Guidance for review of the degree of self-reliance of TB prevention and care activities in selected WHO European Region countries transitioning from Global Fund financed to domestically financed tuberculosis-related activities
Abstract

The WHO Regional Office for Europe, with the financial support from the United States Agency for International Development regional platform project and the Ministry of Health of Germany, has supported a selection of countries to review and document their preparedness for self-reliance in tuberculosis (TB)-related activities in light of reduced development partner support. The Regional Office’s support is in line with the Health 2020 European health policy and seeks to align strategic direction at country level with that of the WHO European Region and recommend priority activities to be carried out by stakeholders.

In line with the End TB Strategy, the WHO Regional Office for Europe’s Roadmap to Implement the Tuberculosis Action Plan for the WHO European Region 2016–2020 outlines such activities, along with the need for continuous and sustainable financing to support countries in identifying and minimizing the potential gaps emerging as a result of development partners scaling-down their support. Activities generally seek to address the lack of sustainable human resources and sound health financing mechanisms, which exacerbate challenges in TB (particularly multidrug and extensively drug-resistant TB) prevention, control and care. Specialized human resources to manage cases of drug-resistant TB in children and adults, deliver adequate services for case detection and scale up diagnostic and laboratory capacities are particularly required. This guidance document provides a framework to assess the size and nature of the above gaps and identify the best approach in the selected countries to address gaps pertaining to political commitment (including universal health coverage policies); health system strengthening; regulatory frameworks; community systems and civil society engagement; and social protection and actions on other determinants of TB, such as TB activities in prisons.

Keywords

ARMENIA, AZERBAIJAN, BELARUS, GEORGIA, MOLDOVA, UKRAINE, TUBERCULOSIS, TRANSITION, GLOBAL FUND, FINANCIAL SUSTAINABILITY, HEALTH SYSTEM STRENGTHENING

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Contributors

Authors

Ms Allira Attwill
Health Economist, consultant, Joint TB, HIV and Viral Hepatitis programme, Division of Health Emergencies and Communicable Diseases, WHO Regional Office for Europe

Dr Nikoloz Nasidze
Consultant, Joint TB, HIV and Viral Hepatitis programme, Division of Health Emergencies and Communicable Diseases, WHO Regional Office for Europe

Dr Martin van den Boom
Technical Officer, Joint TB, HIV and Viral Hepatitis programme, Division of Health Emergencies and Communicable Diseases, WHO Regional Office for Europe

Dr Masoud Dara
Coordinator, Communicable Diseases and Programme Manager, Joint TB, HIV and Viral Hepatitis Programme, Division of Health Emergencies and Communicable Diseases, WHO Regional Office for Europe

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CCM</td>
<td>country coordinating mechanism</td>
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<tr>
<td>CSO</td>
<td>civil society organization</td>
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<td>G20</td>
<td>Group of 20</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
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<td>GNI</td>
<td>gross national income</td>
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<tr>
<td>HIC</td>
<td>high-income country</td>
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<tr>
<td>LIC</td>
<td>low-income country</td>
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<tr>
<td>LMIC</td>
<td>lower-middle-income country</td>
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<tr>
<td>MDR-TB</td>
<td>multidrug-resistant tuberculosis</td>
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<tr>
<td>MIC</td>
<td>middle-income country</td>
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<tr>
<td>NSP</td>
<td>national strategic plan</td>
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<td>NTP</td>
<td>national tuberculosis programme</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>TB</td>
<td>tuberculosis</td>
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<td>THE</td>
<td>total health expenditure</td>
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<tr>
<td>TSP</td>
<td>transition and sustainability plan</td>
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<tr>
<td>UMIC</td>
<td>upper-middle-income country</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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**Purpose and scope of this guidance document**

The WHO Regional Office for Europe is supporting and guiding selected countries to document preparedness for self-reliance in TB-related activities in light of dwindling (financial) support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other development partners. The Regional Office’s support is in line with Health 2020 European health policy (1) and seeks to align strategic direction at country level with that of the WHO European Region and recommend priority activities to be carried out by stakeholders.

This document is intended for use as a guide for countries in reviewing their preparedness for self-reliance. The document follows the WHO Regional Office for Europe’s Roadmap to Implement the Tuberculosis Action Plan for the WHO European Region 2016–2020 (2) and helps in-country TB stakeholders to first identify and then address and minimize the potential gaps emerging as a result of transitioning from development partner-financed to domestically financed TB activities.

In doing so, this guidance document provides an approach to review the size and nature of emergent transition-related gaps in TB programmes in the selected countries. It also provides an approach to identify and prioritize actions to address gaps pertaining to political commitment; health system strengthening; regulatory frameworks; community systems and civil society engagement; and social protection and actions on other determinants of TB, such as prisons.

The reviews conducted based on this document provide an overview of some sustainability aspects, challenges and potential consequences stemming from Global Fund and other development partners scaling-down support from TB and TB/HIV prevention, treatment and care-related activities in the selected countries, and provide recommendations for maximizing sustainability and overcoming challenges.

This guidance document includes engagement and collaboration with key stakeholders from the selected countries and development partners. The review is geared to:

- obtain and analyse key transition-related financial and programmatic data, and financial and human resource gaps;
- explore the triggers and enablers for transition;
- highlight actions that countries could undertake in the transition period to foster sustainability of achievements made and further tackle the challenges encountered;
- underline the risks/consequences of unaddressed development partner withdrawal and transition on the provision of services and progress made by countries in eastern Europe and central Asia; and
- identify common challenges and good practices in transition planning in the framework of health system reforms.
Introduction

This work is conducted in the context of United Nations (UN), including WHO’s global and regional frameworks and guidance documents such as those outlined below.

1. The WHO Regional Committee for Europe approved Health 2020 (1) in 2012 to provide a framework for government and society to pursue health and well-being. Health 2020 presents the WHO European Region’s social and economic imperatives for action, and supports continued strong efforts to combat communicable diseases. Of particular relevance, Health 2020 noted that the Region has the lowest TB treatment success rate globally, reflecting the high rate of TB drug resistance, and that universal access to TB diagnosis and DOTS-plus ((directly observed treatment, short course) and effective diagnosis and treatment of people with multidrug-resistant TB (MDR-TB) represented a “best buy” as evidence-based and cost-effective interventions to combat communicable diseases.

The Tuberculosis Action Plan for the WHO European Region 2016–2020 (3), with its supporting resolution (Annex 1), is in line with Health 2020 (1), and was endorsed at the 65th session of the WHO Regional Committee for Europe on 17 September 2015 in Vilnius, Lithuania (4).

In 2016, the WHO Regional Office for Europe published the Roadmap to Implement the Tuberculosis Action Plan for the WHO European Region 2016–2020 (2). The Roadmap sets a regional goal and targets for the care and control of TB and drug-resistant TB from 2016 to 2020 by defining strategic directions, and describes activities to be carried out by stakeholders.

The Roadmap highlights that overreliance on donor funds in a number of high-priority countries continues to lead to insufficient (and even decreasing) domestic funding. To address this, the Roadmap seeks to support sustainable arrangements for funding using national resources to ensure uninterrupted access to TB services as countries transition from development partner to domestically financed TB activities. Specifically, the Roadmap states that plans should be developed to increase domestic funding and shared responsibility schemes for TB prevention, control and care in countries receiving financial and/or programmatic development partner support.

2. In September 2015, the UN adopted the 2030 Agenda for Sustainable Development (5), which includes 17 Sustainable Development Goals (SDGs) and 169 targets. SDG 3 (Good health and well-being) specifically commits to ending the epidemics of AIDS, TB, malaria and other communicable diseases by 2030. The aim is to achieve universal health coverage and provide access to safe and affordable medicines and vaccines for all.

In the framework of the UN SDG’s Issue-based Coalition on Health and Well-being for All at All Ages in Europe and Central Asia, the WHO Regional Office for Europe led a consultative process to identify shared principles and key actionable areas within and beyond the health sector to address HIV, TB and viral hepatitis in Europe and central Asia (6). This resulted in the United Nations Common Position on Ending HIV, TB and Viral Hepatitis through Intersectoral Collaboration (5), which also informs this work.

In addition to the frameworks outlined above, a catalyst for this project and the need for WHO support has been driven by the withdrawal of development partners – especially the Global Fund – from countries
in the WHO European Region that are observing increasing financial capacity (in the form of gross national income (GNI) per capita). This is prompting a transition from development partner to domestically funded TB programmes.

In the transition from development partner to domestically funded national health programmes, a development partner transfers the responsibility for the financial, managerial and/or technical support of a programme to domestic stakeholders – usually the government. The current landscape in the WHO European Region is characterized by constrained development partner budgets, competition for funds and possible development partner fatigue. However, many low- and middle-income countries (LICs and MICs) in the Region have observed economic growth and growing fiscal capacity in recent years, providing impetus for increasing pressure on governments in the Region to transition towards domestically funded national programmes and design new, efficient models of health services delivery. Partly under the framework of a United States Agency for International Development regional platform project and partly funded by German funding, the WHO Regional Office for Europe sought to assess self-reliance in selected countries transitioning from Global Fund financing of TB-related activities. This document provides a framework to review self-reliance in TB activities in the selected countries during and after the transition from development partner funding.

In 1987, the UN Brundtland Commission defined sustainable development as "meeting the needs of the present without compromising the ability of future generations to meet their own needs" (7). In similar contexts, where countries are transitioning from development partner to domestically funded programmes, WHO has broadly defined sustainability as the likelihood that a programme will continue to function effectively after development partner support comes to an end (8).

In New York, on 26 September 2018, the UN General Assembly held its first high-level meeting on TB to accelerate efforts in ending TB and reaching all affected people with prevention and care. It endorsed a political declaration to accelerate progress towards End TB targets which was adopted by the General Assembly on 10 October 2018 (Resolution document A/73/L.4) (19).

Importantly, the Global Fund defines transition as the mechanism by which a country, or a country component (i.e. a single disease such as TB, HIV or malaria), moves towards fully funding and implementing its health programmes independently of Global Fund support while sustaining the gains and scaling them up as appropriate (9).

The Global Fund is a financial mechanism that transfers and invests development partners’ money into countries’ programmes – the Global Fund does not have in-country staff and there are no Global Fund programmes. As a result, countries receiving its support must design and implement their own programmes and must also plan and implement their own transition plans. This is done with the assistance of partners such as the Joint United Nations Programme on HIV/AIDS, the United Nations Children’s Fund, WHO and the World Bank (10).

At its 35th Board Meeting, the Global Fund presented The Global Fund Strategy 2017–2022: Investing to End Epidemics (11). The importance of sustainability and transition is explicitly recognized within this strategy under objective 1, subobjective e, which is to "support sustainable responses for epidemic control and successful transitions". As mentioned above, the Global Fund provides the financing mechanizing and the partners assist countries in planning for transition. WHO’s support of objective 1, subobjective e formed the basis of this self-reliance review, which will assess key triggers, enablers, gaps, risks and challenges, and contribute to multistakeholder-informed strategic transition plans to support countries in their preparation for and to thrive after transition. Among the key triggers regarding health system functions, the assessment will analyse the progress with changes in the model of care; the human
resources situation; payment methods; the procurement of medicines; the financial gap; and governance features of the national TB programme (NTP).

The analysis is importation because countries must be able to sustain and scale up programmes to achieve a permanent impact in the fight against TB and move towards achievement of universal health coverage following development partner withdrawal. Further, countries that can afford to assume greater domestic responsibility for NTPs should do so to allow development partners to reallocate funding to those countries in greatest need – but if the gains are to be long term, then countries must be supported throughout this transition.

Experience shows that supporting countries to sustainably transition from Global Fund support requires a significant period of time. This is because it includes investing in the development of robust national health strategies, disease-specific strategic plans and health financing plans that consider programmatic sustainability; aligning requirements to ensure that Global Fund programmes can be implemented through country systems; and providing support for countries to carry out self-reliance assessments and develop transition work plans, when needed, to facilitate well-planned and successful transitions. In addition, the revised application focus and co-financing requirements align domestic financing incentives to ensure that as countries move closer to transition, they implement key programmes such as interventions for key and vulnerable populations.

According to a recent publication from the Stop TB Partnership, countries need to have effective, sustainable and adequate transition plans (12). Early and thorough planning helps to avoid interruption of those services provided with Global Fund support by helping to address the challenges and bottlenecks to transition. Observed or anticipated challenges and bottlenecks to transition include procurement mechanisms for critical commodities; unpreparedness of public services, along with legislative or regulatory changes that prevent civil society organizations (CSOs) from being contracted; and addressing unmet needs pertaining to the prevention, treatment and care of TB, HIV and malaria.

Processes that should be included and considered in transition plans include the predictability of transition; involvement of all stakeholders; effectiveness of transition plans; and technical assistance and guidance during transition. As such, these processes and more are described in the TB Regional Project (TB REP), which promotes efficient models of care, and they will be assessed in the self-reliance review of TB activities in the selected countries.

Before defining the methodology and launching the review, it is useful to learn lessons from both successful and unsuccessful transitions. Croatia's transition from a Global Fund financed to a domestically funded HIV/AIDS programme is a successful case study. Here, a well-planned transition acted as a conduit not only for maintenance but also for expansion of the programme. The Global Fund supported Croatia's last project (Scaling up the HIV/AIDS response in Croatia) from 2003 to 2006. Long before completion of the transition process, Croatia had an institutionalized national HIV response mechanism with established governance structures and strong involvement of CSOs. Consequently, 10 years after Croatia assumed full responsibility for the programme, the country succeeded in not only in sustaining the national HIV response but also in expanding many of its components.

On the other hand, as illustrated by the situation in Romania, inadequate domestic funding coupled with the unprepared health systems' functions (including health system governance) and lack of – or poor – legislation, service financing mechanisms and access to medicines can exacerbate the barriers to smooth transition. Due to existing legislation, the National Drug Agency in Romania is unable to approve and, therefore, register the use of anti-TB medicines manufactured outside Western Europe or the United States of America, regardless of their cost–effectiveness, affordability or how well demonstrated their
safety and effectiveness profiles are. Some medicines needed to treat MDR-TB, including extensively
drug-resistant TB, are being blocked for national use from any source (even when received as a donation)
because of the existing legislation application. In addition to ensuring appropriate domestic funding for
TB care, there is a need for revision of current legislation, for instance on service delivery and on
medicines procurement. Further, issues of affordability are promulgated by a continually decreasing
budget for the NTP in Romania, and lack of political commitment meant that when Global Fund support
for HIV services ended in 2010, the prevalence of HIV infection among people who inject drugs rose
(from 3% in 2010 to 29% in 2013, however, the rate of new infections began to slow between 2014 and

This document provides novel and much-needed practical support for TB stakeholders seeking to review
their preparedness for self-reliance in countries receiving development partner support for TB activities. It
supports self-determination and proactive, collaborative involvement from country-level TB teams
working across different areas of program implementation.

It also allows for the consideration and application of indicators and parameters from different UN
organizations, ministries and development partners, including ministries of health, finance, justice and the
interior, the Global Fund, the International Committee of the Red Cross, the Program for Appropriate
Technology in Health, the United Nations Development Programme, the United States Agency for
International Development (USAID), WHO and the World Bank. In doing so, it allows a broad and deep
review of cross-cutting variables in pursuit of capturing a realistic picture of the current and emergent
gaps in TB activities.

The Global Fund grant cycle and eligibility for Global Fund support (TB component) 2017–2019

Since 2002, the Global Fund and WHO have worked together closely to address the HIV, TB and malaria
epidemics. WHO supports countries at all stages of the Global Fund grant cycle (outlined in Error!
Reference source not found.). In addition to its core functions, WHO assists countries in developing
their Global Fund proposals and funding requests; strengthening their TB strategic plans and investment
cases to ensure they are technically sound, feasible to implement and impact oriented; prioritizing
interventions to maximize the impact of limited resources; and assessing quality assurance processes and
remote reviews to ensure that proposals are technically sound and will have an impact on a country’s
epidemics (16).

The WHO Regional Office for Europe is committed to working across all mechanisms to support
implementation of the 2017–2022 Global Fund strategy that is aligned with SDG 3 and the global and
regional strategies for HIV, TB and malaria. This project puts this commitment into action, by supporting
countries as they transition not only through the Global Fund’s Grant Cycle but also towards domestically
funded TB programmes.

Fig. 1. The Global Fund grant cycle
While countries may transition voluntarily from development partner-funded national health programmes (mainly for political reasons), most do so because they are no longer eligible for such support. The Global Fund's Eligibility List 2017 (17) (updated in 2018 (18)) identifies which country components (HIV/AIDS, TB or malaria) may be eligible to receive an allocation for the 2017–2019 period, noting that eligibility does not guarantee an allocation.
The Global Fund Eligibility Policy\(^1\) (Fig. 2) determines whether a country is eligible to apply, whether restrictions apply to funding (e.g. support for vulnerable populations only) and the level of co-financing required. This ensures that available resources are allocated to countries according to need (i.e. those with the highest disease burden and lowest economic capacity) and to populations disproportionately affected by the three diseases. Eligibility is determined by a country's income classification, as measured by GNI per capita (World Bank Atlas method \(^2\)), G20 membership and official disease burden categorization.

World Bank income classifications group countries into five categories: LICs, lower-middle-income countries (LMICs), MICs, upper-middle-income countries (UMICs) and high-income countries (HICs). The Global Fund classification further divides LMICs into two groups, namely lower LMICs and upper LMICs, based on the midpoint of the GNI per capita range of the World Bank's LMIC category. This division of LMICs does not affect eligibility but is relevant to the Global Fund co-financing requirements set forth in the Sustainability, Transition and Co-financing Policy.\(^2\)

Each eligible country, through its country coordinating mechanism (CCM), submits funding requests for eligible disease components on behalf of the country as a whole. Funding is available for a three-year period, known as an allocation period. Countries have been able to apply for the 2017–2019 allocation period since January 2017; they can submit their applications during the submission windows in that

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\(^1\) In Annex 1 to GF/B35/04 – Revision 1 Board Decision (9).

\(^2\) In Annex 1 to GF/B35/04 – Revision 1 Board Decision (9).

LMIC: lower-middle-income country; UMIC: upper-middle-income country.

Source: Global Fund, 2018 (19).
three-year time frame. Table 1 shows the income category, TB burden, eligibility status and 2017–2019 allocation (in US$) for the selected countries discussed herein.

WHO provides guidance during the funding application process to applicant countries and on technical issues to the Global Fund’s Technical Review Panel (quarterly), Grant Approvals Committee (monthly), and partners’ Situation Rooms for HIV, TB and malaria (weekly), and on cross-cutting issues (weekly).

**Table 1. Income category, TB burden, eligibility status and allocation of selected countries: TB component**

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<tbody>
<tr>
<td>Armenia⁴</td>
<td>UMIC</td>
<td>Moderate</td>
<td>Transition</td>
<td>3 138 925</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>UMIC</td>
<td>Severe</td>
<td>Yes</td>
<td>6 529 446</td>
</tr>
<tr>
<td>Belarus</td>
<td>UMIC</td>
<td>High</td>
<td>Yes</td>
<td>7 977 941</td>
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<tr>
<td>Georgia</td>
<td>UMIC</td>
<td>High</td>
<td>Yes</td>
<td>7 175 076</td>
</tr>
<tr>
<td>Republic of Moldova</td>
<td>Lower LMIC</td>
<td>Severe</td>
<td>Yes</td>
<td>8 751 802</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Upper LMIC</td>
<td>Severe</td>
<td>Yes</td>
<td>48 646 090</td>
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Similarly, a country or a disease component (i.e. HIV/AIDS, TB or malaria) may become ineligible for Global Fund support due to one of the following factors.

1. A country moves to a HIC status.
2. A country moves to a UMIC status and the disease burden for a component is low or moderate (as in the case of Armenia; shown in Table 1).
3. The disease burden for a component decreases to low or moderate in a UMIC.
4. A country is a member of the G20 and moves to UMIC status, and the disease burden for a component is less than extreme.
5. A country becomes a member of the Organization for Economic Co-operation and Development’s Development Assistance Committee.

Therefore, LICs and LMICs are eligible to receive an allocation and to apply for funding irrespective of their disease burden, HICs are ineligible regardless of disease burden, and UMICs may be ineligible for one disease component and eligible for others.⁴⁵⁶

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³ Armenia is newly classified as a UMIC as per the three-year average of GNI per capita data (World Bank Atlas method) and income classification thresholds published by the World Bank. As a result, the TB component is now eligible for a final allocation of Transition Funding.

⁴ With the exception of countries certified as malaria free by WHO or on the WHO supplementary list of countries free of malaria that are not eligible for funding (paragraph 8, Annex 2 to GF/B35/06 – Revision 1 (11)).
The Global Fund Eligibility Policy allows for Transition Funding for up to three years to cover priority transition needs for disease components that become ineligible from one allocation period to the next, unless a country moves to HIC status; is a member of the G20 and moves to UMIC status and has less than an extreme disease burden; or becomes a member of the Organization for Economic Co-operation and Development's Development Assistance Committee.7

Such eligibility criteria are important because they provide a platform from which the WHO Regional Office for Europe can identify countries approaching transition, estimate the speed at which each may be forced to move through the transition process and, from here, support countries to identify and prioritize the most important gaps to address in transition plans.

Elements of the self-reliance review in the selected countries

Triggers for transition

The Global Fund defines a trigger as "the conditions that put a country in a better position to take up greater responsibility for their HIV/AIDS, TB and malaria programmes" (22). These triggers include the population growth rate and gross domestic product (GDP) growth rate; per capita income; disease burden; proportion of external financing as a percentage of total funding to HIV/AIDS, TB and malaria programmes; services being supported by the Global Fund; and proportion of Global Fund financing as a proportion of external funding.

Such critical determinants should be considered when developing transition and sustainability plans (TSPs), and the WHO Regional Office for Europe's implementation of this guidance document will support countries to ensure that TSPs reflect their current and future financing and programmatic requirements to prevent gaps in TB services. In addition to the triggers recommended by the Global Fund, the self-reliance review that will emerge from this guidance document endeavours to include all of the indicators listed in the following section.

Triggers included in the financial sustainability assessment can be broadly divided into four categories: demographic, economic, disease burden and health finance. Disease burden indicators are further divided into health related and cost related, and health financing indicators are further divided into general health system financing indicators and those specific to TB.

With regard to health system functions, the key triggers reviewed shall include, to the fullest extent possible, the progress of changes in the model of care; human resources situation; payment methods; procurement of medicines; financial gap; and governance features of the NTP.

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5 UMICs designated under the small island economy exception to International Development Association lending requirements are eligible regardless of the national disease burden.

6 Paragraph 5.d., Annex 2 to GF/B35/04 – Revision 1 Board Decision (9).

7 Paragraph 13, Annex 2 to GF/B35/06 – Revision 1 (21).
\textbf{Demographic indicators}

A country's size and rate of population growth, particularly alterations in age composition (e.g. age dependency ratio), affect long-term planning of health service delivery mechanisms. The \textit{age dependency ratio} is a measure showing the proportion of dependents (aged 0–14 years and over 65 years) to the total population (aged 15–64 years). This is useful because different age groups have varying impacts on infrastructure needs and contributions to (or reliance on) publicly provided resources. Similarly, understanding the age structure of a population is useful for analysing future policy and planning goals involving infrastructure, taxation generation and development patterns.

Further, these indicators in relation to current and projected available resources partly determine the size and nature of the gap that must be addressed via resource mobilization efforts to ensure that health systems meet the health-care needs of the entire population (23). The population size and growth rate relative to other indicators also provide important insights. For example, low population growth alongside high GDP growth facilitates increased domestic financing.

In addition to population size and growth, which impact the quantity and type of health services demanded, the growing complexity of TB cases – mainly due to increasingly complicated drug resistance patterns and cases of such – is another key influencer. The impact of this should be carefully considered, particularly in terms of reconfiguring models of TB care, the allocation or re-allocation of funds, and the corresponding payment and human resources mechanisms.

Demographic indicators are as follows:

- population size
- population growth rate
- age dependency ratio

These indicators will be sourced and informed by World Bank data (24).

\textbf{Economic indicators}

The economic performance of a country determines its financial capacity to fund health budgets and expenditure at both national and individual levels; however, it should be noted that increasing capacity does not necessarily translate into increased prioritization of health.

\textbf{GDP} measures the monetary value of final goods and services – that is, the output generated within the borders of a country. It provides information on the size of the economy and how an economy is performing. The \textbf{growth rate of real GDP} is often used as an indicator of the general health of the economy. GDP also provides an indicator of the financial capacity of a country to meet its budgetary obligations – including those for health. A higher GDP increases government revenue, presenting an opportunity for enhanced financing and sustainability of health services through increased budgetary allocations and spending. \textbf{GNI per capita}, on the other hand, determines the financial capacity of individuals to spend. A higher income per capita results in a higher disposable income at the individual level; this can be spent on various services including health. Although changes in the output of goods and services per person (GDP per capita) and income per capita are often used as measures of whether the average citizen in a country is better or worse off, they do not capture things that may be deemed important to general well-being, such as standard of living. To address this shortfall, the Human Development Index provides a composite statistic of life expectancy at birth, education (years of
schooling) and standard of living (as GNI per capita), which is used to rank countries into four tiers of human development. These indicators provide important insights into a country's capacity to domestically finance an NTP (25).

Economic indicators are as follows:

- GDP
- % GDP growth
- GNI
- per capita income (as GNI per capita)
- Human Development Index (HDI)

These indicators will be sourced from the World Bank (24) and United Nations Development Programme Human Development Report (2016) (26).

**Burden of disease**

The burden associated with TB will provide an overview of the impact it has on each of the selected countries in terms of costs – both human and financial. This will be measured in terms of disease-related indicators and cost-related indicators (the latter of which are largely dependent on the former, since overall cost is a function of volume and price per health-care input).

One disability-adjusted life-year is equal to one year of healthy life lost, and the sum of disability-adjusted life-years across the population (or disease burden) can be thought of as a measure of the gap between current health status and an ideal health situation in which the entire population lives to an advanced age, free of disease and disability (27).

The equation for total health expenditure (THE) is:

\[ \text{THE} = P \times V, \]

where \( P \) = price and \( V \) = volume of services.

The economic impact of TB evolves with changes to both factors on the right-hand-side of the equation, that is changing price (e.g. treatments) and volumes (e.g. prevalence, diagnosis), and should therefore be systematically revisited to accurately inform policy decisions based on changing prices (for example, if changing procurement mechanisms) or demographic shifts.

The disease burden observed in a country determines the resources required to establish and maintain a health system capable of achieving universal access to health-care services. In measuring lost productivity, the disease burden also illustrates the opportunity cost of ill health and the impact that disease has on the country's productivity – both of these factors demonstrate the importance of investing in health to maximize productivity and avert direct and indirect costs. As such, the disease burden is an important factor driving decision-makers' motivation to commit financial resources to the development, maintenance and sustainability of health-care service delivery.
Disease-related indicators are as follows:

- morbidity:
  - prevalence of TB
  - prevalence of MDR-TB/rifampicin-resistant TB
  - prevalence of TB/HIV coinfection
  - incidence of TB
  - incidence of MDR-TB/rifampicin-resistant TB
  - incidence of TB/HIV coinfection; and
- mortality.

These indicators will be sourced from WHO (28), unless otherwise specified.

For **cost-related indicators**, see TB-specific funding and sustainability indicators (listed below).

**Health financing indicators**

THE is also influenced by the financial capacity of government and individuals (as outlined in the economic indicators, above), the prioritization of health services relative to other services (e.g. defence, education) and the health-seeking behaviour of citizens.

Higher GDP and per capita incomes *should* translate into higher prioritization of domestic funding of health services. Therefore, higher public health expenditure as a percentage of THE is a manifestation of a government's commitment to investing in the health of its people, and a prerequisite for assuming increasing (and eventually, total) domestic financial responsibility. The combination of these factors determines a country's capacity to sustain or assume increasing financial responsibility for health services.

General health system financing indicators are as follows:

- expenditure on health care by financing schemes and functions of care
- THE
- THE, public (% of total government spending)
- health expenditure per capita (current US dollars)
- health expenditure, public (% of THE)
- health expenditure, total (% of GDP)
- out-of-pocket health expenditure (% of THE)
- development partner spending on health (% of THE)
- Global Fund spending on health (% of THE)
- Global Fund spending on health (% of total development partner spending on health).
These indicators will be informed by the following sources, unless otherwise specified:

- WHO SHA2011 manual (Table 15.2 on page 353) (29)
- WHO TB data (28)
- the Global Fund (30)
- the World Bank (24)
- Trading Economics (31).

**TB-specific funding and sustainability indicators** are as follows (historic and current expenditures and resources required):

- total contribution to TB services by years 5–10 by:
  - government
  - the Global Fund
  - USAID
  - other development partners;
- TB patient cost by model of care:
  - ambulatory
  - community\
  - hospital;
- TB patient cost (when available; when cost data unavailable, expenditure data will be used as an indicator) by:
  - direct medical costs (split into four: public | private | development partner | Global Fund)
  - indirect medical costs (split into four: public | private | development partner | Global Fund)
  - societal costs (e.g. lost productivity)
  - pharmaceutical expenditure only (split into four: public | private | development partner | Global Fund);
- government contribution distributed by main budget items:

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8 Community model-related costs mainly consider outreach expenses, with the remaining being attributed to ambulatory care. This model is not well developed in the selected countries and, as such, meaningful conclusions related to this indicator may not be possible.
- wages/salaries\(^9\)
- anti-TB drugs and other TB supplies
- total pharmaceutical and other medical supplies
- constructions/renovations of TB health-care service delivery infrastructure
- nutrition-related costs for TB inpatients in public hospitals
- other\(^{10}\),

• development partner contribution by main budget items:
  - anti-TB drugs
  - technical assistance and health system strengthening
  - patient support
  - other;

• underfunded services for TB patients
  - hospital services
  - ambulatory services
  - salaries for TB staff (all staff in TB facilities)
  - salaries for staff in non-TB-specific facilities (as % of time dedicated to TB patients)
  - anti-TB drugs
  - non-TB drugs
  - laboratory services and consumables
  - other.

These indicators will be informed by various sources (to be determined), depending on availability of data from the selected countries. **When cost data is unavailable, expenditure data will be used as an indicator and referenced accordingly.**

Important factors influencing sustainability are countries' spending on TB programmes and Global Fund financing as a proportion of total programme spending and as a proportion of development partner funding. The level of spending on TB and the respective sources of funding will influence the decision to take up financial responsibility, the size and nature of the gap to be filled, and the sustainability of services and activities supported by national programmes. The data presented above will be collected

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\(^9\) TB-related medical staff engaged only with TB and working in TB hospitals and dispensaries.

\(^{10}\) This classification is expected to include communication, transportation (some facilities have cars), electricity and water costs.
from the selected countries and used to highlight the most important gaps. In turn, this will inform
country-specific transition plans.

**Enablers of sustained transition**

To avoid disrupting TB programmes and to ensure the long-term sustainable impact of development
partner investments, it is vital that governments succeed in transitioning from development partner
assistance to domestic financing of TB programmes. WHO’s Health Financing Country Diagnostic
provides a foundation for national strategy development (32). Elements of this tool were used to inform
the assessment of the performance of the country’s progress against the objectives and goals of universal
health coverage. The probability of successful transitions can also be increased by following a
collaborative and coordinated process for managing transitions (33). This process includes: pre-transition
assessment of readiness; an agreed transition plan that proactively mitigates identified risks; a framework
for monitoring the transition process; and a mechanism for ensuring accountability. This guidance
document supports pre-transition assessment and the development of TSPs that reflect important gaps.

Critical enablers of a successful transition from development partner-financed to domestically financed
TB programmes include the availability of predictable financing for TB programmes, strong
programmatic and institutional capacity to sustain and improve TB services, and political will to support
the TB programme. Governments need time to develop accurate medium-term budgetary and planning
frameworks to finance existing and scaled-up programmes and invest in increasing service coverage,
strengthen institutional capacities for procurement and service delivery, and advocate to create the
political will to support TB programmes in establishing better and more efficient models of care. This is
particularly true for countries that are assuming increasing financial responsibility across multiple health
programmes (e.g. NTPs and National Immunization Programmes) and are therefore taking on significant
financial commitments within the broader context of competing priorities and finite funds.

Barriers also exist and, paradoxically, some may even be linked to enablers. For example, if a country
experiences a rapid increase in GNI and is subsequently required to progress rapidly through the
transition process, there may be inadequate time to prepare for the transition and inadequate engagement
with development partners in preparation for the end of Global Fund support. This can be particularly
challenging for countries with institutional and programmatic weaknesses, which require more time and
greater investments to expand coverage and strengthen systems, in addition to financing requirements.
Lessons learned from countries transitioning through the GAVI Alliance programme show that countries
are at a higher risk of failing to transition successfully when faster-than-expected growth is coupled with
weak immunization programmes (34).

**Income category of the country, economic trends and health financing**

The economic performance of a country determines its financial capacity and predictability to fund health
budgets and expenditure at both national and individual levels. However, it should be noted that
increasing capacity does not necessarily translate into increased prioritization of health.

Health financing capacity indicators are as follows:

- income category
• movement within/between income category (predicted movement will also form the analysis)
• health financing mechanism
• health budget trends

These indicators will be informed by various sources including the World Bank, the Global Fund and data from the selected countries.

Health system functions

Health systems include many important interconnections between the functions and roles of decision-makers and stakeholders. These functions are often described as health system building blocks, and include governance (e.g. policy-making, regulation), health service provision (e.g. clinical services, health promotion), and financing, and managing resources (e.g. pharmaceuticals, medical equipment, information) (35).

Financing and governance

Countries should invest in health systems in a manner that improves access to services for target populations with the ultimate aim of achieving equitable and universal access to health care. Therefore, countries should have clear policies and strategies for strengthening public health systems. Governance and leadership in the health sector is also critical and as such, investments should be directed towards establishing and improving both.

Financing and governance indicators:
• integrated models of health service delivery
• adequate supply of well-trained health-care workers
• health system leadership and governance
• TB treatment coverage
• access to health protected in the constitution
• protections for key populations in place
• community engagement activities for TB.

These indicators will be informed by various sources including WHO Health Observatory (36), Global Fund country-specific documentation (30) and, when necessary, self-reported inputs from surveys.

Political will

Political will determines whether policy-makers prioritize or deprioritize an issue on the political agenda, and this is reflected at the macro level (e.g. health vs defence) and micro level (e.g. TB vs hepatitis, reimbursement of one anti-TB drug over another). Political will is based largely on constituent support, and is a particularly relevant consideration in health policy because returns on investment may not be observed for many years, or even decades – far beyond policy-makers' political terms. As such, constituents (including CSOs) must understand the future value of health policies (e.g. prevention and harm minimization approaches to HIV/AIDS, TB and malaria) and advocate for or support such policies.
With this in mind, investments in health (including those specific to TB, HIV and malaria) are dependent on policy-makers and their key constituencies understanding the value of such, and their willingness and ability to champion, support, allocate and maintain sufficient investments. It is also important to ensure that decisions are not only made according to lobbying efforts, which tend to address the demands of those with the loudest voice, rather than to those with unmet needs. Instead, policies and legal frameworks should be evidence based and facilitate long-term, sustainable service delivery for those that rely on them. To facilitate this, a platform should exist to support a multistakeholder and multisectoral approach to policy-making, which allows for the engagement and involvement of all relevant stakeholders. Doing so will ensure that theory aligns with pragmatic aspects, with the latter determining the feasibility and success of implementation.

Political will cannot be measured easily: it is multidimensional, and a single quantitative indicator does not exist. Further, political will exists on a continuum: at the negative extreme, you may have leaders who silence or dismiss patient advocacy groups; towards the middle of the continuum, you may have leaders who are neutral then leaders that champion TB and are expressing a commitment to the issue and creating a climate that encourages solutions; and at the positive extreme, leaders may have established enabling policies, propose, support, implement, evaluate and maintain TB programmes, provide funding, appoint the most capable people to key positions, demand accountability, and participate in regular programme reviews and evaluations. With this in mind, each of the selected countries should be assessed against these considerations and logged on the continuum of political will.

Political will and support for TB activities will be informed by various sources including WHO, the Global Fund, country-specific documentation and, when necessary, self-reported inputs from surveys.

**Institutionalized frameworks for coordination, management and implementation of TB programmes**

Effectively integrated and institutionalized national HIV/AIDS, TB and malaria programmes enable health systems to deliver a bundle of services that reflect the needs of the population (in terms of breadth/service type, depth/quantity and mode of delivery). Further, countries with strong coordination and management mechanisms for the three programmes have demonstrated effective service delivery, as seen in the cases of South Africa and Thailand (22). However, the Global Fund has no policy or guidelines in place for evaluating the need for continuing CCMs. Rather, this is done in a non-systematic and informal manner, often on an ad hoc or case-by-case basis following the transition from Global Fund to domestic responsibility.

The order in which the evaluation process currently occurs precludes countries from adequately identifying potential barriers and opportunities and from preparing for these accordingly. Further, there is no policy addressing the extent of funding for CCMs following transition, nor on securing alternative sources of funding for CCM operations. Of the 50 countries reviewed in the Global Fund's Audit Report, nine have already transitioned from the Global Fund and only one of the nine has a CCM in place (37). Further details were not available to present a relevant case study on a country that has undergone the transition process and emerged with a functioning CCM. Nonetheless, factors known to support this, include effective integration of the CCM into national systems, strong coordination with stakeholders and

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11 Country Coordinating Mechanisms are national committees in each country that submit funding applications to the Global Fund on behalf of the entire country. They include representatives from government, the private sector, technical partners, civil society and communities living with the diseases.
full engagement of civil society. A well-structured managerial body capable of filling this remit has the appropriate mandate, authority and capacity to act.

As such, the following indicators will be used (informed by various sources including WHO, the Global Fund, country-specific documentation and when necessary, self-reported inputs from surveys):

- well-structured managerial body responsible and accountable for TB activities (NTP)
- health information system in place
- CCM integrated into national system
- CCM funding following transition
- estimated cost of CCM
- sources of funding for CCM
- plan exists for securing funding for CCM
- stakeholder engagement plan or approach in place
- national TB plan in place with SMART\textsuperscript{12} objectives in line with WHO Regional Office for Europe action plan and implemented according to intention
- earmarked budget for HIV/TB/malaria
- earmarked budget for TB services
- up-to-date guidelines for screening, diagnosis and treatment of TB.

**Collaboration with other development partners**

Empirical evidence shows that transition from development partner to domestically funded programmes is more difficult for countries when development partners collaborate inadequately with them during the process. For this reason, it is important to engage and coordinate activities with all necessary TB stakeholders to achieve the smoothest transition possible. Key TB stakeholders include, but are not limited to, USAID and those managing USAID-funded projects, Médecins Sans Frontières, and the International Committee of the Red Cross, the latter of which is primarily involved in TB-related activities in the penitentiary system. As such, all key stakeholders and development partners involved in TB prevention, treatment and care in the selected countries should be engaged with the aim of reviewing, revising and aligning TB sustainability plans.

Accordingly, the self-reliance review will assess collaboration efforts (observed and planned) between and among development partners and countries. This will be informed by a formal or informal survey.

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\textsuperscript{12} Specific, measurable, achievable, relevant and time based.
Involvement of the Global Fund

Involvement of the Global Fund in guiding countries during the planning, implementation and monitoring of the transition process enables countries to transition more smoothly. According to its Sustainability, Transition and Co-financing Policy (9), the Global Fund is committed to supporting countries through partnerships at all levels in developing and implementing appropriate health financing strategies. Through its grants, with WHO technical assistance and the expertise of other technical partners, the Global Fund will contribute to financing the identified reforms and actions needed to increase domestic resources for health and enable greater efficiency and effectiveness in health spending.

It is desirable that the Global Fund adopts a country-specific approach to sustainability planning and implementation to ensure that the most relevant challenges and opportunities in each country are addressed. This in turn will provide each country with a tailored sustainability and implementation plan that highlights the best path towards thriving in a post-transition environment.

As such, a platform should be created to ensure regular touchpoints and progress updates are shared between the Global Fund and countries in transition.

Sustainability approaches by other development partners in health

Examining the practices in using guidelines and strategies of other key development partners in the health sector will be useful to identify lessons that inform financial sustainability plans for TB programmes. These development partners include the United States Government's President's Emergency Plan for AIDS Relief, GAVI Alliance, World Bank and Department for International Development. For example, GAVI Alliance goals are formulated to ensure countries can independently sustain high immunization coverage and equal access to life-saving vaccines. Eligibility, transition and co-financing policies are at the core of the GAVI Alliance approach to sustainability.

GAVI Alliance support is aimed at lower-income countries, it is time-limited and directly linked to the governments' ability to pay for vaccines, depending on which phase of the GAVI Alliance transition process they have reached. A country's ability to pay is determined by their GNI per capita, as calculated by the World Bank Atlas method (20). Countries are eligible to apply for GAVI Alliance support when their GNI per capita is below or equal to US$ 1580, on a three-year rolling average (according to World Bank data (25) issued in July each year).

LICs enter GAVI Alliance support in the initial phase, where they pay a small amount towards their vaccine costs (in 2010, this was 20 cents per vaccine dose). Countries then move to the intermediate transition phase, during this period the price fraction of their co-financing is set at 20 cents per dose plus a 15% increase per year. For example, they would pay 20 cents in year 1, 23 cents in year 2, 27 cents in year 3, 36 cents in year 4 and 40 cents in year 5. As their GNI per capita grows, they enter the accelerated transition (graduation) phase – a five-year period when co-financing reaches 100% of vaccine costs and support is phased out. The first year is considered a so-called "grace year": countries observe only a 15% increase from the last year in the intermediate phase to the first year of the graduation phase. Therefore, countries would pay 46 cents in year 1 of this phase, but a steeper increase in financial accountability is required from year 2 onwards (i.e. 20% of vaccine costs in year 1, 40% in year 2, 60% in year 3, 80% in year 4 and 100% in year 5.

While this appears straightforward, it is important to note that this transition process does not operate in a vacuum. For example, if a country's exchange rate weakens or the price of a vaccine increases during the graduation phase, affordability may again be at risk, regardless of the country's overall economic
performance. Further, it is important to consider that Ministry of Health budgets are probably being required to assume greater financial accountability across multiple areas – for example, national immunization programmes and NTPs.

In addition to vaccine financing, the GAVI Alliance, WHO and the United Nations Children’s Fund work to provide technical assistance and support in health system strengthening, as needed, throughout and beyond the transition period. In 2016, three of the countries discussed herein (Armenia, Azerbaijan, Georgia) were in the accelerated phase of transition, and all three country’s national immunization programmes are now 100% self-financed (38–40).

With the above-mentioned points in mind, this project will include case studies to highlight lessons learned from comparable transitions.

**Review of recent TB national strategic, transition or sustainability plans**

The TB national strategic plans (NSPs) of the selected countries discussed herein should be reviewed and revised to ensure that financial sustainability is considered in the long term. When relevant, the following elements of NSPs will be reviewed and presented as case studies to highlight good practices and lessons learned:

- how the process of sustainability planning was established;
- how stakeholders were identified, engaged and involved in the planning process;
- whether the finance ministry, health ministry, health insurance funds (if/when relevant) participated in the process and considerations for such involvement;
- whether and how CSOs were engaged in the planning process, and to what extent and to what outcome;
- whether the Global Fund was involved in planning and the factors and outcomes associated with its exclusion/inclusion; and
- whether the sustainability plan is harmonized with the plans of partners.

**Self-reliance: transition-related challenges**

There are three key challenges facing countries transitioning from development partner-financed TB programmes to domestically financed programmes: (i) limited expertise in the development of sustainability plans; (ii) allocation of limited domestic funding to prevention services, especially for TB/HIV coinfection, targeting key populations and delivered through the community health system; and (iii) poor coordination of development partners in development and implementation of sustainability plans (22). The commonality between these challenges is related to the difficulty in gradually integrating and financing the vertical TB programme areas to provide a sustainably financed continuum of care for all public health services (41).

As such, the degree of expertise will be assessed, along with allocation of domestic funding and coordination of development partners. This will be informed by country reports, development partner reports and self-reported responses and observations from key in-country stakeholders and development partners.
In addition to the above, every effort must be made to ensure the strategic plans that emerge from this process are functional, sustainable and realistic.

**Limitations**

While this guidance document provides much-needed practical support for TB stakeholders seeking to review their preparedness for self-reliance in countries receiving development partner support for TB activities, it has some important limitations.

The completeness and applicability of the resulting reviews will depend on the reliability and availability of quantitative and qualitative data in each country. Moreover, the size and nature of the gaps identified and the relevance and priority of possible solutions to address such will only be as robust as the data that informs them.

A further data-related limitation to the application of this guidance document pertains to its reliance on self-reported data. The application of this guidance will require in-country stakeholders to assess their current and future situations in regards to decreasing funding. Even where there is no incentive or propensity to over- or understate the size and nature of the gaps emerging from development partner investment scale-down, the potential for unintentional bias in reporting remains a possibility. To limit this, quantitative and qualitative data could be reviewed by in-country peers.

Finally, this review guidance should be reapplied and progress evaluated repeatedly throughout the transition process to ensure that strategies are shifting countries towards self-reliance within the required time frame.
Conclusions

This document provides guidance to assess the size and nature of current or emergent financial and programmatic gaps in countries transitioning from development partner to domestically financed TB activities, and to identify the best approach in the selected countries to address these gaps. Key areas considered include political commitment with adequate resources, including universal health coverage policies; health system strengthening in all of its functions, including well aligned financing mechanisms for TB and human resources; regulatory frameworks for surveillance, registration, quality and the rational use of medicines, and pharmacovigilance; infection control in all relevant health-care facilities and community systems, and civil society engagement; and actions on other determinants of TB, such as TB activities in prisons.

This guidance document will be used to support a review of self-reliance in selected countries in the WHO European Region.
References


The Regional Committee,

Having considered the Tuberculosis action plan for the WHO European Region 2016–2020 (document EUR/RC65/17 Rev.1);

Recognizing the importance of tackling tuberculosis within the framework of Health 2020,¹ the WHO European policy framework, to improve the health and well-being of populations and to reduce health inequalities;

Noting the commitment of the WHO European Region to respond urgently to the threat tuberculosis poses to public health and among those Member States that participated, through the Berlin Declaration on Tuberculosis, adopted by the WHO European Ministerial Forum – All Against Tuberculosis in 2007, and the Eastern Partnership Ministerial Conference on Tuberculosis and Multidrug-resistant Tuberculosis; and to end tuberculosis in the European Region through the Joint Riga Declaration on Tuberculosis and its Multidrug-resistance in 2015;

Recalling World Health Assembly resolution WHA62.15 on prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis (M/XDR-TB)

as part of the transition to universal health coverage, and the 2009 Beijing “Call for Action” on tuberculosis control and patient care;

Recalling resolution EUR/RC61/R7, which adopted the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015 as a strategic framework for action by Member States in the European Region;

Recalling resolutions EUR/RC61/R6 and WHA68.7 on antibiotic resistance as policies to prevent and mitigate antimicrobial resistance, which also contribute to the prevention and control of M/XDR-TB;

Acknowledging that most of the milestones for Member States, the Secretariat and partners to scale up a comprehensive response to prevent and control tuberculosis and M/XDR-TB under the Consolidated Action Plan have been achieved, including significant increases in case detection and treatment coverage, and that Millennium Development Goal 6 on reversing tuberculosis incidence has been reached;

Concerned that despite this progress, there is continuing primary transmission of MDR-TB and decreasing treatment success rates among M/XDR-TB patients in several Member States;

Concerned over an increasing prevalence of HIV among tuberculosis cases and a growing inequality highlighted by the divergent epidemiological picture of tuberculosis across the Region and within countries, particularly among vulnerable groups, and aware that tuberculosis and MDR-TB are also cross-border health threats due to increased mobility of the population;

Recognizing the need for increased political commitment to ensure efficient and evidence-based tuberculosis prevention and expanded access to new models of care, new drugs and tools, as well as social approaches and strategies for tuberculosis management in the context of health systems strengthening;
Noting that the post-2015 global End TB Strategy for ending the global tuberculosis epidemic by 2035, endorsed by resolution WHA67.1, calls for regional support in the implementation of the Strategy; and acknowledging alignment of the Tuberculosis action plan for the WHO European Region 2016–2020 with the global End TB Strategy;

Understanding that this resolution covers the period from 2016–2020 and thereby succeeds resolution EUR/RC61/R7, which endorsed the Consolidated Action Plan from 2011–2015;

1. ADOPTS the Tuberculosis action plan for the WHO European Region 2016–2020 and its targets;

2. URGES Member States:2
   (a) to align, as appropriate, their national health strategies and/or national tuberculosis and M/XDR-TB response with the Tuberculosis action plan for the WHO European Region 2016–2020 and to closely monitor and evaluate implementation as outlined in the action plan;
   (b) to facilitate equitable access to early diagnosis and effective treatment until completion for all forms of tuberculosis including rational and adequate use of new drugs;
   (c) to identify and address health systems challenges related to the prevention and care of all forms of tuberculosis, particularly to integrate tuberculosis services into the primary health care level and to scale-up patient-centred care initiatives and approaches and improve access to tuberculosis prevention and care for hard-to-reach and vulnerable populations;
   (d) to address social determinants of tuberculosis, the prevention of insurmountable costs to patients and their households due to tuberculosis, and the provision of social support to patients, including multisectoral and civil society collaboration as appropriate;

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2 And regional economic integration organizations, where applicable
(e) to adopt sustainable financial mechanisms and strengthen human resources capacity for tuberculosis prevention and care, particularly in countries with decreasing external funding, and to move from external financing to self-financing: working with all relevant actors, including ministries of health and finance, parliaments, intergovernmental and non-State actors, to secure the long-term sustainability of programmes, including services for hard-to-reach and vulnerable populations, from domestic resources;

3. REQUESTS the Regional Director:

(a) to support Member States in the implementation of the Tuberculosis action plan for the WHO European Region 2016–2020 by providing leadership, strategic direction and technical support to Member States, upon request;

(b) to continue working in partnership with international, intergovernmental and non-State actors;

(c) to monitor implementation and report to the Regional Committee at its 68th and 70th sessions in 2018 and 2020, respectively, on implementation of the Tuberculosis action plan for the WHO European Region 2016–2020.

Reference

The WHO Regional Office for Europe

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

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
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World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel: +45 45 33 70 00   Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int