyond DR-TB to DS-TB patients based on vulnerability screening; standardize an 'enabler package' (cash/voucher/food) • Integrate/ Institutionalize social welfare assessments into routine TB services and linkage to appropriate social support including community health insurance and, once operational, to the National Health Insurance Scheme (NHIS) benefits; • Establish formal bi-directional referral pathways between health facilities and existing social protection programmes (e.g., SAGE, UWEP, YLP, PDM), with named focal persons and service directories • Engage employer and employee associations to adopt workplace TB policies: non-discrimination, paid sick leave, flexible duty and return-to-work plans; include TB in occupational health services • Leverage CSOs and community structures to connect households to income-generating activities and savings groups (VSLA); include post-TB livelihood support • Conduct another patient centred catastrophic cost survey to better understand the status of costs involved or averted ***References:*** *SO1 Community systems; SO4 Case holding/patient support; SO6 UHC & social protection*

	Earlier, Decentralized & Patient-Centered Care to Cut Time and Travel Costs	• Guarantee same-day WRD testing at DTUs and a TAT of 2 days for DTUs without onsite testing; expand mobile X-ray with CAD and outreach screening linked to on-site Xpert or rapid specimen transport • Remove patient fees for chest X-ray in public facilities; contract PNFP/PFP facilities to provide CXR and WRD at no cost to patients (reimbursed via MoH/NHIS) • Strengthen the hub specimen referral system and monitor patient-important turnaround time (sample collection → clinician result → treatment start) with district dashboards • Scale up eCBSS, LabXpert connectivity and automated alerts to reduce missed follow-up and expedite linkage to treatment • Expand decentralized DR-TB initiation/monitoring and maintain enablers (transport, food) to reduce long-distance travel; transition to differentiated follow-up using VDOT/pillboxes where feasible • Undertake continuous maintenance & service contracts for diagnostic equipment and ensure uninterrupted supplies to avoid costly repeat visits ***References:*** *SO2 TB prevention & screening; SO3 Diagnosis; SO4 Treatment; PPM activities under SO3.2.*
	Prevent Disease and Recurrence to Avert Household Costs	• Scale TB preventive treatment (TPT) among eligible contacts and PLHIV; integrate with private sector outlets per PPM strategy • Strengthen household contact tracing with integrated TB/leprosy screening and single-dose rifapentine/isoniazid where policy allows; align with SDR-PEP for leprosy where relevant • Integrate nutrition assessment, counselling and support for undernourished TB patients; link to local food security and livelihood programmes • Strengthen TB/HIV collaborative activities, IPC in health facilities, and post-TB care (including mental health and lung health) to reduce catastrophic sequelae ***References:*** *SO1 Community prevention; SO2 TB prevention; SO3.1 Contact investigation; SO4 Post-TB care*

	Health Financing & Insurance Integration for Financial Risk protection	• Define an explicit TB benefits package for NHIS/community insurance (diagnostics, treatment, follow-up tests, transport vouchers for vulnerable clients) • Leverage • Create a budget line for TB enablers & social protection in the NTLP and integrate into MoFPED MTEF; explore domestic co-financing with districts • Contract and reimburse PNFP/PFP providers for TB services within the PPM framework, tied to reporting in DHIS2/eCBSS and quality metrics • Adopt performance-based contracting for mobile outreach and specimen referral to incentivize shorter TATs and higher linkage-to-treatment rates • Cost and periodically re-cost the 'enabler package' using updated patient-cost data; adjust benefits to stay on track for the 20% target **References:** *SO6 UHC/health financing; PPM under SO3; M&E under SO6/NSP*
	Governance, Data & Accountability (CRG & MAF-TB)	• Update the national TB CRG/MAF-TB plan to explicitly include social protection actions, roles (MoGLSD, MoFPED, MoPS, MoL) and district accountability • Integrate social-protection indicators into the NTLP results framework (proportion receiving any social support; median out-of-pocket costs; catastrophic-costs %) • Repeat the TB Patient Cost Survey in 2027 and 2029/30; conduct annual rapid facility-based cost monitoring to course-correct • Institutionalize community-led monitoring with PLHIV/TB networks to track fees, stock-outs, transport barriers, stigma and workplace discrimination • Issue guidance on workplace TB policy and anti-discrimination, including appeal mechanisms and legal aid referrals • Advocate for the institutionalization and mainstreaming of TB in sectoral planning and reporting frameworks. • Strengthen subnational governance and coordination structures to plan and budget for TB intervention. • Advocate for increase domestic financing to reduce external funding dependence for expanding coverage in social protection • Develop comprehensive monitoring systems to measure progress in coverage of social protection services (M&E team) ***References:*** *SO6 M&E and CRG; SO1 Community systems; governance arrangements in NSP*

4.2.2 Strengthening TB and Leprosy Laboratory systems management

Gap.

1) Low coverage of TB diagnostic services (only 27% of DTUs are equipped with WHO-recommended molecular testing platforms (GeneXpert or TrueNat)

Objective. To increase access to timely and quality laboratory services

Outcome Targets	Strategic interventions
1. 90% of notified new and relapse cases tested using WHO-recommended TB rapid diagnostic test (WRD)	Scale up WRD coverage by equipping all DTUs with GeneXpert or TrueNat and training staff in their use.
2. 90% of notified new and relapse TB cases with bacteriological confirmation	• Strengthen sample referral networks and ensure universal access to sputum testing with WRDs
3. 90% of notified, bacteriologically confirmed TB cases with DST for rifampicin	• Integrate reflex DST testing for all Xpert-positive TB cases at point of diagnosis
4. 100% of notified, rifampicin-resistant TB cases with DST results for Fluoroquinolones and second-line drugs	• Expand line probe assay and sequencing capacity in reference labs to cover all RR-TB cases
5. 90% of laboratories participating in EQA for microscopy and GeneXpert	• Institutionalize quarterly EQA panels and mandatory feedback mechanisms for all labs
6. 90% of laboratories not reporting stock out of microscopy and GeneXpert reagents	• Strengthen supply chain monitoring with buffer stocks at regional hubs
7. 90% of accredited laboratories with microscopy and Xpert on their scope of accreditation	• Support accreditation processes and mentorship to include WRDs under laboratory quality standards
8. 100% of DST laboratories demonstrating proficiency for EQA for all DST methods performed	• Conduct regular proficiency testing and targeted mentorship for DST laboratories
9. 90% of DR-TB patients with resistance to second-line drugs and culture positive at month 4 tested by sequencing	• Scale up sequencing platforms and ensure timely referral of culture-positive samples from treatment sites
10. 90% of laboratories with errors in either microscopy or GeneXpert (or both) which receive support	• Implement routine on-site supervision and corrective training for labs with persistent errors
11. 100% of testing sites with a WRD with a data connectivity system that transmits results electronically to clinicians and NTRL/NTLP	• Achieve full digital connectivity of all WRD sites to clinicians and NTRL/NTLP through interoperable electronic systems

4.2.3 Strengthening Supply Chain Management

Gap.

1) 8% of facilities report stock out of anti-TB medicines in 3 months prior to assessment
2) 18% of diagnostic treatment units report stock outs of TB supplies in 3 months prior to assessment

Objective. To increase availability and access to TB and Leprosy medicines and supplies

Outcome target	Strategic interventions	Activities
SO6.2 The percentage of treatment unitsreporting no stock outs of anti-TB medicines increased from 82% to 95%	Strengthen quantification, ordering and inventory management for anti-TB medicines	• Update national quantification and supply plans twice per year; hold quarterly pipeline review calls with NMS/JMS and partners • Upgrade and fully deploy eLMIS to all treatment units, including shelf-life tracking and near-expiry alerts; train store managers and DTLS to use dashboards • Institutionalize district-led stock audits during integrated support supervision; implement OTIF (On-Time, In-Full) delivery KPIs • Provide standardized dispensing and dispensing-log books to improve traceability at patient level; reconcile monthly with stock cards • Operationalize facility-to-facility redistribution using clear triggers (min–max levels) and transport arrangements coordinated by DHT
	Build human resource capacity for TB commodities management	• Conduct national and regional trainings/ mentorships for pharmacy and clinical teams on ordering, stock monitoring, and new treatment regimens (including pediatric and DR-TB) • Empower district leadership to enforce timely eLMIS order submission and data quality checks; provide job aids and help-desk support • Sustain Medicines Management Supervisors (MMS) and SPARS mentorships with quarterly visits focused on TB commodities
	Increase visibility, accountability, and patient-level continuity of supply	• Publish monthly national and sub-national stock status and consumption bulletins for key molecules (e.g., BPaLM, paediatric FDCs, pyridoxine) • Introduce periodic (e.g., quarterly) cycle counts and reconciliation at facilities with variance investigation and corrective actions • Maintain emergency buffer stocks (≥3 months) for first-line medicines at national warehouses; define clear draw-down rules • Strengthen direct delivery arrangements to accredited PNFP and selected PFP facilities to reduce last-mile gaps

SO6.3 The percentage of diagnostic and treatment units reporting no stock outs of TB laboratory supplies (reagents, consumables) increased from 88% to 95%	Stabilize supply of TB reagents and consumables across the network	Quantify GeneXpert cartridges (Ultra and XDR), MGIT/culture, sequencing, LF-LAM and biosafety consumables using consumption + morbidity + algorithm changes; review quarterly Establish national buffer stock levels (≥3 months) for priority reagents at NMS/JMS and NTRL with first-expiry, first-out (FEFO) controls Standardize pack-size reporting and ordering units across tools; update eLMIS forms to prevent unit-of-measure errors Track reagent shelf-life and temperature excursions; implement near-expiry re-allocation with automated alerts
	Improve laboratory logistics execution and connectivity	Expand LabXpert/data connectivity to all WRD sites; integrate with LIMS/eLMIS to auto-populate consumption and stock reports Implement service & maintenance contracts with KPIs for analyzers; monitor uptime and parts availability Strengthen specimen referral (hub system) with end-to-end tracking of samples and results; monitor TAT for mWRD and culture/DST Integrate PNFP/PFP labs into national ordering and distribution, including direct delivery where feasible
	Build workforce capacity for laboratory supply management	Cross-train clinical and lab staff on ordering cycles, minimum stock levels, and use of updated diagnostic algorithms Mentor DR-TB sites on planning for monthly monitoring tests and second-line DST commodities to avoid routine stock-outs

SO6.4 Funding gaps for TB commodities and supplies reduced from 18% to 5%	Close the financing gap for TB commodities and supply chain activities	• Develop and adopt a costed NTLP Resource Mobilization Strategy and Investment Case; align to MoH Strategy and NDP IV • Conduct annual resource mapping (GoU, Global Fund, PEPFAR, PNFP, private sector) and publish biannual funding-gap analyses • Synchronize donor and GoU disbursement schedules with quantification outputs; share procurement plans with funders before funding windows • Advocate for increased domestic allocations (including PHC and PNFP grants) and explore innovative financing (results-based purchasing, structured CSR) • Pursue policy options to allow direct sourcing from manufacturers or local agents for priority TB commodities; expand local manufacturing where feasible
	Strengthen financial governance and partner alignment	• Institutionalize quarterly financial performance reviews with MoFPED/MoH Planning on absorption and execution rates, issue corrective actions • Consolidate partner AOPs into a single 'One-NTLP' plan with geographic and budget alignment, minimizing duplications and unfunded gaps
SO6.5 Procurement lead-time reduced from 10 months to 6 months	Compress end to end procurement lead-times to ≤6 months	• Adopt rolling forecasts and early ordering calendars tied to donor cycles; use framework agreements/long-term agreements with call-offs • Seek PPDA waivers or special arrangements for offshore direct sourcing of critical TB commodities when market conditions justify • Activate fast-track port clearance (target <7 days) and pre-shipment quality assurance to reduce delays • Use consolidated shipping and pre-positioning for time-sensitive reagents (e.g., Xpert cartridges, sequencing kits) • Operationalize a national procurement & pipeline tracker with stage-gates (tendering, manufacturing, shipment, clearance, delivery) and public dashboards

	Optimize warehousing and distribution to cut turnaround time	• Leverage interconnected warehouse platforms (e.g., NMS CSSP ERP; JMS online ordering) for faster order processing and visibility • Define and monitor OTIF delivery and average lead-time KPIs by region; implement corrective actions with NMS/JMS and transporters • Prioritize procurement of high-throughput diagnostic equipment to reduce bottlenecks that cause downstream delays (e.g., cartridge shortages)

4.2.4 Community Systems Strengthening

Reaching the community with services and ensuring timely, equitable service delivery will require building strong and resilient community systems that will help to address gaps in coverage and access. Strengthening community interventions will call for strategic partnerships and integration with HIV and Malaria and other programs to maximize efficiency, while achieving scale as well as leveraging on the support from such programs. Strategic collaboration will include but not limited to; (i) maintain integration of TB data elements in HIV data collection and reporting tools including HIV screening and testing tools, (ii) inclusion of TB in the mandate of the district and sub-district AIDS committees, (iii) inclusion of TB treatment support and follow up in the roles of the community support agents, (iv) integrated selection, training, mentorships and support supervisions for community human resources, (v) inclusion of TB in the HIV and Malaria service packages like the drop-in centres, ICCM, the integrated service delivery models etc. (vi) as well as the involvement of the national HIV coordination mechanisms including for the private sector. Below are the specific interventions for strengthening community systems to support the TB response.

Figure 5. Strategies for strengthening community system for TB and Leprosy control

4.2.5 Human rights and gender

Uganda continues to face persistent equity and human rights barriers in TB and leprosy care, particularly among key and vulnerable populations such as people living with HIV, prisoners, urban poor, and hard-to-reach rural communities. A recent national assessment highlighted that stigma, discrimination, and gender-related barriers continue to limit access to timely diagnosis and treatment, with women and children often experiencing delayed care-seeking and reduced access to preventive therapy. The National Plan for Achieving Equity in Access to HIV, TB and Malaria Services (2020–2024) has provided a strong foundation for addressing these barriers. Its principles are being carried forward into the new NSP, emphasizing the integration of human rights, gender equity, and stigma reduction in TB and leprosy programming. The NSP 2025/26–2029/30 will prioritize:

- Expanding equitable access to TB and leprosy services for marginalized and high-risk groups
- Strengthening gender-responsive programming to address disparities in service uptake
- Implementing stigma-reduction interventions at community and health system levels
- Ensuring patient-centered care that protects human rights and promotes dignity for all affected persons.
- This approach aligns with Uganda's commitments to the WHO End TB Strategy, the 2023 UNHLM Declaration, the Leprosy Strategy and the country's broader equity and human rights agenda

Outcome target and strategic interventions to improve equity in TB and leprosy care

Outcome target	Strategic interventions
Stigma and discrimination among TB patients reduced from 53.7% to 10% in 2029/30	**Cross-Cutting Interventions** • Finalize, launch and disseminate a National Anti-Stigma & Discrimination Policy covering TB and key/vulnerable populations • Embed human-rights, gender and disability perspectives across TB programming and national policies/guidelines • Run a sustained national multimedia TB literacy campaign with tailored content for key and vulnerable populations • Institutionalize community-led monitoring (CLM) of stigma, rights violations and patient experience; integrate findings into district/facility quality improvement • Track stigma through integration of indicators on stigma, human rights and gender in HMIS/DHIS2/eCBSS

	• Align with the End TB Strategy principle to protect and promote human rights, ethics and equity **Health Systems Interventions** • Reinforce pre-/in-service training on Patients' Charter, non-discrimination, confidentiality and respectful care for all cadres • Provide inclusive service capacity for persons with disabilities, including the blind and deaf • Integrate mental health support and self-stigma reduction into TB/HIV services and community follow-up • Establish patient feedback mechanisms and grievance redress at facility and district levels, with results integrated into QI processes • Standardize IEC materials (gender-responsive, rights-based) and use radio/outreach/dialogues with district leadership • Mainstream TB services within existing service packages (HIV, malaria, drop-in centres, integrated models) to reduce stigma at entry points **Key Populations Interventions** • Develop male- and youth-focused stigma reduction interventions with tailored messaging and friendly service hours • Engage TB survivors and key/vulnerable population networks as champions and peer supporters • Use quality-assured drop-in centres (DICs) as safe spaces for literacy, screening, referral and adherence support • Strengthen networks of persons with disabilities (PWDs) and equip institutions with referral tools for timely TB care • In prisons and closed settings, train all cadres, improve infection control standards and adopt rights-respecting TB management procedures • Empower settlement and refugee leadership structures to promote TB prevention, care and protection from discrimination

4.2.6 Programmatic management

The National Tuberculosis and Leprosy Programme (NTLP) has continued to build on lessons from the NSP 2015/16–2019/20, which emphasized decentralization of TB services, increased community engagement, and integration of TB and leprosy into the broader health system. These lessons highlighted the importance of improving diagnostic coverage through expansion of mWRDs, strengthening drug supply management, and addressing stigma and discrimination. The program has consistently received technical support from the World Health Organization (WHO) country office, ensuring alignment with the End TB Strategy and global elimination targets. WHO's support has included guidance on adopting rapid molecular diagnostics, updating treatment guidelines, and strengthening surveillance systems. In addition, partners such as the Global Fund, USAID, PEPFAR, KNCV, and FIND have played a critical role in financing TB and leprosy activities, rolling out digital health innovations, supporting active case finding, and implementing community-based interventions. These collaborations, together with lessons from the past NSP 2020/21-2024/25, have shaped the strategic interventions of the new NSP (2025/26–2029/30). The focus is on sustaining diagnostic and treatment coverage, expanding preventive therapy, integrating human rights and gender perspectives, and addressing health system bottlenecks to accelerate progress towards ending TB and leprosy in Uganda.

Strategic Objective SO6. To build effective and efficient systems that ensure quality, equitable and timely services

Outcome Target	Strategic interventions	Activities
SO6.1 Capacity of management of TB & Leprosy services at all levels strengthened	Reconstitute and operationalize coherent governance and coordination mechanisms at national, regional and district levels to align plans, budgets and performance management for TB and leprosy	• Define and approve Terms of Reference (ToRs) for NTLP governance bodies: Programme Steering Committee, Technical Working Groups (diagnostics, case finding, treatment/PMDT, CRG/PPM, M&E), and the Leprosy Desk Committee • Institutionalize TB–Leprosy Coordination Committees (TLCCs) in all districts/cities, chaired by the DHO/City Health. Require quarterly data-to-action meetings, joint supervision plans and an annual coordination scorecard • Publish a 'One-NTLP Partner Compact' annually: align partner geographies, budgets and outputs with the NSP/MoH SP; include a resource map, financing gaps and agreed corrective actions • Integrate TB & leprosy deliverables into RRH performance contracts and PHC supervision plans; ensure joint supportive supervision with NHLDS/NTRL and Supply Chain teams • Establish a policy and SOP document-control portal for all NTLP guidance (algorithms, referral, biosafety, CLM, PPM) with version control and dissemination tracking • Adopt a unified Annual Operational Planning (AOP) calendar and templates for national, regional and district levels; require that partner AOPs are uploaded and consolidated into a single 'One-NTLP' workplan • Create a standing 'Coordination & Performance Huddle'—monthly national dashboard review (eCBSS/DHIS2/LabXpert/LMIS), with action logs cascaded to RTLPs/DTLS • Embed multisectoral links: designate TB focal points in MoES, MoIA/UPS, MoGLSD, OPM/Refugees and KCCA/LGs; sign MoUs with annual plans and reporting formats • Set up a public PPM/CRG forum each quarter to gather feedback from PNFP/PFP providers and people affected by TB/leprosy; feed issues into NTLP decision-making • Update curricula in pre-service training institutions to strengthen child and adolescent TB TB content

		Reference: operational activities in SO1.1–SO5.6 when TLCCs develop quarterly workplans (ACF, diagnostics, treatment/DSD, leprosy disability prevention, PSM).
SO6.1.1 Increased resource envelope for TB and Leprosy	Strengthen financing and resource mobilization for TB & Leprosy	• Develop and approve a costed NTLP Resource Mobilization Strategy and Investment Case, aligned to NDP IV and the MoH SP financing framework • Undertake annual resource mapping (GoU, Global Fund, PEPFAR, WHO, PNFPs, CSR/private sector) and publish a funding-gap analysis to inform reprioritization • Increase domestic financing: operationalize MAF-TB budget lines across priority sectors and advocate for at least 0.1% GoU health spending earmarked for TB & Leprosy coordination and essential operations at national and sub-national levels • Grow external funding: proactively manage proposal pipelines (Global Fund, bilateral donors, philanthropic foundations) and align partner AOPs and geographies to the One-NTLP plan • Institutionalize quarterly financial performance reviews with MoH Planning/MoFPED to track execution rates, absorption, and bottlenecks; issue corrective action memos • Leverage innovative financing: explore results-based purchasing for selected outputs (e.g., eCBSS coverage, TLCC functionality), and structured private sector contributions (PPM, CSR) • ***Reference:—****operational budgets for ACF, diagnostics, treatment/PMDT, leprosy disability services and PSM under SO1–SO5; ensure they appear in the consolidated NTLP AOP*

SO6.1.2 Planning and co-ordination of TB & Leprosy at all levels strengthened	Strengthen integrated planning and coordination at all levels	• Adopt a unified Annual Operational Planning (AOP) calendar and standard templates for national, regional and district levels; consolidate partner AOPs into the 'One-NTLP' plan • Institutionalize TLCCs in all districts/cities with quarterly data-to-action reviews, joint supervision plans, and a coordination scorecard (reference case-finding, diagnostics, treatment, leprosy and PSM activities from SO1–SO5) • Conduct joint performance reviews for TB & Leprosy biannually (national and regional), integrating laboratory, eCBSS/DHIS2 and supply-chain dashboards; issue action trackers • Strengthen multisectoral planning: ensure MAF-TB partners have annual workplans, budgets and indicators; convene biannual accountability forums and publish a sector report card • Coordinate financial and procurement planning with NMS/JMS, NHLDS/NTRL and districts to prevent stock-outs and align diagnostic algorithms, specimen referral and maintenance schedules • Integrate private sector and civil society: quarterly PPM/CRG platforms with feedback loops to NTLP governance; incorporate community-led monitoring findings into AOPs • Embed risk management in planning (HR vacancies, funding delays, TAT bottlenecks) with mitigation actions and escalation protocols.

Partnership with WHO to develop program capacity for policy development, implementation and management

WHO using global, regional and national resources supports countries to close the system gaps by providing sustainable technical support. This support will continue for the TB and Leprosy program and will include capacity for research to inform better programming, and technical capacity for program implementation. Collaboration with WHO will include the following strategic interventions

1) Transfer of resources and technical support by WHO to selected specialized national institutions that are dealing with public health training and management of health services e.g. Medical Schools, Mbale Man-Power Development Centre, Uganda Management Institute (UMI) and Makerere Lung Institute (MLI) and others that may be identified in due course
2) Capacity building by WHO through trainings and technical oversight for conducting research and specialized studies as well as dissemination of findings.
3) Provision of quality mentorship, skills transfer and technical oversight to selected institutions for supporting the scale up proven interventions.
4) Adaptation of global technical guidance to the country context

Advocacy for TB and Leprosy control

Situational Analysis

The implementation of the NSP 2025/26–2029/30 will require enhanced budgetary allocation and the active engagement of all stakeholders in the fight against TB and leprosy. While the previous plan (2020/21–2024/25) registered gains in political and financial commitments, sustaining progress and achieving the new ambitious goals calls for stronger, coordinated, and data-driven advocacy. Evidence from the End Term Review (2025) and the TB Epidemiological Review (2025) shows that Uganda has made strides in expanding diagnostic coverage (e.g., GeneXpert and CXR), treatment coverage (93%), and reducing TB mortality; however, gaps remain in financing, community involvement, and addressing stigma at grassroots level.

Key achievements of previous advocacy efforts

- Secured additional human resources through Government of Uganda (GoU) recruitment, complemented by Global Fund and USAID support
- Budget advocacy contributed to a significant rise in GoU allocations for NTLP, sustaining the operationalization of annual plans.
- Mobilized an additional US$8.5 million from Global Fund Above Allocation Request to support case finding and diagnostic commodities.
- Strengthened coordination via the Advocacy, Communication and Social Mobilization (ACSM) Technical Working Group, linked to the Uganda Stop TB

Partnership

- Enhanced visibility of TB and leprosy in parliamentary debates and integration into the NDP-IV and MoH Strategic Plan.

Priority Gaps

1) Inadequate advocacy for financing community-based interventions, including contact tracing, community outreaches, and stigma reduction.
2) Absence of a structured national advocacy plan, resulting in ad hoc rather than continuous engagements with policy makers.
3) Limited data on the TB and leprosy investment gap, hindering evidence-based advocacy.
4) Minimal involvement of TB and leprosy survivor groups in advocacy efforts, especially at district and community levels
5) Weak engagement of district-level leaders and cross-sectoral actors, limiting local ownership of TB/Leprosy control
6) Underutilization of media platforms and insufficiently tailored advocacy messages
7) Low use of program data to drive advocacy campaigns, despite availability of epidemiological evidence

Strategic interventions

The NSP 2025/26–2029/30 will strengthen advocacy through six interlinked strategies coordinated by the ACSM Technical Working Group under the Uganda Stop TB Partnership with guidance from WHO. These include: (i) Building coalitions with MoH Department of Health Promotion, CSOs, Parliament (including the TB Parliamentary Caucus), NHIS taskforce, cultural/religious leaders, and community actors; (ii) Using data-driven advocacy by quantifying the TB/Leprosy investment gap, opportunity costs, and returns on investment; (iii) Mobilizing political support at national and district levels, leveraging TB champions, survivor groups, cultural institutions, and human rights organizations; (iv) Institutionalizing professional advocacy through development of TB/Leprosy advocacy guidelines, training advocates, and mainstreaming advocacy into MoH/NTLP structures; (v) Expanding TB survivor/patient-led advocacy platforms at community and national levels to strengthen patient voices; (vi) Enhancing advocacy skills among district leaders, CSOs, VHTs, CHEWs, and TB champions; and commemorating national and international TB/Leprosy days.

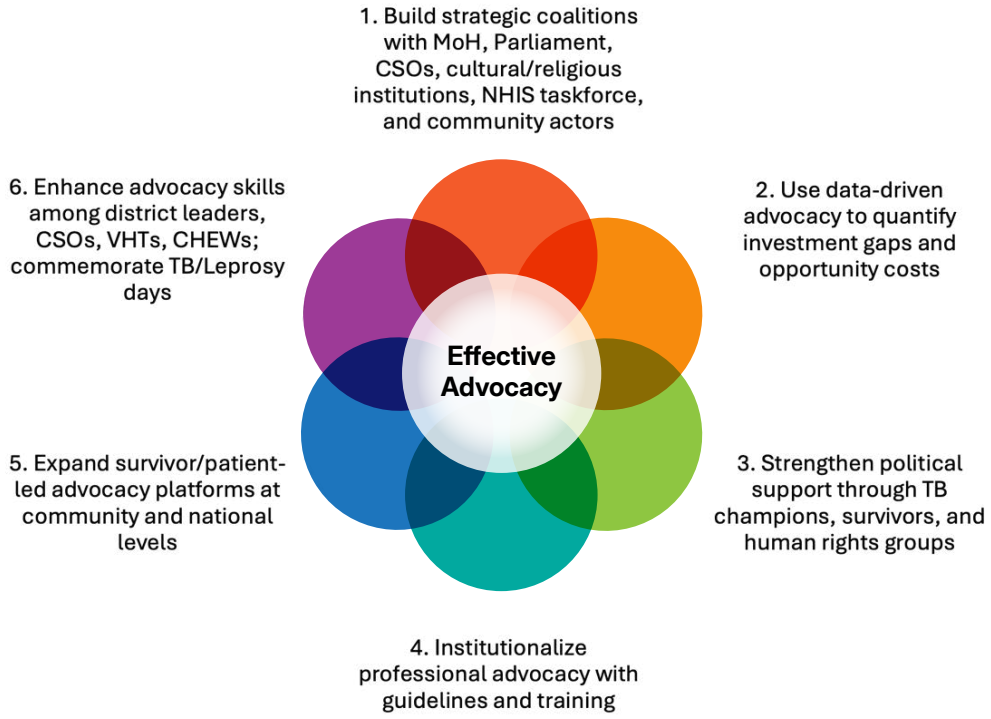


Figure 6. Six strategic advocacy priorities that are to be in focus in the new NSP to Edit.

Multi-sectoral collaboration

The End TB Strategy and the 2018 UN High-Level Meeting underscored the importance of multisectoral collaboration to achieve a 90% reduction in TB deaths by 2030. Uganda has adopted the Multisectoral Accountability Framework (MAF-TB), which highlights shared commitments across government ministries, private sector, and civil society. Despite progress in inter-sectoral dialogues, engagement of private providers and informal health actors remains limited.

Priority Gaps

1) Lack of formalized partnerships between ministries, departments, and agencies for coordinated TB/Leprosy interventions
2) Inadequate involvement of the private sector in TB prevention, case finding, and notification, leading to underreporting
3) Absence of clear incentives and regulatory mechanisms to engage the private sector
4) Weak technical support from district TB teams to private practitioners
5) Limited engagement with informal health providers and community drug outlets despite their large patient volumes

Strategic Interventions for improving multi-sectoral collaboration

To accelerate Uganda's progress towards ending TB and leprosy, the NSP 2025/26–2029/30 emphasizes a stronger multi-sectoral response, building on the Multisectoral Accountability Framework (MAF-TB). This framework was operationalized with clearly defined commitments, monitoring, and reporting mechanisms to ensure that all actors are held accountable for their roles in the response. Coordination of these efforts was institutionalized under the Office of the Prime Minister, enabling high-level inter-ministerial collaboration and ensuring that TB and leprosy control remain a national development priority.

A critical shift in this plan is the deliberate engagement of the national and sub national level including private and informal health sectors. Incentives, training, and supportive regulatory frameworks will be scaled up to expand case notification and improve treatment outcomes. At the same time, district TB and leprosy teams will provide structured mentorship and technical support to private providers, strengthening their capacity to deliver quality services.

Finally, the strategy recognizes that TB and leprosy are not only health challenges but also socio-economic issues. Multi-sector platforms across education, labor, agriculture, justice, gender, and finance will be leveraged to mainstream TB prevention, integrate social protection mechanisms, and reduce stigma. This comprehensive and coordinated approach ensures that TB and leprosy control is embedded within Uganda's broader development agenda, paving the way for sustainable progress toward the End TB targets.

Outcome	Strategic interventions	Activities
Enhanced multi-sectoral accountability and integration of TB and Leprosy in MDAs by 2029/30	Strengthen collaboration with MDAs	• High level engagements with MDAs to strengthen oversight provided by an inter-ministerial committee • Develop annual TB mainstreaming guidelines with OPM, MoH, and NPA • Development of activity-specific multi sectoral collaborative task force to guide implementation • Conduct strategic advocacy engagements at National and Subnational levels *Specific interventions for the various MDAs are included in the Multisectoral accountability framework*
	Capacity building and advocacy	• Train MDA focal persons on TB and Leprosy integration and monitoring • Build advocacy coalitions with CSOs, cultural/ religious institutions, and TB/Leprosy survivors • Organize TB and Leprosy advocacy dialogues with District Councils and traditional leaders. • Organize regional capacity-building workshops for RDCs, CAOs, and District Planners to mainstream TB and Leprosy in district plans and budgets
	Strengthen governance and accountability mechanisms	• Operationalize MAF-TB framework with commitments, monitoring, and reporting • Advocate MDAs to include TB and Leprosy in sector development plans
	Leverage multi-sector financing and partnerships	• Mobilize TB and Leprosy financing through sector budgets and partners • Develop PPPs with industries, construction firms, and transport companies
	Engage USTP to coordinate civil society entities	• Provide ENGAGE-TB training for CSOs • Support district-level private sector coordination mechanisms • Mentor CSOs on M&E, advocacy, and TB and Leprosy integration
	Integrate TB and Leprosy services in non-health sector platforms	• Scale up TB and Leprosy in school health programs and higher institutions • Implement integrated workplace TB screening policies • Expand intensified TB and Leprosy case finding in prisons • Integrate TB and Leprosy -sensitive protection in PDM, SAGE & YLP

	Strengthen engagement of business associations & companies	• Implement workplace TB policies • Conduct workplace screening and awareness campaigns • Engage UMA, Federation of Uganda Employers, and CSR platforms for TB advocacy
	Strengthen engagement of regulatory bodies	• Enforce NDA and UMDPC regulations on TB service delivery • Update pre-service and CPD curricula with TB and Leprosy content • Supervise PNFP facilities through UCMB, UPMB, and UMMB

4.2 RESEARCH AND INNOVATIONS

To achieve the ambitious targets of this NSP and sustain momentum beyond 2025, Uganda will need to adopt and scale new tools such as rapid molecular diagnostics, optimized shorter drug regimens, and future vaccines. The country must also generate evidence to inform implementation, strengthen data systems, and promote operational research. The NTLP will prioritize building capacity in research, innovation, and digital health while fostering collaboration with academic institutions, CSOs, and international partners.

4.2.1 Data for programmatic monitoring and planning

Situational Analysis

Uganda has significantly expanded access to digital data systems, including the electronic Case-Based Surveillance System (eCBSS) and the District Health Information System (DHIS2). By 2024, over 95% of districts were reporting through these systems, with timeliness improving to 83%. However, underreporting remains a challenge, particularly among private-for-profit providers, whose contribution to TB notifications is less than 15% despite serving a large patient population.

The TB DNA 2024 assessment highlighted weaknesses in diagnostics data management, noting delays in turnaround times and poor integration of diagnostic platforms with eCBSS. Meanwhile, the End-Term Review (2025) found that leprosy surveillance remains fragmented, with limited reporting tools and weak integration into the national HMIS.

Community-level data is also underdeveloped: although VHTs and CSOs contribute to case finding and treatment support, their data is inconsistently captured in HMIS and rarely used for planning. Furthermore, there is no dedicated budget for M&E at national and sub-national levels, limiting independent data audits, surveillance strengthening, and operational research.

Gaps

1) Persistent under-reporting and incomplete notification from private and PNFP facilities
2) Limited capacity for advanced data analysis and use among district and facility staff
3) Weak surveillance for leprosy, with inadequate integration into eCBSS and HMIS
4) Insufficient community-level data, especially on interventions, outcomes, and patient costs
5) No independent and sustained budget for M&E and data system strengthening
6) Limited interoperability between diagnostic platforms (LabXpert, CXR AI tools) and surveillance databases
7) Limited operational research and innovation by National Tuberculosis Reference Laboratory (NTRL)

Strategic interventions	Activities
Improve the quality of data	• Support integration and use of standardized digital reporting tools & platforms (e.g., LabXpert, eCHIS, eCBSS, DHIS2 etc.) • Update and display diagnostic algorithms and reporting flowcharts in facilities • Train and mentor health workers, DTLS, and DLFPs in data management, dashboards, and analysis • Include data quality modules in pre-service and CPD curricula • Establish structured feedback loops and quarterly data review meetings • Institutionalize regular Data Quality Audits (DQAs) and facility data-review meetings; include private sector and integrate incentives for timely/complete reporting • Form multi-disciplinary data improvement teams at facilities including private sector • Customise EMR to cater for private and PNFP facilities, pharmacies, and workplace clinics • Introduce performance-based financing and non-financial incentives for reporting • Scale up real-time laboratory reporting (LabXpert, CXR AI tools, DST) with 100% Xpert connectivity by 2027 • Streamline laboratory data to focus on actionable indicators and integrate multi-disease testing

	• Develop interoperable systems linking HMIS, eCBSS, labs, and community digital tools • Work with DHI to ensure connectivity and backup systems in remote areas • Strengthen Knowledge for the data scientists and biostatisticians at national/regional hubs for advanced analytics • Build district-level dashboards (maps, heat plots) to support micro-planning • Introduce digitalized leprosy registers integrated with HMIS/eCBSS • Strengthen reporting on grade 2 disability, contact tracing, and chemoprophylaxis monitoring
Strengthen surveillance for TB and Leprosy	• Adopt a national Unique Patient Identifier (UPI) across eCBSS, DHIS2, LMIS and NIRA to enable end-to-end patient tracking, de-duplication and cohort monitoring • Roll out GIS-enabled surveillance and dashboards for TB and Leprosy to map hotspots, clusters and service gaps; use geo-coordinates at facility and community levels • Integrate laboratory and case-based systems to link diagnostics (mWRDs, culture, DST) with patient records for timely clinical and public health action • Define a national TB/Leprosy minimum data set and standard operating procedures (SOPs) for routine surveillance (data definitions, validation, timeliness and completeness thresholds) • Support Innovations in ML and AI for TB/leprosy
Improve data collection from the community	• Standardize and deploy community TB/Leprosy data tools (paper and digital) aligned to eCBSS/eCHIS to capture screening, presumptives, X-ray, sample referral and outcomes. • Train and mentor CHWs/peer networks on data entry, quality checks and timely reporting; include feedback loops to communities and facilities • Establish routine community data review meetings at health-facility catchment level with actionable dashboards for outreach planning and micro-targeting

Strengthen the research and innovation arm of the NTRL	Strengthen the operational research and innovation arm of the National Tuberculosis Reference Laboratory (NTRL). • Participate in TB operational research studies • Support procurement of reagents, supplies, and operational costs needed for research studies at the NTRL • Publications on TB diagnostic Implementation studies in Uganda • Support the NTRL in conducting webinars to disseminate research findings and guidelines within the TB network • Participation in international conferences to disseminate findings from studies conducted at NTRL Uganda
Establish a vital registration system	• Strengthen linkage between health facilities and NIRA to improve completeness of birth and death registration and enable routine TB/Leprosy cause-of-death analytics • Scale ICD-10/11 coding of causes of death nationwide, with training, audit and data-quality checks; institute verbal autopsy for community deaths • Integrate mortality data into TB/Leprosy surveillance for cohort outcome analyses and excess-mortality tracking • Scale up and strengthen cohort monitoring for patients
Strengthen research arm of the TB/Leprosy program	• Update and fund a national TB/Leprosy operational research agenda (case finding, care cascade losses, pediatric TB, Leprosy surveillance, stigma, private sector reporting) • Hold periodic TB/Leprosy research forums and engagements with stakeholders • Formalize partnerships with academia and research institutes for protocol development, ethics, implementation, and rapid translation of findings into policy • Train program staff in operational research methods and manuscript writing; embed OR into AOPs with timelines and budgets • Publish five journal articles annually
Strengthen implementation of e-TB systems beyond DR-TB	• Complete nationwide roll-out of electronic case-based surveillance (eCBSS) to 100% facilities, public and private, for both DS-TB and DR-TB. • Connect all GeneXpert and other TB diagnostics to a national connectivity platform (e.g., LabXpert/GxAlert/connected LIMS) for real-time result transmission and remote monitoring • Deploy end-to-end interoperability across eCBSS, DHIS2, LIMS and supply chain (eLMIS/NDMS); implement barcode/QR code sample tracking and automated TAT analytics • Implement routine electronic feedback reports and alerts to facilities (missed follow-up, abnormal results, stock-out risks) and monitor performance through dashboards

4.2.2 Research Priorities

To achieve the ambitious NSP targets and accelerate progress towards ending TB and Leprosy, Uganda will prioritize research that directly informs programming, strengthens surveillance, and evaluates innovative tools. The following research areas build on the 2020/21–2024/25 agenda but update priorities based on emerging gaps and recommendations.

Research priorities for the NSP 2025/26 – 2029/30

1) **Population Awareness and Stigma**

   Low awareness and persistent stigma remain major barriers to TB and Leprosy control. Research is needed to better understand community perceptions and to evaluate interventions that reduce stigma and discrimination

   - Conduct national surveys on TB and Leprosy awareness and update the TB & Leprosy Stigma Index, with emphasis on vulnerable populations (children, PLHIV, migrants, urban poor)
   - Assess stigma reduction interventions, particularly community engagement and patient-led advocacy

2) **Equity, Social Protection and Catastrophic Costs**

   Many TB and Leprosy patients experience catastrophic costs and inequitable access to services. Research in this domain will ensure that future programming is pro-poor, gender-sensitive, and integrates social protection interventions

   - Implement equity and gender analyses of TB/Leprosy services to inform pro-poor and gender-responsive programming
   - Evaluate social protection models (integration with PDM, SAGE, YLP) and their impact on catastrophic costs.

3) **Health Systems and Service Delivery**

   Health system inefficiencies and limited engagement of private providers reduce the effectiveness of TB and Leprosy services. Research is needed to evaluate innovative models that improve service delivery and harness digital technologies.

   - Operational research on digital tools (eCBSS, LabXpert, CAD for CXR, AI decision support) for TB/Leprosy surveillance
   - Evaluate public–private mix (PPM) models, including incentives for pharmacies, PNFPs, and private clinics
   - Assess differentiated service delivery (DSD) models for TB/DR-TB/LEPROSY (e.g., community-based DOT, digital adherence technologies)

4) Diagnostics and Case Finding

Despite progress, diagnostic delays and inefficiencies in sample referral systems continue to undermine TB and Leprosy case detection. Research on new tools, technologies, and strategies will improve access to accurate and timely diagnosis.

- Cost-effectiveness studies comparing molecular diagnostics
- Evaluate sample referral networks (efficiency, turnaround time, cost) and integration with other disease programs
- Research on GIS-based hotspot mapping for TB and Leprosy, targeting high-risk populations.

5) Epidemiology and Surveillance

Reliable epidemiological data remain critical for planning and monitoring progress. Research will fill knowledge gaps in prevalence, incidence, and long-term outcomes for TB and Leprosy.

- Conduct the second national TB Burden Estimate and a national and subnational Leprosy prevalence survey by 2027
- Undertake inventory studies to quantify missed TB/Leprosy cases and improve incidence estimation
- Research on TB associated disability and long-term morbidity outcomes Equity analysis of TB services and develop/implement a comprehensive, multi-sectoral action plan to address the findings
- Transmission Trends for Leprosy
- Equity analysis of TB services and develop/implement a comprehensive, multi-sectoral action plan to address the findings

6) TB Resistance and drug resistance

The emergence of drug resistance threatens TB control, and new treatment regimens require evidence on effectiveness and safety. Research will guide regimen selection, pharmacovigilance, and optimization of treatment outcomes.

- Operational research on shorter regimens (BPaL/M, 4-month DS-TB regimens, child-friendly formulations)
- Pharmacovigilance studies on new TB and Leprosy drugs, including adverse event monitoring. Mortality and Vital Registration.

7) Mortality and Vital Registration

Underreporting of TB and Leprosy-related deaths undermines program accountability. Research is needed to validate mortality estimates and strengthen vital registration systems.

- Strengthen mortality surveys using linkage with NIRA, verbal autopsies, and

ICD-10 coding

- Research to validate mortality estimates and causes of death for TB and Leprosy.

8) Prevention and Vaccines

Preventive therapy and vaccine research represent the future of TB and Leprosy elimination. Evidence is required to guide the roll-out of new preventive regimens and ensure readiness for upcoming vaccines

- Evaluate implementation of TB preventive treatment (TPT) regimens (1HP, 3HP, 3HR) including uptake, completion, and adherence
- Support vaccine readiness studies for TB vaccines under trial, and operational research on chemoprophylaxis for leprosy contacts.
- Evaluate and implement skin-based testing (e.g., Tuberculin Skin Test or newer LTBI diagnostics) for latent TB among healthcare workers as feasible
- Prevalence of active latent TB among Health Care workers, and other high groups

9) Child and adolescent TB

- Conduct root cause analysis for missed pediatric TB cases, especially in children under 5 years
- Evaluate implementation of shorter regimens in facilities without CXR.
- Pilot AI-enabled decision support tools for pediatric TB screening and diagnosis
- Assess effectiveness of integrated school-based TB screening models

10) Leprosy

- Why West Nile- Sequencing study?
- Evaluate implementation effectiveness of SDR
- Trends of Transmission of leprosy

11) Study on Climate change

SECTION FIVE.
IMPLEMENTING THE NATIONAL STRATEGIC PLAN 2025/26-2029/30

5.1 IMPLEMENTATION ARRANGEMENTS OF THE NSP

5.1.2 Role of stakeholders

Ending TB and Leprosy requires a whole-of-government, whole-of-society response. Uganda will operationalize a Multisectoral Accountability Framework for TB (MAF-TB) anchored in high-level government stewardship, clear institutional roles, and routine monitoring of jointly agreed commitments. This approach follows the End TB Strategy Pillar 2 (bold policies and supportive systems), Pillar 1 (government stewardship with M&E), and the Global Leprosy Strategy's emphasis on national partnerships, effective surveillance, and rights-based action.

Office of the Prime Minister (OPM) and National High-Level Coordination

- Chair and enforce the MAF-TB: convene inter-ministerial reviews, agree annual targets and accountability compacts, and publish a national TB/Leprosy scorecard
- Resolve cross-sector bottlenecks (financing, HRH, data sharing, regulatory issues) and align MDAs to NDP-IV priorities

Ministry of Health (MoH) / NTLP (Secretariat of the Response)

- Provide overall technical leadership, policy and standards, strategic planning, partner coordination, resource mobilization, programme M&E and reporting
- Integrate TB and Leprosy across service delivery platforms; strengthen e-surveillance and routine data use; commission operational research
- Direct and support implementing departments, councils and partners in line with MoH governance arrangements.

National Health Laboratory & Diagnostics Services (NHLDS)/CPHL/NTRL

- Lead the TB/Leprosy diagnostics network: policy, quality management, supervision and EQA; expand access to rapid molecular testing, CXR/CAD and culture/second-line DST
- Strengthen the integrated sample-referral system, calibration/maintenance, and performance dashboards
- Scale connectivity (e.g., LabXpert) for real-time test monitoring, including private labs, and streamline essential indicators for decision-making

Local Governments (District Councils, DHMTs, DTLS/DLFPs)

- Plan and deliver TB/Leprosy services; implement PPM at district level; supervise public and private facilities; convene quarterly data reviews and community engagement
- Report to the MAF-TB through routine indicators and district compacts

Sector MDAs (examples)

- Education & Sports: implement school health programmes, curricula and stigma reduction
- Gender, Labour & Social Development: workplace TB policies, social protection linkages and community systems
- Internal Affairs/Prisons/Immigration: screening, notification and continuity of care in closed and cross-border settings
- ICT & NITA-U: digital infrastructure, interoperability and unique patient identifier adoption
- Water/Environment; Works/Transport; Agriculture: address risk factors and reach mobile/remote populations through sector platforms

UBOS and NIRA (Statistics and Civil Registration)

- Improve vital registration coverage and cause-of-death coding (ICD-10)
- Enable data linkage with e-TB systems and unique identifiers to improve surveillance and mortality estimates

Supply Chain Agencies (NMS/JMS) and MoH Pharmacy Division

- Lead quantification, procurement and last-mile distribution of quality-assured TB/Leprosy commodities
- Track stock status and expiry; facilitate access for accredited private notifiers
- Implement performance monitoring to reduce downtime of diagnostic equipment and avert stock-outs

Regulatory and Professional Councils (e.g., NDA, UMDPC, UNMC)

- Enforce standards for TB diagnostics, treatment and reporting across public and

private sectors

- Integrate TB into CPD/CME; license and supervise facilities and laboratories

Private Health Sector (PFP and PNFP), Pharmacies and Diagnostic Providers

- Join the national PPM network; notify all cases; participate in sample referral and connectivity; provide quality-assured TB care
- Engage through incentives, contracting and routine supervision to expand coverage

Business Associations and Employers

- Implement workplace TB/Leprosy policies (awareness, screening, referral, treatment support)
- Contribute to social protection and resource mobilization through corporate platforms

Civil Society and the Uganda Stop TB Partnership (USTP)

- Coordinate community and rights-based actions: demand creation, contact investigation support, treatment literacy and patient-led advocacy
- Implement ENGAGE-TB-aligned community systems and represent affected persons in accountability processes

Communities, VHTs and Networks of People Affected

- Lead community awareness, stigma reduction, contact tracing and treatment support
- Organize patient groups and champions to sustain demand and accountability

Academia and Research Institutions

- Conduct prevalence, inventory and drug-resistance surveys
- Undertake implementation research on digital tools, differentiated care, and operational research to inform policy updates

Development and Technical Partners

- Provide catalytic financing, procurement support, and technical assistance for diagnostics, digital systems, HRH, and community systems
- Participate in joint reviews under the MAF-TB and align resources to national priorities.

Accountability and Monitoring

All stakeholders will sign onto the MAF-TB, report quarterly against agreed indicators, and participate in annual joint reviews convened by OPM and MoH. This embeds stewardship, equity and research across the response, fully consistent with End TB pillars and the Leprosy Strategy's partnership and surveillance requirements

COSTING AND FINANCING THE NATIONAL STRATEGIC PLAN

Introduction

The NSP was costed using the integrated health Tool reflecting the resource requirements to meet the aspirations of the program for the various interventions. The cost inputs were derived from an extensive review of the program reports, funding proposal data from surveillance reports data, Operational annual plans among others

The target populations and the services coverage were informed through consultations from the technical working groups the results of the modelling using the integrated health tool.

The unit costs of service were guided by the GoU standing orders for payments, expenditure analysis of the program with country wide coverage. The unit costs of the medicines, drugs, and supplies were drawn from the key suppliers' indicative price indexes and grossed up with the last mile distribution costs.

Resource requirements by strategic objective

The total resource requirement for the NSP is estimated at USD 396 million for the five-year period from 2025/26 to 2029/30. The largest investments are projected under the objectives of TB treatment coverage and treatment success, with major cost drivers including medicines, laboratory supplies, and related expenses. Detailed estimates of resource requirements by strategic objective are provided in the table below.

Table 9. NSP Resource Requirements by Strategic Objective (2025/26–2029/30)

Strategic Objectives	2025/26	2026/27	2027/28	2028/29	2029/30	Total
SO1: Awareness creation	2,249,617	2,081,627	2,081,627	2,041,869	1,770,005	10,224,746
SO2: TB Prevention	7,305,960	7,532,200	7,075,104	7,376,037	7,338,595	36,627,895
SO3: TB Treatment Coverage	31,144,748	29,692,351	32,172,441	32,436,790	33,611,319	159,057,649
SO4: TB Treatment Success	31,947,897	32,358,222	34,355,198	36,944,157	43,330,608	178,936,083
SO5: Leprosy Control	120,898	127,366	114,165	120,632	127,100	610,161
SO6: Systems Strengthening	1,190,618	5,361,340	1,323,101	1,370,478	1,376,804	10,622,341
Grand total	**73,959,738**	**77,153,106**	**77,121,636**	**80,289,963**	**87,554,431**	**396,078,875**

Financing of the NSP

The NSP will be financed primarily by then Government of Uganda with support from key development Partners who include the USG, the Global fund for AIDS Tuberculosis and Malaria, the Germany Leprosy and Relief Agency (GLRA). Financing of the NSP necessitates identification of the financing mechanisms that are able to sustainably raise substantial amount of funds in the short and medium term.

Financing will focus on two goals; i) to mobilize substantial amounts of resources to match expansion in service coverage and bridge the funding gap, and ii) to enhance predictability in flow of funding and improve program efficiency.

In order to achieve the stated goals, the Program will step up efforts to advocate for additional funding from the GoU at the same time deepen its relationships with the external partners in order to seek additional resources to finance the TB and Leprosy national response.

SECTION SIX.
MONITORING AND EVALUATION

The Monitoring and Evaluation (M&E) framework is designed to systematically track progress in implementing activities, achieving results, and meeting national and global targets for TB and Leprosy. The framework responds to gaps identified in the End Term Review, which highlighted persistent weaknesses in data quality, limited capacity for analysis and use at sub-national levels, and inadequate integration of private sector and community-based data. It also builds on global standards under the WHO End TB Strategy and the Global Leprosy Strategy 2021–2030, emphasizing accountability, equity, and innovation.

Coordination and Governance

The National TB and Leprosy Programme (NTLP) will lead the M&E agenda, ensuring coordination across government ministries, development partners, civil society, and the private sector. Oversight will be aligned with the MoH Strategic Plan's results-based approach, with inter-ministerial linkages coordinated by the Office of the Prime Minister. A revitalized NTLP M&E Unit, strengthened with additional technical staff, will oversee resource mobilization for M&E, capacity building, data quality assurance, advanced analytics, and dissemination.

Core Functions

Monitoring and evaluation will include periodic reviews of:

i) Program goals and objectives against NSP outcome and impact targets

ii) Coverage and equity of interventions compared to planned milestones

iii) Status of core indicators along the TB and Leprosy care continua, from prevention to cure and rehabilitation.

iv) Implementation quality of strategic activities and alignment with End TB and Zero Leprosy goals.

These reviews will employ harmonized national indicators as defined in the NSP M&E framework, with periodic updates guided by the WHO-recommended

standards and the Multisectoral Accountability Framework for TB (MAF-TB).

Data Flow, Validation and Use

Data reporting will continue through the **District Health Information System (DHIS2)**, supported by electronic case-based surveillance systems (eCBSS) for TB and integrated Leprosy modules. Reporting will begin at community level through VHTs and health facilities, aggregated at district level, and transmitted to the MoH. Districts and facilities will be capacitated to analyze and use their data for local planning. To address weaknesses identified in the DNA report, data connectivity solutions (e.g., LabXpert, CAD-enabled CXR reporting) will be scaled to all diagnostic sites.

Quarterly regional performance reviews will convene district stakeholders to discuss progress, identify gaps, and agree on remedial actions. Biannual national Data Quality Assurance (DQA) exercises will validate priority indicators and feed into annual performance reviews. Mid-term (2027/28) and end-term (2029/30) NSP evaluations will provide comprehensive assessments of effectiveness, efficiency, and impact.

Strengthening Data Systems

Key reforms will include:

- Adoption of a unique patient identifier to enable longitudinal tracking from diagnosis to treatment outcomes, critical for both TB and Leprosy.
- Deployment of interoperable, end-to-end digital reporting platforms linking laboratory, clinical, and community systems.
- Integration of private sector and community-based reporting, supported by incentives and performance-based mechanisms.
- Regular GIS-based analyses to map case detection, identify hotspots, and optimize resource allocation.
- Building human capacity at all levels, including training District TB/Leprosy Supervisors (DTLS) and focal persons in data analysis, dashboard use, and dissemination.

NSP Reviews

In addition to ongoing monitoring, the NSP will undergo structured reviews:

- **Mid-term Review (2027/28):** to assess trajectory towards 2029/30 targets and refine implementation strategies.
- **End-term Review (2029/30):** to evaluate overall achievements, document lessons, and provide evidence for the post-2030 TB and Leprosy strategy.
- Thematic evaluations may also be commissioned on priority issues such as digital health innovations, public-private mix models, or catastrophic cost mitigation.

Monitoring and Evaluation Framework Matrix

The M&E framework also includes a results matrix summarizing the NSP goal, strategic objectives, outcomes, key outputs, indicators, data sources, means of verification, periodicity, and annualized targets over the five-year plan period.

Monitoring and Evaluation framework for the NSP 2025/26 – 2029/30

Table 11. Monitoring and Evaluation framework for the NSP 2025/26 – 2029/30

Goal	**To reduce the incidence of TB by 6.5% from 198/100,000 population to 185/100,000 and the proportion of Leprosy cases that are children from 17% to less than 3%**											
Results	**Indicators**	**Indicator definition/ calculation**	**Data sources**	**Periodicity**	**Who collects data?**	**Level of data**	**Baseline (Value, Year)**	**Annualised Targets**				
								2025/26	**2026/27**	**2027/28**	**2028/29**	**2029/30**
Impact level indicators	TB incidence rate (per 100,000 population)	Estimated number of new and relapse tuberculosis cases in a given year per 100,000 population	WHO TB Country Profile	Annually	WHO	National	198 (2024)	197	192	187	187	185
		Numerator: Total number of new and relapse TB cases for all forms expected in a given year	WHO TB Country Profile	Annually	WHO	National	90,893	93,056	93,325	93,530	96,243	97,974
		Denominator: Country Population projections based on UBOS	UBOS Census report	Annually	UBOS	National	45,905,417 (2024)	47,236,674	48,606,538	50,016,127	51,466,595	52,959,126
	TB prevalence rate (per 100,000 population)	Total number of existing tuberculosis cases (new & pre-existing) as a rate per 100,000 of the country population	Survey report	Every 5 years	NTLP	National	253 (2015)	-	-	-	-	-
	TB mortality rate	Estimated number of deaths due to TB in a given year as rate per 100,000 of the country population	Global TB report / vital registration data	Annually	WHO	National	21	19	16	14	12	9
		Numerator: Estimated number of deaths due to TB	WHO TB Country Profile/ DHIS2	Annually	WHO	National	9,900 (2024)	8,910	7,920	6,930	5,940	4,950
		Denominator: Country Population projections based on UBOS	UBOS Census report	Annually	UBOS	National	45,905,417 (2024)	47,236,674	48,606,538	50,016,127	51,466,595	52,959,126

	TB catastrophic cost index	The proportion of TB affected households facing catastrophic costs reduced from 53.1% to 0% (i.e., total costs exceeding 20% of their annual household expenditure)	TB patient cost survey report	Every 5 years	NTLP	National	53.1% (2019)	45%	35%	25%	10%	0%
	Incidence of Grade 2 disability among new leprosy cases	Incidence of new leprosy cases with Grade 2 disability per 1,000,000 population	Annual/quarterly Reports	Annually/ quarterly	NTLP	Facility, District National	1.1 (2024)	0.85	0.46	0.22	0.09	0.03
		Numerator. Number of new Leprosy cases with grade 2 disability at diagnosis	DHIS2: HMIS 106a	Annually/ quarterly	NTLP	Facility, District National	49 (2024/25)	40	22	11	5	1.5
		Denominator: Country Population projections based on UBOS	Census Report	Annually	UBOS	National	45,905,417 (2024)	47,236,674	48,606,538	50,016,127	51,466,595	52,959,126
	Proportion of Leprosy notifications that are children from 14% to less than 3%	Proportion of Leprosy notifications that are children	Annual/quarterly Reports	Quarterly, Annually	NTLP	Facility, District National	14% (2024/25)	14%	11%	8%	5%	3%
		Numerator. Number of new paediatric leprosy cases (<15 years) notified during the reporting period	DHIS2: HMIS 106a	Quarterly, Annually	NTLP	Facility, District National	38	33	20	11	4	1
		Denominator. Total number of new leprosy cases notified during the reporting period	DHIS2: HMIS 106a	Quarterly, Annually	NTLP	Facility, District National	273	235	185	135	80	30
Theme: Promoting care seeking and TB prevention in the communities												
SO1: To increase TB & Leprosy awareness and increase care seeking from health facilities from 61% to 90% by 2029/30												
SO1.1 People with knowledge about TB symptoms increased from 46% to 90%	Proportion of people aware about TB signs and symptoms	Proportion of people aware about TB signs and symptoms	Survey (LQAS, UDHS, TB Prevalence)	Every 2.5 years	NTLP	National	46% (2019)	55%	64%	73%	82%	90%

SO1.2 People with TB symptoms seeking appropriate care from health facilities increased from 61% to 90%	Proportion of people with symptoms of TB that seek appropriate care from health facilities	Proportion of people with symptoms of TB from the community that seek appropriate care from health facilities	Survey (LQAS, UDHS, TB Prevalence	Every 2.5 years	NTLP	National	61% (2020)	67%	73%	80%	85%	90%
SO1.3 Stigma and discrimination among TB patients reduced from 53.7% to less than 10%	Proportion of TB patients facing stigma and discrimination	Proportion of TB patients facing stigma and discrimination	Survey	Every 2.5 years	NTLP	National	53.7% (2019)	45%	37%	29%	21%	10%
SO2: To increase TB preventive treatment coverage among eligible people to 95% by 2029/30												
SO2.1 TB contact tracing coverage increased from 59.4% to >95%	Percentage of PBC TB patients whose contacts were traced	Proportion of PBC TB patients whose household/ workplace/ social club/ education institution contacts were traced	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	59.4% (2024/25)	66.5%	73.6%	80.8%	87.9%	95%
	Number of TB contacts identified	Household or close contacts of people with bacteriologically confirmed TB disease line-listed	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	420,803 (2024/25)	381,065	401,818	427,957	466,815	502,609
SO2.2 TB contact screening coverage increased from 91.6% to >95%	Proportion of identified contacts of bacteriologically confirmed TB index cases who are screened for TB	Proportion of TB contacts screened (symptom or CXR) for TB disease	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	91.6% (2024/25)	93.0%	93.3%	93.7%	94.4%	95.0%
SO2.3.1 TB preventive treatment coverage increased among eligible TB contacts <5 years from 79% to >85%	Proportion of eligible TB contacts <5 years-old started on TPT	Proportion of eligible TB contacts <5 years-old started on TPT	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	79% (2024/25)	80%	81%	82%	83%	85%

SO2.3.2 TB preventive treatment coverage among eligible TB contacts 5+ years increased from 79% to > 85%	Percentage of eligible TB contacts 5+ years-old started on TPT	Proportion of eligible TB contacts 5+ years-old started on TPT	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	79% (2024/25)	81%	82%	83%	84%	85%
SO2.3.3 TB preventive treatment coverage among eligible PLHIV increased from 94% to 95%	Percentage of eligible PLHIV started on TPT	Percentage of eligible PLHIV started on TPT	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	94% (2024/25)	94.1%	94.3%	94.5%	94.7%	95%
SO2.3.4 To increase TB preventive treatment completion rates from 97% to 100%	Proportion of people expected to complete TB preventive treatment (TPT) that completed treatment	Proportion of people expected to complete TB preventive treatment (TPT) that completed treatment	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	97% (2024/25)	97%	97%	98%	99%	100%
SO2.4 TB notification rates among healthcare workers reduced from 316/100,000 to 250/100,000	The TB notification rate among healthcare workers	Number of health workers notified with TB disease / Number of lay and qualified healthcare workers at reporting health facilities x 100,000	DHIS2	Annually	District Biostat, NTLP	District, National	316/100,000 (2024)	303	290	276	263	250
SO2.5 Proportion of new & relapse TB patients with a documented HIV status increased from 97% to 100%	Proportion of new & relapse TB patients with a documented HIV status	All New and Relapse TB Patients present HIV Test results or are tested onsite. (New and Relapse TB cases with newly documented HIV status/Total number of TB patients (new & relapse) registered)*100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	97% (2024/25)	97%	98%	98%	99%	100%
SO 2.6 Percentage of HIV-positive new and relapse TB patients on ART during TB treatment increased from 96.8% to 100%	Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	All New and Relapse TB Patients with HIV Positive Result newly tested or Known and documented are started on ART	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	96.8% (2024/25)	97%	98%	99%	99%	100%

SO 2.7 Proportion of TB patients screened for comorbidities (diabetes, nutrition status, alcohol use, tobacco use) sustained at ≥ 80%.	Proportion of TB patients screened for diabetes	Proportion of new & relapse TB patients screened for diabetes	DHIS2	Quarterly / Annually	District Biostat, NTLP	District, National	-	80%	80%	80%	80%	80%
	Proportion of TB patients assessed for nutritional status.	Number of new & relapse TB patients that had a nutritional asessment / Total number of new & relapse TB patients diagnosed x 100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	-	80%	80%	80%	80%	80%
	Proportion of TB patients screened for alcohol use	Number of new & relapse TB patients screened for alcohol use disorder / Total number of new & relapse TB patients diagnosed x 100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	-	80%	80%	80%	80%	80%
	Proportion of TB patients screened for tobacco use	Number of new & relapse TB patients screened that are smokers / Total number of new & relapse TB patients diagnosed x 100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	-	80%	80%	80%	80%	80%
SO2.8 The proportion of chronic care clients & substance users (e.g. alcohol & tobacco) screened for TB increased to >80%.	Proportion of diabetics screened for TB	Number of diabetics that had a clinical contact screened for TB / Total number of diabetics that had a clinical contact x 100	OPD register, eAFYA	Monthly, Quarterly	HIA, District Biostat, NTLP	Health Facility, District, National	-	20%	35%	50%	65%	80%
	Proportion of undernourished patients screened for TB	Number of undernourished patients screened for TB / Total number of undernourished patients that had a clinical contact x 100	OPD & IPD register, eAFYA	Monthly, Quarterly	HIA, District Biostat, NTLP	Health Facility, District, National	-	20%	35%	50%	65%	80%

	Proportion of mental health patients (including tobacco & alcohol users) screened for TB	Number of mental health patients screened for TB / Total number of mental health patients that had a clinical contact x 100	OPD & IPD register, eAFYA	Monthly, Quarterly	HIA, District Biostat, NTLP	Health Facility, District, National	-	20%	35%	50%	65%	80%
Theme. Accelerating appropriate and timely diagnosis for TB												
SO 3: To increase treatment coverage for all forms of TB from 91% to 95% by 2029/30												
SO3.1 TB treatment coverage increased from 91% to 95%	TB Treatment coverage	Number of new & relapse TB cases notified /Total number of TB cases expected from Total Population *100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	91% (2024/25)	91%	92%	93%	94%	95%
SO3.2 TB case notification rate reduced from 181 to 172/100,000	TB case notification rate, new and relapse	Number of new and relapse TB cases notified in given year as a rate per 100,000 of the country population	DHIS2	Annually	District Biostat, NTLP	District National	181 (2024/25)	179	177	174	173	172
SO3.2.1 The proportion of TB patients notified by the private sector increased from 20% to 35%	Proportion of TB cases notified from the private sector	Percentage of new and relapse TB cases notified from the private sector	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	20% (2024/25)	20%	23%	27%	31%	35%
SO3.2.2 The Proportion of PFPs and PNFPs diagnostic and treatment units reporting on TB in DHIS2 increased from 24.8% to 75% and from 59.4% to 90% respectively	Proportion of PFPs diagnostic and treatment units reporting on TB in DHIS2	Percentage of PFPs diagnostic and treatment units reporting on TB in DHIS2:	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	24.8% (2024/25)	35%	45%	55%	65%	75%
	Proportion of PNFPs diagnostic and treatment units reporting on TB DHIS2	Percentage of PNFPs diagnostic and treatment units reporting on TB in DHIS2	DHIS2	Quarterly, Annual	District Biostat, NTLP	District National	59.4% (2024/25)	66%	72%	78%	84%	90%

SO 3.2.3 Proportion of TB patients registered referred from the community (by CHWs & volunteers) increased from 20.8% to 30%	Proportion of new and relapse TB patients registered referred from the community (by CHWs & volunteers)	New and relapse TB patients registered referred from the community (by CHWs & volunteers) /Total TB patients registered	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	20.8% (2024/25	22.6%	24.4%	26.2%	28.0%	30.0%
SO 3.3 Percentage of people attending clinics health facilities who are screened for TB increased from 82.2% to 95%	TB screening coverage at health facilities	Number of people attending health facilities who were screened for TB symptoms/ Total number of people attending health facilities * 100	DHIS2	Quarterly	District Biostat, NTLP	District National	82.2% (2024/25)	85%	87%	90%	93%	95%
SO 3.3.1 Percentage of presumptive TB patients who accessed mWRD tesing increased from 81.5% to 90%	Proportion of individuals with presumptive TB that are tested with a mWRD	Number of individuals with presumptive TB that are tested with a mWRD /Total number of presumptive TB Cases Identified *100	DHIS2	Quarterly	District Biostat, NTLP	District National	81.50%	83%	85%	88%	89%	90%
SO3.4 Proportion of notified new and relapse TB cases that are bacteriologically confirmed increased from 66% to 90%	The percentage of all new and relapse TB cases notified whose diagnosis was confirmed bacteriologically	Proportion of notified new and relapse TB cases with bacteriological confirmation	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	66% (2024/25)	75%	78%	82%	86%	90%
SO 3.4.1 : The proportion of primary health-care facilities that have access to mWRDs either on site or through sample referral increased from 39% to 60%	Proportion of primary health-care facilities that have access to mWRDs either on site or through sample referral	Primary health-care facilities that have access to mWRDs either on site or through sample referral/ Total number of Primary health-care facilities *100	Labspatial Analysis Report	Annually	NTRL, NTLP	National	39% (2024)	40%	45%	50%	55%	60%

SO 3.5: The proportion of notified new and relapse TB patients tested using mWRDs increased from 82% to 90%	Proportion of notified new and relapse TB patients tested using WHO recommended rapid tests	TB patients diagnosed using WHO recommended rapid tests/Total number of TB patients (new & relapse) notified *100	DHIS2	Quarterly, Annually	District Biostat, NTLP	District, National	82% (2024/25)	84%	86%	88%	89%	90%
SO 3.6: DST coverage among bacteriologically-confirmed pulmonary TB tested for susceptibility to rifampicin increased from 72% to 90%	Proportion of people with bacteriologically-confirmed pulmonary TB tested for susceptibility to rifampicin	Bacteriologically-confirmed pulmonary TB patients tested for susceptibility to rifampicin/ Total number of Bacteriologically-confirmed pulmonary TB patients *100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	72% (2024/25)	75%	80%	82%	85%	90%
SO 3.7 MDRRR-TB Treatment coverage increased from 58% to 80%	Proportion of diagnosed MDR-TB patients who are enrolled on appropriate MDR-TB treatment	Proportion of diagnosed MDRRR-TB patients who are enrolled on appropriate MDR/RR-TB treatment	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	58% (2024/25)	60%	65%	70%	75%	80%
SO3.8 Childhood TB treatment coverage increased from 62% to 95%	TB treatment coverage for children	Number of new and relapse childhood TB cases notified/ Total number of childhood TB cases expected	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	62% (2024/25)	69%	75%	82%	88%	95%
	Notification rate ratio for TB in children (0-4 years: 5-14 years)	Notification rate for TB in children 0 - 4 years per 100,000/Notification rate for TB in children 5 - 14 years per 100,000	DHIS2	Annually	District Biostat, NTLP	District National	1.2	1.3	1.4	1.5	1.6	1.7
	Proportion of DR TB cases who are children	Number of children 0-14 year with DRTB Notified/ Total number of DR TB patients notified	DHIS2	Annually	District Biostat, NTLP	District National	8.4%	8.5%	9.0%	9.6%	10.0%	10%

SO 3.9: The proportion of laboratories participating in EQA for molecular methods increased from 85% to 95 %.	Proportion of laboratories participating in EQA for molecular methods	Laboratories participating in EQA for molecular methods/Total number of TB Molecular laboratories *100	NTRL EQA Data Base	Biannually	NTRL	National	85% (2024/25)	87%	89%	91%	93%	95%
SO 3.9.1 : The proportion of TB testing laboratories that achieve a turnaround time of ≤ 48 h for ≥ 80% of samples received for mWRD testing increased from 36% to 80%	Proportion of TB testing laboratories that achieve a turnaround time of ≤ 48 h for ≥ 80% of samples received for mWRD testing	TB testing laboratories that achieve a turnaround time of ≤ 48 h for ≥ 80% of samples received for mWRD testing/ Total number of mWRD laboratories *100	DHIS2	Quarterly, Annually	NTRL, NTLP	National	36% (2024)	40%	50%	70%	75%	80%
SO 3.9.2: The proportion of laboratories passing EQA for molecular methods with satisfactory score increased from 73% to 90%	Proportion of laboratories passing EQA for molecular methods with satisfactory score	laboratories passing EQA for molecular methods with satisfactory score/Total number of laboratories passing EQA for molecular methods *100	NTRL EQA Data Base	Biannually	NTRL	National	73% (2024/25)	77%	80%	83%	86%	90%
SO 3.9.3: The proportion of laboratories participating in EQA for Microscopy from 66% to 80%	Proportion of laboratories participating in EQA for Microscopy	Laboratories participating in EQA for Microscopy/ Total number of AFB Microscopy laboratories *100	NTRL EQA Data Base	Quarterly	NTRL	National	66% (2024/25)	69%	72%	74%	77%	80%
SO 3.9.4: The proportion of laboratories passing Microscopy EQA with satisfactory score increased from 70% in 2024 to 85%	Proportion of laboratories passing Microscopy EQA with satisfactory score	Laboratories participating in Microscopy EQA with satisfactory score /Total number of laboratories participating in Microscopy EQA *100	NTRL EQA Data Base	Quarterly	NTRL	National	70%	75%	80%	85%	85%	85%

SO3.10: The proportion of patients notified with bacteriologically confirmed Rifampicin resistant (RR) pulmonary TB with DST results for Fluoroquinolones (FQ) increased from 51% to 90%	Proportion of patients notified with bacteriologically confirmed Rifampicin resistant (RR) pulmonary TB with DST results for Fluoroquinolones (FQ)	Patients notified with bacteriologically confirmed Rifampicin resistant (RR) pulmonary TB with DST results for Fluoroquinolones (FQ)/Total number of Patients notified with bacteriologically confirmed Rifampicin resistant (RR) pulmonary TB *100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	51% (2024/25)	73%	80%	85%	87%	90%
SO 3.11: The proportion of notified patients with bacteriologically confirmed RR and FQ resistant pulmonary TB with DST results for Bedaquiline and Linezolid increased from 0% to 100%	Proportion of notified patients with bacteriologically confirmed RR and FQ resistant pulmonary TB with DST results for Bedaquiline and Linezolid	Patients with bacteriologically confirmed RR and FQ resistant pulmonary TB with DST results for Bedaquiline and Linezolid)/Total number of patients with bacteriologically confirmed RR and FQ resistant pulmonary TB *100	DHIS2	Quarterly / Annually	District Biostat, NTLP	District National	0% (2024/25)	70%	80%	90%	95%	100%
Theme. Accelerating treatment and cure												
SO4: To increase TB treatment success from 91% to 95% by 2029/30												
SO4:1: Proportion of TB Patients diagnosed and not started on treatment (pre-treatment lost to follow up) reduced from 1% to <0%	Proportion of notified TB patients who are not started on treatment (pre-treatment lost to follow up)	Notified TB patients (new and relapse) not initiated on treatment/Total number of Notified TB patients (new & relapse) *100	DHIS2	Annually	District Biostat, NTLP	District , National	1% (2024/25)	1.0%	1.0%	1.0%	0.0%	0.0%
SO4.2: TSR for Drug Susceptible TB increased from 91% % to >95%	Treatment Success Rate	Proportion of new TB cases successfully treated (cured plus treatment completed)	DHIS2, Facility registers	Quarterly, Annually	HIA, District Biostat, NTLP	Facility, District, National	91%, 2024/25	93%	93%	93%	93%	95%

SO4.2.1: Lost to follow among TB patients initiated on treatment reduced from 2.7% to <1%	Percentage of TB patients in a given treatment cohort who were lost to follow-up (initiated on treatment but interrupted treatment for ≥2 consecutive months)	DS TB patients initiated on treatment who are lost to follow up/Total number of DS TB patients initiated on treatment *100	DHIS2,	Quarterly, Annually	HIA, District Biostat, NTLP	Facility, District, National	2.7% (2024/25)	2.4%	2.0%	1.6%	1.2%	<1%
SO4.3 Treatment success rate for the TB/HIV co-infected increased from 90% to 95%	The proportion of TB/HIV co-infected patients who successfully completed TB treatment (cured or treatment completed) among all TB/HIV co-infected patients who were registered in the same treatment cohort	TSR for TB/HIV co-infected (%) = (Cured + Treatment Completed among TB/HIV co-infected) / Total TB/HIV co-infected registered for treatment × 100	DHIS2	Quarterly, Annually	D/Biostat, SMEAR Unit	National, District	90% (2024/25)	91%	92%	93%	94%	95%
SO4.4 TB related mortality reduced from 4% to < 3%	Number of TB patients (all forms) who die from any cause during TB treatment, regardless of whether the cause of death was TB or not	TB patients initiated on treatment who are declared dead/Total number of patients initiated on treatment *100	DHIS2	Annually	District Biostat, NTLP	District , National	4%	3.8%	3.6%	3.4%	3.2%	3%
SO4.5 Treatment success rate for Drug resistant TB increased from 88.3% to > 92%	The proportion of drug-resistant TB patients who successfully completed treatment among all DR-TB patients who started treatment in the same cohort	Treatment Success Rate for DR-TB (%) = (Cured + Treatment Completed among DR-TB patients ÷ Total DR-TB patients who started treatment) × 100	DHIS2,eCBSS, Facility registers	Quarterly, Annually	HIA, District Biostat, NTLP	National	88.3%	90%	91%	91%	92%	92%

SO4.6 Proportion of TB patients assessed for TB associated diasability and provided with appropriate care during treatment and 12 months after treatment completion increased from 0% to 80%.	Proportion of TB patients assessed for TB associated disability (TBAD)	TB patients assessed for TB associated disability (TBAD) ÷ Total number of TB patients notified in the year	Cohort follow-up data, facility-level TB registers with post-treatment follow-up modules, Post-TB surveys, QoL/disability tools WHODAS 2.0, St George Respiratory questionnaire, DHIS2	Quarterly, Annually	NTLP	National	0%	20%	35%	50%	65%	80%
	Proportion of TB patients diagnosed with severe disability accessing pulmonary rehabilitation programs	TB patients diagnosed with severe disability accessing pulmonary rehabilitation programs /TB patients diagnosed with TB associated disability.	Cohort follow-up data, facility-level TB registers with post-treatment follow-up modules, Post-TB surveys, QoL/disability tools WHODAS 2.0, St George Respiratory questionnaire, DHIS2	Annually / Quarterly	NTLP	National	0%	20%	35%	50%	65%	80%
Theme: Ending Leprosy Transmission and Disability												
SO5: To reduce proportion of Leprosy notifications that are children from 17% to 3% by 2029/30												
SO5.1. Proportion of districts reporting zero new autochthonous leprosy patients, increased from 79% to ≥90%	This indicator measures the geographical extent of interruption of local (autochthonous) transmission of leprosy	Proportion of districts with zero autochthonous leprosy patients = (Number of districts with zero new autochthonous cases ÷ Total number of districts) × 100	DHIS2 / HMIS 106a (Leprosy reporting).	Annually	D Biostat, SMEAR Unit	District, National	79%	80.8%	82.2%	85.6%	89.0%	90%

SO5.2. The number of new and relapse leprosy patients detected annually reduced from 273 to 30	Absolute number of new and relapse leprosy cases that are detected and reported to the national leprosy program (NLP) within a given calendar year	The total number of new and relapse leprosy patients detected and notified to the NLP during the reporting year	DHIS2 / HMIS 106a (Leprosy reporting).	Quarterly	D/Biostat	Facility	273	235	185	135	80	30
SO5.3. The proportion of Child Leprosy patients reduced from 14% to < 3%	Proportion of new child leprosy patients	Proportion of Child Leprosy Patients (%) = (Number of new child leprosy cases (<15 years) / Total number of new leprosy cases (all ages)) × 100	DHIS2	Quarterly, Annually	District Biostat, NTLP	District, National	14% (2024/25)	14%	11%	8%	5%	3%
SO5.3.1 Leprosy household contact tracing increased from 67% to 90% by 2029/30	Leprosy contact tracing coverage	Number of Leprosy registered patients whose contacts were traced / Total number of Leprosy registered cases	DHIS2	Quarterly, Annually	District Biostat, NTLP	District, National	67%	72%	76%	81%	85%	90%
SO5.3.2 The proportion of Index leprosy patient's contacts screened from 74% to 90%	The proportion of identified contacts of index leprosy patients who are screened for signs and symptoms of leprosy within a reporting year	Proportion of Index Leprosy Patients' Contacts Screened (%) = (Contacts screened for leprosy ÷ Total identified contacts) × 100	DHIS2	Quarterly	D/Biostat	facility	74%	75%	80%	85%	90%	90%

SO5.3.3. The proportion of eligible leprosy contacts given Leprosy preventive therapy increased from 55% to 90%	The percentage of identified eligible household and close contacts of newly diagnosed leprosy patients who were provided with leprosy preventive therapy (LPT), within a defined reporting period	Proportion of Contacts Given LPT (%) = (Number of eligible contacts who received LPT/ Total eligible contacts identified) × 100	DHIS2	Quarterly	D/Biostat	facility	55%	60%	70%	80%	85%	90%
SO5.3.4. The proportion of new and realpse leprosy patients with grade 2 Disability reduced from 18% to 5%	Percentage of new and relapse leprosy patients who present with Grade 2 Disability (G2D) at the time of diagnosis	Proportion of New and Relapse Leprosy Patients with G2D (%) = (New and relapse leprosy patients with G2D at diagnosis ÷ Total new and relapse leprosy patients) × 100	DHIS2	Quarterly	D/Biostat	District	18%	17%	12%	8%	6%	5%
SO5.4 The proportion Leprosy patients completing treatment increased from 91% to >95%	The proportion of registered leprosy patients who successfully complete the prescribed full course of multidrug therapy (MDT) within the recommended treatment duration	Proportion of Leprosy Patients Completing Treatment (%) = (Number of leprosy patients completing treatment / Total number of leprosy patients registered for treatment) × 100	DHIS2	Quarterly, Annually	District Biostat, NTLP	District, National	91%	92%	93%	94%	95%	95%
SO5.5 The proportion of Leprosy patients in need of protective footwear provided with footwear increased from 72% to > 90% by 2030	The proportion of leprosy patients with disabilities (usually Grade 1 or Grade 2 disability affecting feet) who require protective footwear and actually receive it	Proportion of Leprosy Patients Provided with Protective Footwear (%) = (Number of leprosy patients in need who received footwear ÷ Total number of leprosy patients in need of footwear) × 100	DHIS2	Quarterly, Annually	District Biostat, NTLP	District, National	72%	75%	80%	85%	90%	90%

Theme: Building Effective and Efficient Systems												
SO6: To build effective and efficient systems that ensure quality, equitable and timely TB and Leprosy services												
SO6.1 The proportion of TB affected households facing catastrophic costs reduced from 53.1% to 0%	The percentage of TB-affected households who experience catastrophic total costs that exceed 20% of the household's annual income.	Proportion of households facing catastrophic costs (%) = (Number of TB-affected households with TB-related costs >20% of annual income ÷ Total number of TB-affected households surveyed) × 100	National TB patient cost survey	Every 5 years	NTLP	National	53.1% (2019)	45%	35%	25%	10%	0%
SO 6.2 Stigma and discrimination among TB patients reduced from 53.7% to less than 10%	Proportion of TB patients facing stigma and discrimination	Proportion of TB patients facing stigma and discrimination	Prevalence Survey	Every 2.5 years	NTLP	National	53.7% (2019)	45%	37%	29%	21%	10%
SO 6.3 The proportion of households affected by TB who access available social protection programs increased from 2% to 70% by 2030.	Proportion of households affected by TB who access available social protection programs	Proportion of households affected by TB who access available social protection programs	Survey	Every 2.5 years	NTLP	National	2% (2017)	5%	25%	45%	60%	70%
SO6.4 The percentage of treatment units reporting no stock outs of anti-TB medicines increased from 82% to 95%	Proportion of treatment units reporting no stock outs of anti-TB medicines	Number of treatment units reporting no stock out of anti-TB medicines/Total number of TB treatment units	eLMIS/DHIS2	Quarterly, Annually	D Biostat, NTLP	District, National	82%	83%	86%	89%	92%	95%

SO6.5 The percentage of diagnostic and treatment units reporting no stock outs of TB laboratory supplies (reagents, consumables) increased from 88% to 95%	Proportion of diagnostic and treatment units reporting no stock outs of TB laboratory supplies	Number of diagnostic and treatment units reporting no stock out of TB laboratory supplies and consumables/Total number of TB diagnostics and treatment units	LIS/DHIS2	Quarterly, Annually	D Biostat, NTLP	District, National	88%	89%	90%	92%	93%	95%
SO6.6 Funding gaps for TB commodities and supplies reduced from 18% to 5%	Proportion of TB commodities requirements that is unfunded	Cost of unfunded commodities/ Total budget for commodities	Quantification report	Biannual	PSM	National	18%	15%	12%	9%	6%	<5%
SO6.7 Procurement leadtime reduced from 10 months to 6 months	Average number of months between order placement with supplies and delivery to the national warehouse	Total number of months between order placement with supplies and delivery to the national warehouse/ Number of orders delivered	PSM reports	Annual	PSM	National	10 months	11 months	9 months	8 months	7 months	6 months
SO 6.8 Improved Timeliness and completeness of data reporting i.e. ≥ 98 % reporting rates & 95 % timeliness of reporting	Percentage of Health facilities that are required to report that submit TB & Leprosy reports increased from 97% to 100%	Number of health facilities that are required to report that submit TB & Leprosy reports / Total number of health facilities (DTUs) that are required to report.*100	DHIS2	Quarterly	NTLP D/ Biostat	National; District	97%	97%	98%	98%	99%	100%
	Percentage of Health facilities required to report that submit TB & Leprosy reports on time as per national guidelines increased from 87% to 95%	Number of health facilities that are required to report that submit TB & Leprosy reports on time as per national guidelines/ Total number of health facilities (DTUs) that are required to report.*100	DHIS2	Quarterly	NTLP D/ Biostat	National; District	87%	88%	90%	92%	93%	95%

SO 6.9 Real-time TB & Leprosy surveillance operationalised in 100 % diagnostic units	Proportion of TB cases notified in the electronic Case Based Survaillance System (eCBSS) increased from 85% to 100%	Number of TB cases notified in eCBSS during reporting period/Total number of TB cases notifed during reporting period*100	eCBSS	Quarterly	NTLP; D.Biostat; HIA	National; District; Facility	85%	85%	90%	93%	96%	100%
	Proportion of Leprosy cases notified in the electronic Case Based Survaillance System (eCBSS) increased from 81% to 100%	Number of Leprosy cases notified in eCBSS during reporting period/ Total number of TB cases notifed during reporting period*100	eCBSS	Quarterly	NTLP; D.Biostat; HIA	National; District; Facility	81%	85%	88%	90%	95%	100%
	Percentage of Diagnostic & Treatment Units with operational electronic Case Based Survaillance System (eCBSS)	Number of Diagnostic & Treatment Units with operational electronic Case Based Survaillance System (eCBSS)/Total number of Diagnostic & Treatment Units * 100	eCBSS	Quarterly	NTLP; D.Biostat; HIA	National; District; Facility	75%	75%	80%	85%	90%	100%
SO 6.10 Number of research studies on TB/Leprosy supported and completed annually in line with national research agenda.	Number of research studies on TB/Leprosy supported and completed annually in line with national research agenda.	Number of research studies on TB/Leprosy supported and completed annually in line with national research agenda.	NTLP/Research forum	Annually	NTLP	National	3	5	5	5	5	5

ANNEXES

Annex 1. Multi sectoral accountability framework for TB

Priority Sector actions to address tuberculosis

Table 3.

Office of the President
Provide directive on key actions on TB prevention
Champion efforts to end TB in Uganda
Incorporate TB indicators in coordination of all Agencies fighting the HIV/AIDS pandemic
Incorporate support for TB affected families in “Prosperity for All” programs
Include TB prevention in promotion of national security
TB services incorporated into HIV workplace policy

Table 4.

Office of the Prime Minister
Establish inter-ministerial forum for TB
Coordination and monitoring of all government entities - TB mainstreaming
Support the establishment of and steer a national high level inter-ministerial coordination platform to drive accountability by government sectors towards ending Tuberculosis by 2030
Ensure programs under OPM involved in cross border activities such as refugee programs, NUSAF Karamoja and disaster management and response integrate TB prevention and control activities within their interventions
Provide overall guidance and operationalize a model for technical and political coordination of all government entities towards mainstreaming TB activities into MDA’s operational plans and budgets
Assign officers as part of the technical secretariat and coordination structure to drive monitoring, reporting and accountability on agreed actions by MDAs
Integrate TB in cross border activities
Incorporate TB issues in special programs (refugees, displaced persons, Karamoja, Northern Uganda)
TB services incorporated into HIV workplace policy

Table 5.

Ministry of Local Government and Local Governments, Municipal councils and cities
Providing funding for TB services at local levels
Liaison of the MAF-TB with other government ministries departments and agencies, private sector, regional and international organizations
Sensitize labour, community development and probation officers on TB
Enacting bye laws for promotion of uptake of TB interventions
Commemoration of annual World TB Week/Day at District
Ensure pre-and in-service screening of health workers for TB
Incorporate TB services into HIV workplace policy
Development and enforcement of by-laws and ordinances of Health-smart (TB) building standards, infrastructure, in both the public and private establishments.
Review and monitor TB-propagating activities: review all sectors operation, practices, procedures and production systems
DHT/ District Council meetings with TB as a constant agenda item (minutes).
Promote TB prevention (awareness creation, contact tracing and preventive therapy), diagnosis (active TB case finding and improving diagnostic capacity at health facility level) treatment (linkage, improved access and patient support/reporting)
Engage all district stakeholders in TB planning and implementation: Engage the private sector and civil society, affected communities
Avail health work force
Facilitation of Health workers, to improve motivation, working environment, timely and quality reporting.
Ensure safety of diagnostic equipment
Ensure supply of drugs and other supplies to Health centres
Ensure adequate infrastructure for service delivery with sufficient ventilation
Monitoring service delivery
Introduction of TB /public health inspectors at all levels
Assign and facilitate District TB supervisors to perform their responsibilities
Enforcement of the Public health Act
Monitor TB indicators as part of district performance assessment
Supervision of District leadership (CAO, RDC, DISO, DPC, LCV, Mayors, MPs) and follow up on TB Actions
Set up District TB Task force to oversee TB service provision

Table 6.

Ministry of Justice and Constitutional Affairs
Educate masses to understand their rights and responsibilities with regard to TB services
Draft relevant laws and regulations to help in implementation and compliance to the TB guidelines at the workplace and the community at large.
Educate and create awareness among staff and clientele about their rights and responsibilities regarding TB control, spread, prevention treatment and cure for those infected
Pre- and regular screening for TB of judicial officers
TB services incorporated into HIV workplace policy
Pre-service and regular screening for TB of State Attorneys and other ministry staff in collaboration with the Ministry of health
Observe social distance at work place where possible to prevent the spread of TB
Procedure for discharge of those on TB Treatment

Table 7.

Judiciary
Educate masses to understand their rights and responsibilities with regard to TB services
Enforcement of TB prevention in courts of law
Implement infrastructural guidelines for court houses
Pre- and regular screening for TB of judicial officers
TB services incorporated into HIV workplace policy
Orient staff of JSC on TB transmission and how to manage detainees with TB
Incorporate TB services to the HIV/AIDS workplace policy
Observe social distance at work place where possible to prevent the spread of TB
Procedure for discharge of those on TB Treatment agreed with Prisons services

Table 8.

Ministry of Agriculture and Animal Industry and Fisheries; National Agricultural Advisory Services
Integrate TB activities in the One Health approach, including zoonotic TB.
Nutrition support and income generating activities (IGAs)
Screening for TB at the workplace among farmers, plantation workers etc.
TB services incorporated into HIV workplace policy
Include TB affected communities as priority group for smallholder farmers requiring input
TB messaging and screening to farmer groups/cooperatives

Table 9.

Ministry of Finance, planning and economic development
Provide/ mobilize local and external financial resources required for TB response
Ensure accountability of funding

Table 10.

Ministry of works and transport; Uganda National Roads Authority
Mobile populations on construction, civil aviation
Participate in joint planning for TB related activities
UNRA: Campsites inspection and support, as well as routine screening of workers.
Screening of Taxi drivers and operators annually for TB
Sensitization of the masses (TB prevention messages in public transport spaces)
Regulation of vehicles (ventilation, overcrowding)
TB services incorporated into HIV workplace policy
Enforcement of TB messaging, screening and services on major construction sites and works

Table 11.

Ministry of Energy and Mineral Development
TB screening, diagnosis and treatment support among miners
Enforce public health act among living conditions for miners
TB services incorporated into HIV workplace policy

Table 12.

Ministry of Internal Affairs
Pre- and on-job screening at all institutions (barracks, detention centres);
On-entry and regular screening for all detainees
Integrate TB in cross border activities
Isolation spaces for TB cases at all detention facilities
DOT for all TB cases
Ventilation for detention centres and housing
TB prevention, care and treatment services
Collaborate with NTLP on vital registration data use
TB services incorporated into HIV workplace policy
Establish screening at detention centres, Ventilation for the housing of officers and detention centres/units
Prevention Messages, orientation of officers

Table 13

Uganda Prisons Services
On-entry and regular screening for all detainees
Isolation spaces for TB cases at all detention facilities
Ventilation for detention centres and housing
TB prevention, care and treatment services
TB services incorporated into HIV workplace policy

Table 12

Ministry of Defence and Veterans Affairs/ Uganda Peoples Defence Forces
Conduct TB screening at enlisting into forces
Conduct pre-mission screening for TB
Ventilation for barracks
TB prevention, care and treatment services - DOT for all TB cases
Improve isolation space for TB cases
TB services incorporated into HIV workplace policy

Table 13.

Ministry of lands housing and urban development
Pre service screening and health education.
Incorporate TB services into HIV workplace policy
Enforcing the housing standards
Integrate TB prevention into the slum upgrading strategy
Provide Personal Protective Equipment (masks) among road construction workers
Liaison with District TB focal persons on campsite orientation, inspection
Screening at the workplace, landing sites and markets
Support housing prototype plans at local government level and online (including manyattas)
Implement physical development plans, guidelines and standards
TB infection control evaluation (occupational safety) and Involvement in Health and wellness talks to staff, messaging,
Support development of Abattoir standards with MAAIF/Veterinary medicine.

Table 14

Ministry of education and Sports
Educating the masses about TB in schools (debates and competitions, compound messages, assembly themes)
Championing TB messaging through national council of sports to reach men and youth
Screening pupils and students at opening of school terms, sports events, etc.
Inspector of schools to enforce standards of school structures, beds, dormitories
Hygiene standards (sharing utensils and personal items that could contribute towards TB transmission)
Promotion of health clubs
Protective equipment for at risk trainee students e.g. Nurses
TB services incorporated into HIV workplace policy
Integrating TB training in the curriculum for Health worker training.
Matron/ Warden/ nurses capacity development for detection, prevention and treatment support

Table 14.

Ministry of public service
Enforce Pre-employment and annual in-service TB screening for public servants
Enforce incorporation of TB services into HIV workplace policy
Incorporate TB in the performance management framework
Incorporate TB in the training modules for public servants

Table 16.

Parliament
Parliamentary caucus on tuberculosis
Appropriate legislation for the rights of people affected by TB
Resource mobilization and allocation
Advocacy communication and social mobilization

Table 17.

Ministry of Science, Technology and Innovation
Monitoring the utilization of diagnostic and treatment innovations
Support TB research to inform policy and the response
TB services incorporated into HIV workplace policy

Table 18.

Ministry of Information and Communications Technology and National Guidance; Uganda Communications Commission; National Information Technology Authority
Sensitization of masses on TB – integrate messaging in prime time in media houses
Tagging licensing of media houses to TB health messaging.
Support community empowerment through support of community strategy for TB
Strengthen rural community communication capacity through existing structures of health and leadership
TB services incorporated into HIV workplace policy
Support desk review of the ICT infrastructure for case-based surveillance solution(s)
Advise on case-based surveillance project management services.
IT capacity building for public and private health facilities

Table 19.

Ministry of Gender, Labour and social Development
Awareness creation about TB
Ensure subscribers for insurance are screened for TB
Engage religious and cultural institutions in TB case finding
Periodic in-service screening
Income generating activities
Integrate TB prevention in labour inspection activities to ensure occupational health and safety
Enforce the policies on health inspection together with the community development office at MoLG
TB services incorporated into HIV workplace policy
Prevent discrimination of workers affected by TB
Establish social protection programs for TB affected households

Table 20.

Funding agencies
Increase resources for TB
Accountability to MoH
TB services incorporated into HIV workplace policy

Table 21.

Civil Society Organizations
Advocacy and communication
Social mobilization and sensitization for demand and uptake of TB services
Service delivery participation
TB services incorporated into HIV workplace policy
Monitor client satisfaction and accountability for TB services
Citizen ownership through education of the masses on their rights and responsibilities

Table 22.

Community leaders (Political leaders, celebrities)
Relaying TB messages for health education, linkage, demand creation and social support.
Target special events (cultural days, festive season, gatherings) to speak about TB and get binding commitments
Capacity building for political leaders
TB services incorporated into HIV workplace policy

Table 23.

Cultural and religious leaders, Inter-religious Council of Uganda (IRCU)
Relaying TB messages for health education, linkage, demand creation and social support.
Target special events (cultural days, festive season, gatherings) to speak about TB and get binding commitments
Capacity building for religious leaders
TB services incorporated into HIV workplace policy
Produce a pastoral letter on TB prevention and management
Integration of TB messages into sermons &holy scriptures
Use senior religious leaders for national TB advocacy

Table 24.

Private sector
Access to materials for TB awareness creation
Involvement of HIV AIDs Coordination Committee at national level planning and subnational implementation
Continuing education of the private sector constituency
Using performing artists' platforms for TB communication
Utilize coordination structures for joint running of business and health fairs
Engage in Corporate Social Responsibility ventures
Identifying champions
Staff screening, treatment and support
TB services incorporated into HIV workplace policy
Provide and report on TB services
Monitoring implementation of agreed activities
Traditional healers

Table 25.

Implementing partners and mechanisms
Supporting local government in the TB response
M&E, Awareness, Implement the TB IL
Funding contribution to service delivery
TB services incorporated into HIV workplace policy

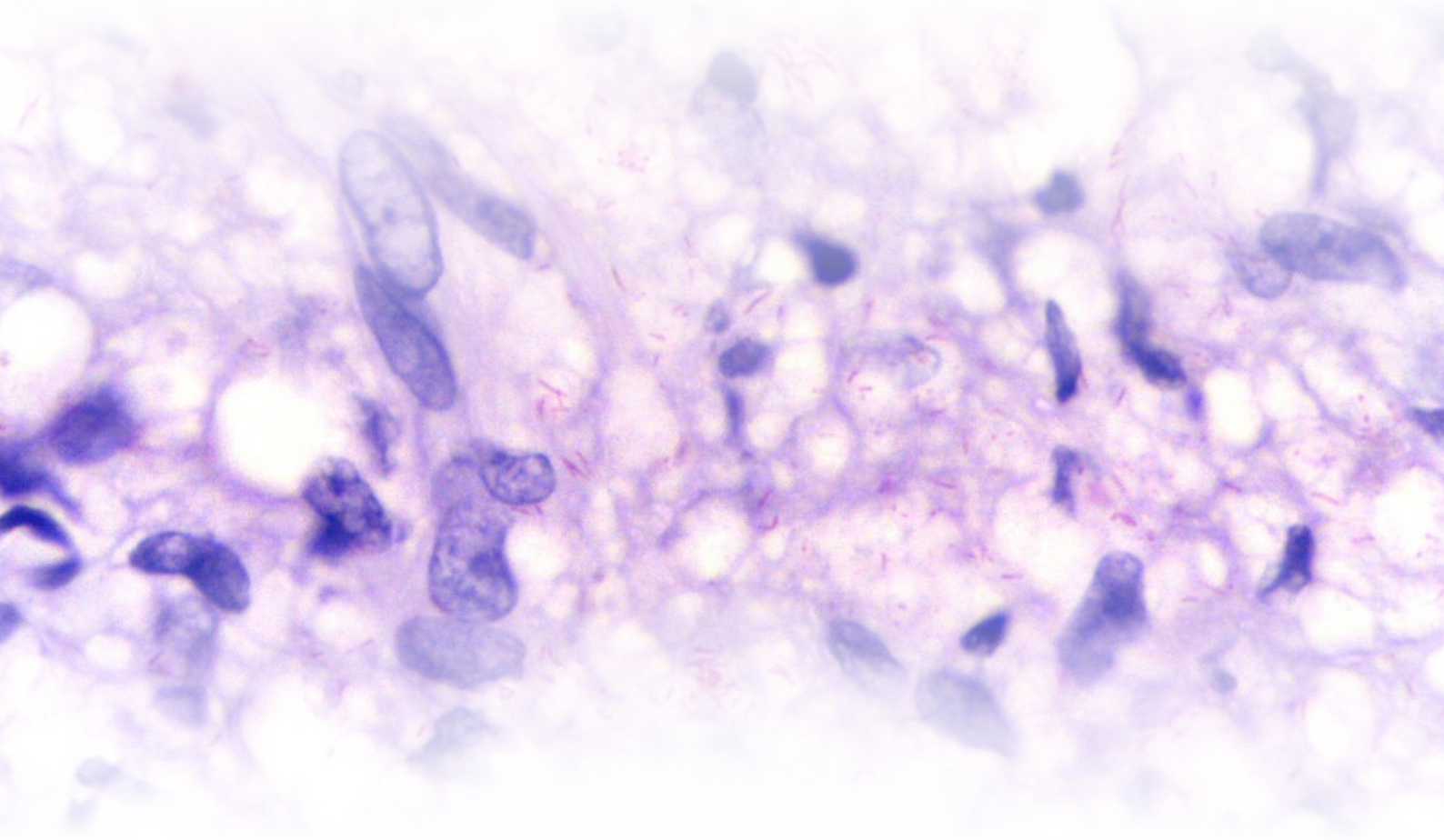
Table 26.

Technical Agencies
Technical assistance to the development and implementation of TB response
Support development of the progress reports on implementation of TB response plans
Non biased brokerage among stakeholders
Support resource mobilization

Table 26.

2026	2027	2028	2029	2030	Total
30,814,813	33,425,263	36,195,554	39,263,189	45,726,169	185,424,989
8,587,367	5,138,649	5,176,749	5,185,451	5,194,152	29,282,368
10,304,670	11,160,255	12,067,771	13,075,739	15,219,933	61,828,368
24,252,890	27,428,939	23,681,561	22,765,585	21,414,176	119,543,150
73,959,739	77,153,106	77,121,636	80,289,964	87,554,431	396,078,875

2026	2027	2028	2029	2030	Total
2,249,617	2,081,627	2,081,627	2,041,869	1,770,005	10,224,746
7,305,960	7,532,200	7,075,104	7,376,037	7,338,595	36,627,895
31,144,748	29,692,351	32,172,441	32,436,790	33,611,319	159,057,649
31,947,897	32,358,222	34,355,198	36,944,157	43,330,608	178,936,083
120,898	127,366	114,165	120,632	127,100	610,161
1,190,618	5,361,340	1,323,101	1,370,478	1,376,804	10,622,341
73,959,739	77,153,106	77,121,636	80,289,964	87,554,431	396,078,875



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