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The Global Fund

Interregional workshop in preparation for transitioning towards domestic financing in TB, HIV and Malaria response

Tbilisi, Georgia, 17–19 October

Workshop Report

Interregional workshop in preparation for transitioning towards domestic financing in TB, HIV and Malaria response

Tbilisi, Georgia, 17–19 October

Abstract

An interregional workshop to prepare countries for transitioning to domestic financing in the tuberculosis, HIV and malaria response, organized jointly by the WHO Regional Office for Europe, WHO headquarters, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States Agency for International Development, took place on 17–19 October 2018, in Tbilisi, Georgia. The overall objective was to provide a platform for countries and key partners to exchange good practices, lessons learned and common challenges in transitioning to domestic financing, and to define the next steps and technical assistance needs. Participants included representatives from 23 countries that have transitioned, are transitioning or may soon transition from external financing; representatives from civil society and community organizations; representatives from donor and partner organizations; and staff of the Global Fund, WHO headquarters, and several WHO regional offices. This document reviews the meeting content and summarizes outcomes and action points.

KEYWORDS
HIV
TUBERCULOSIS
MALARIA
THE GLOBAL FUND
ECONOMIC DEVELOPMENT
CIVIL SOCIETY ORGANIZATIONS
KEY AND VULNERABLE POPULATIONS

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Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral (drug)
CCM	country coordinating mechanism
CSO	civil society organization
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	German Society for International Cooperation [Deutsche Gesellschaft für Internationale Zusammenarbeit]
NGO	nongovernmental organization
NSP	needle and syringe programme
PAHO	Pan American Health Organization
PSM	Procurement and Supply Management
TB	tuberculosis
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

1. Introduction

RATIONALE

Owing to economic growth and a shift towards higher income levels and/or lower disease burdens, many low- and middle-income countries are gradually transitioning from external financing towards domestically funded health systems. The Global Fund to Fight AIDS, Tuberculosis and Malaria and other international donors actively support countries in transitioning from externally financed to domestically funded programmes. As part of its Sustainability, Transition and Co-Financing Policy, the Global Fund encourages countries to proactively plan and prepare to shift from Global Fund resources with the ultimate goal of both maintaining and scaling up health programmes and systems that support the elimination of HIV, tuberculosis (TB) and malaria.

Many countries have or are experiencing challenges related to the financial and programmatic sustainability of donor-funded interventions to address the three diseases. A variety of issues potentially hinder the response to HIV/AIDS, TB and malaria, including weak health systems or health system approaches, including challenges to access quality medicines and health products; budget allocations that favour secondary[1] care solutions and inequitable financing mechanisms; suboptimal governance structures that affect transparent procurement and the distribution of health products; inefficient service delivery models; and challenges related to key and vulnerable populations. Economic growth does not guarantee equal access to health, particularly for key populations which are disproportionately affected by some diseases. With reduced external monetary assistance, some middle-income countries encounter challenges in assuming full fiscal responsibility for the HIV/AIDS, TB and malaria response.

Comprehensive national strategic plans that are budgeted, evidence informed and prioritize key populations are essential to guide the changeover process and ensure the sustainability and integration of disease-specific programmes. The process of adequate and timely planning for transition is an opportunity for countries to assess how governance, financing and service delivery should be optimized to ensure the sustainability of effective coverage for priority interventions.

Given the competing health and non-health priorities in countries, it is critical to document how to sustain progress made by sharing lessons and good practices among countries and external partners. Tailored technical assistance platforms and the tailored application of development tools (e.g. country transition and sustainability plans and strategies) should be in place to support countries preparing for transition during and after the transition period.

GOAL AND OBJECTIVES

The workshop was jointly organized by the WHO Regional Office for Europe in collaboration with WHO headquarters, the Global Fund and the United States Agency for International Development (USAID). The overall goal was for countries and key partners to exchange good practices and lessons learned related to transitioning from external to domestic financing of the TB, HIV and malaria response and to further define the actions necessary for successful transition (see Annex 1, Workshop programme). The workshop was attended by country representatives, representatives from the Global Fund, WHO headquarters, WHO regional offices, USAID, and other international donor and partner organizations, and as well as civil society organizations (CSOs) and community organizations (see Annex 2, List of participants).

[1] Medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialized knowledge, skill or equipment than the primary care physician can provide.

MEETING OBJECTIVES

The objectives of the meeting were to:

- review and exchange the existing concepts and frameworks on financial and programmatic sustainability;
- identify, discuss and document regional and country-specific mechanisms, approaches and lessons learned on issues related to transition;
- share, discuss and analyse specific thematic areas and gaps that are hindering successful transitions and discuss solutions to address these;
- define the technical assistance needs of countries; and
- agree on follow-up action points for countries, WHO and other partners.

METHODOLOGY

Throughout the interregional workshop, a diverse range of methodologies was used to facilitate interaction and the sharing of experiences between governments, international organizations and CSOs, including presentations, poster presentations,[2] storytelling exercises, World Café discussions, talk show style panel discussions, moderated workshops and gallery walks.

Representatives from 23 countries that have transitioned, are transitioning or may soon transition from Global Fund grant funding attended the workshop. These included government representatives engaged in transition planning such as those from the country coordinating mechanism (CCM), ministries of health and/or ministries of finance, and managers of national TB, HIV/AIDS or malaria programmes, depending on the country context.

WELCOME AND INTRODUCTIONS

Participants were welcomed by Dr Maia Lagvilava (Deputy Minister, Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, Georgia), Dr Mubashar Riaz Sheikh (Director of Strategic Partnerships and Cross-Cutting Coordination, WHO headquarters) and Dr Masoud Dara (Coordinator, Communicable Diseases and Programme Manager, Joint Tuberculosis, HIV and Viral Hepatitis programme, WHO Regional Office for Europe). Opening remarks were made by Dr Osamu Kunii (Head of Strategic Investment and Impact Division, Global Fund) and Dr Sevim Ahmedov (Senior TB Advisor, USAID). Dr Sayohat Hasanova (Technical Officer, Joint Tuberculosis, HIV and Viral Hepatitis programme, WHO Regional Office for Europe) provided an overview of the scope and purpose of the meeting.

[2] Posters by WHO regional offices and countries are presented in Annexes 3 and 4.

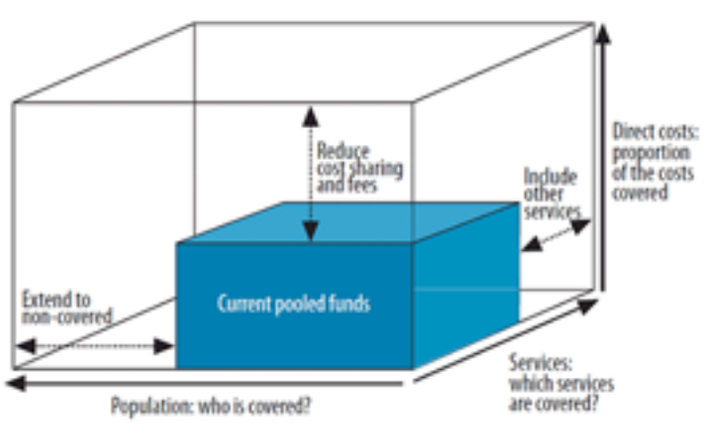
2. Conceptualizing sustainability and transition under the UNIVERSAL HEALTH COVERAGE FRAMEWORK

ACHIEVING UNIVERSAL HEALTH COVERAGE – CHALLENGES AND OPPORTUNITIES FOR TRANSITION

Universal health coverage (UHC) ensures "that all people can use the promotive, curative, rehabilitative and palliative health services that they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the users to financial hardship" *(1)*. WHO has used the UHC cube to represent the three dimensions of UHC: the population(s) that are covered; the services that are covered; and what expenses remain out of pocket (Fig. 1). When considering how transition will affect UHC, countries and programme managers should consider the following key questions: is the funding sufficient? is it sustainable? will services have the same quality after donors exit? and what can be done to maintain or increase coverage while not compromising on quality?

Although vertical programmes may be effective in supporting improvement in disease outcomes, during the Millennium Development Goal era they relied substantially on governance and implementation structures that might be costly to sustain. The UHC2030 platform *(2)* and the Sustainable Development Goals *(3)* were developed to promote sustainability to strengthen health systems. The UHC2030 platform has three key policy areas: service delivery, health financing and governance. At the level of service delivery, UHC2030 advocates for quality, equity and accessibility of services for the whole population. At the level of health financing, UHC2030 stresses the need for efficiency, sustainability and pooling for financial protection. At the level of governance, UHC2030 emphasizes giving the public a voice, freedom of data and multisectoral collaboration. The UHC2030 platform measures health system performance in five areas: equity, quality, responsiveness, efficiency and resilience.

Fig. 1. The three dimensions of UHC.



Source: WHO, 2019 *(4)*.

In preparation for transition, policies should be developed that focus on strengthening the health system and maintaining or increasing UHC. This will require the allocation of domestic funding to the health sector as a whole, along with increased financing for specific interventions that are often highly

donor dependent, including services for key and vulnerable populations. Finally, there should be national ownership and social accountability for effective transition policies.

THE GLOBAL FUND'S APPROACH TO SUSTAINABILITY, TRANSITIONING AND CO-FINANCING

The Global Fund strategy 2017–2022 recognizes the need to support successful transitions from external financing, increase domestic financing, support countries to use resources more efficiently, and strengthen the resilience and sustainability of health systems *(5)*. These concepts are reflected in the Global Fund sustainability, transition and co-financing policy, which outlines its approach to strengthening the national management, financing and ownership of HIV, TB and malaria programmes *(6)*. The ultimate goal is to support countries to proactively prepare for transition and address strategic challenges in order to sustain the gains and continue to scale up, even beyond Global Fund financing.

Most countries approaching transition already finance and manage a significant percentage of their national HIV, TB, and malaria programmes (including health products, service provision and delivery, and human resources). However, transition bottlenecks and challenges remain across a variety of thematic areas. While these are always dependent on country context, cross-cutting challenges include (but are not limited to) insufficient and inefficient planning, insufficient and inefficient financing, necessary health system reforms, legal and policy barriers, and the sustainability of CSOs and the services they provide. Disease-specific challenges include (but are not limited to) inefficient programmes, dependence on donor support for specific interventions, suboptimal national procurement mechanisms, and inadequate funding for key and vulnerable populations. Specific strategies to address transition-related challenges depend heavily on the country context; however, they include strengthening national strategic plans; increasing the focus on health financing and the development of health financing strategies; enhancing alignment with country systems; the early and progressive absorption of key programme costs; addressing the strategic challenges of ensuring resilient and sustainable systems for health, including those related to patient data and drug procurement; optimizing grant design to promote sustainability; ensuring ambitious, progressive and targeted co-financing; and using transition funding to address specific transition-related challenges, including using transition grants to strengthen aspects of health systems that are essential for effective transition.

3. Setting the scene: past, present and future of TB, HIV and Malaria response

A GLOBAL OVERVIEW OF HIV, TB AND MALARIA TRENDS

Globally HIV incidence and mortality have a declining trend: in 2017 the estimated number of people newly infected with HIV was 1.8 million, down from a peak of 3.4 million in 1996 *(7)*. The estimated number of AIDS-related deaths was 940 000 in 2017; AIDS-related deaths have declined by 34% since 2010. Key populations are at a higher risk of acquiring HIV, with approximately half of all new infections globally occurring among key populations and their sexual partners *(8)*. Despite this, all key populations continue to have inadequate access to health services.

From 2000 to 2017, the average rate of decline in TB incidence was 1.5% per year (far below the required rate of 17% per year needed to reach the 2030 targets), and since 2000 the number of deaths from TB has fallen by 29% among people without HIV and by 44% among people living with HIV. The latest estimates of global burden reveal that the number of new HIV infections and TB cases are not decreasing fast enough to achieve the global milestones set for 2020 and the number of cases of HIV-associated TB remains high. In addition, multidrug-resistant TB (MDR-TB) remains a public health crisis: over half a million-people had MDR-TB in 2017 and only one in four of these had access to MDR-TB treatment. Of those treated, only 55% were cured *(9)*.

Although there were an estimated 20 million fewer malaria cases in 2017 than in 2010 (237 million in 2010 versus 219 million in 2017), no significant progress in reducing global malaria cases was made during the 2015–2017 period and the incidence began to rise again *(10)*. The estimated number of malaria deaths globally was 607 000 in 2010 and reduced to 435 000 in 2017. Children aged under 5 years are the most vulnerable group affected by malaria. In 2017, this group accounted for 61% (266 000) of all malaria deaths worldwide. However, countries with malaria can be divided into two distinct groups: 21 malaria-eliminating countries and 11 high-burden countries that accounted for 71% of malaria cases and 70% of malaria deaths globally in 2016 *(10)*.

TRANSITION FROM DONOR FINANCING: COMMON BARRIERS, CHALLENGES AND LESSONS LEARNED FROM TRANSITIONED COUNTRIES

The Transition Preparedness Assessment Framework developed by the Curatio International Foundation assesses the readiness of countries for transitioning towards domestic financing and examines the internal (economic and political context) and external (inputs, governance and programme) environment of a country *(11)*.

To date, the Framework has been used to assess readiness and prescribe recommendations for 12 countries and areas: Armenia, Belarus, Bulgaria, Georgia, Jamaica, Kosovo,[3] Kyrgyzstan, Morocco, Philippines, Republic of Moldova, Ukraine and Uzbekistan. Some important barriers to transitioning have been identified across countries. First, even if overall the country is not heavily dependent on donor funding, some elements of its responses may be. For example, in many countries, key population preventive interventions and surveillance are heavily supplemented by donor funding. Secondly, there is a lack of engagement with CSOs and nongovernmental organizations (NGOs) that are also delivering support and are often in receipt of donor funding. Lastly, health workforce shortages and poor capac-

[3] In accordance with United Nations Security Council Resolution 1244 (1999).

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Osamu Kunii, The Global Fund to Fight AIDS, Tuberculosis, and Malara, Head of Strategic Investment and Impact Division

Sevim Ahmedov, USAID HQ, Senior TB advisor

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ity persists. If these barriers are not addressed, then there is a risk that transition will result in interruptions in the supply of sustainable, affordable and quality-assured health services, as well as in the generation of epidemiological and programmatic data. Similar results were also recently reported by WHO Regional Office for Europe, which undertook reviews of six countries of the WHO European Region in order to assess their degree of self-reliance through transitioning from external donor support for TB prevention and care.

TRANSITION EXPERIENCES – THE STORIES OF NORTH MACEDONIA AND MEXICO

Two countries that have successfully addressed many challenges of transition and are generally regarded to have successfully transitioned from the Global Fund financing are North Macedonia and Mexico. Although Mexico has a much larger population, both countries had received approximately the same amount of donor funding. North Macedonia received support to build HIV and TB responses over 13 years, while Mexico received support to strengthen the national component on HIV prevention among key populations over three years. Both countries shared good practices for developing and sustaining services for key populations through the engagement of civil society.

The experience of North Macedonia has shown that timely responses which are tailored to the country context, including transition planning supported by political leadership, are critical for a successful transition. The country underwent transition during a political crisis, which delayed formal endorsement of the country's transition plan by national authorities. As a result, increased technical assistance was needed, with most processes moved forward by CSOs. However, early preparation and planning provided sufficient time and a favourable environment for implementing the planned changes. Today, financing levels for services for key populations and disease services are at the same level as under the previous Global Fund support. A social contracting mechanism is still being developed.

Mexico is a good example of how collaboration with CSOs can be used to scale up the response among key populations. Mexico has a long tradition of working together with CSOs and a comprehensive legal framework for encouraging cooperation with CSOs. The single round of Global Fund support enabled Mexico to scale up its services for key populations. After transition, a similar level of public financing was allocated to these interventions and implemented by civil society. In Latin America, CSOs are often not contracted to provide services to the people most in need and the funding does not cover public needs. To ensure that the money was being spent in the most effective way possible, results-oriented contracts with CSOs were developed in Mexico.

Common obstacles which countries may find challenging to address before, during and after transitioning include:

- securing the political will to keep three diseases on the priority agenda and ensuring multisectoral approach to the process;
- having methodology for guidance and readiness assessment tools for transition;
- generating sufficient evidence of public funding;
- monitoring the implementation of transition sustainability plans through frameworks for measuring success, and the roles and responsibilities of key stakeholders in monitoring;
- addressing human rights, stigma and discrimination during and after transition;

- guaranteeing the inclusion of all key and vulnerable populations[4] in the development of transition plans while providing them with continued and uninterrupted medical and social support;
- ensuring sustainable capacity-building and expansion of coverage with services without compromising quality;
- sustaining service provision and advocacy by CSOs during and after transition;
- maintaining access to and procurement of high-quality medicines and health products;
- providing technical support during the post-transition period; and
- responding to changing environment (e.g. crises) during the transition process.

Inputs by members of ministries of health, national programme managers, CSOs and other voices of health governance were made during the two-day meeting and workshop.

WHO REGIONAL APPROACHES TO TRANSITION

Poster presentations by WHO regional offices shared their perspectives and insights on transition (key findings in Table 1; Member State posters in Annex 3).

Table 1. Key findings of poster presentations by WHO regional offices

WHO regional office	Key findings
WHO Regional Office for Africa	• Continued support through the Global Fund/WHO Regional Office for Africa collaboration is needed to strengthen countries surveillance systems; integrate programmes, including those related to reproductive, maternal, neonatal, child and adolescent health, into resilient health systems with UHC; provide support during the Global Fund funding application process and grant implementation • Additional support is needed for countries in pre-transition and transition to conduct transition readiness and risk mitigation assessments; increase political leadership and multisectoral engagement; identify the best approaches to involve the private sector; identify innovative financing opportunities; ensure community involvement; provide guidance on assessing sustainability and value for money in strategic plans • It is the first experience of transition for countries in the Region; thus countries should be better prepared for transition but may also need support beyond transition

[4] Key populations in the HIV response include people living with HIV, men who have sex with men, people who inject drugs, migrants, prisoners, commercial sex workers and transgender persons (and their sexual partners) (12).

Table 1. *contnd.*

WHO Regional Office for Europe	• The WHO Regional Office for Europe provides support to Member States in accordance with guidance documents endorsed by the WHO Regional Committee for Europe: the *Roadmap to implement the Tuberculosis Action Plan for the WHO European Region 2016–2020 (13)* and the *Action Plan for the Health Sector Response to HIV in the WHO European Region* (2017) *(14)* Support is provided to support Member States in providing people with • sustainable access to essential and affordable quality-assured medicines and medical devices; developing comprehensive national strategies and regulatory systems; support national regulatory authorities; capacity-building on the management of procurement and supply chains; best practices for regulating, selecting, procuring and distributing pharmaceuticals, along with their pricing and reimbursement and responsible use. • Support is provided to countries in implementing effective and efficient TB service delivery systems through shifting towards more outpatient-oriented and integrative models of care, with sustainable financing and well-aligned payment mechanisms • Continuous support to countries is needed to scale up rapid diagnostic testing, adopt shorter regimens that include new medicines, and undertake research to develop new tools; implement an essential package of services, update national strategies and targets, reinforce political commitment and ensure sustainable financing; facilitate partnership and monitor and report on progress towards regional and global targets


PAHO Strategic Fund
Public financing for CSO service delivery
4

Table 1. *contnd.*

WHO Regional Office for the Eastern Mediterranean	• The WHO Regional Office for the Eastern Mediterranean is supporting many countries with challenging operating environments due to conflicts or crises, including financial barriers, collapsed health services, weak governance and an increased burden of disease • Support was provided to develop a transition support plan for TB and malaria (Iran); integrate TB/HIV services into the basic health package (Morocco); and develop an investment case for supporting preventive activities for HIV and ensure advocacy for domestic funding; and integrate TB and HIV medicines and diagnostics into the national procurement system (Egypt) • Support was provided countries without challenging operating environments to advocate for domestic resources to integrate the different functions of national health services and CSOs/NGOs, while maintaining Global Fund support for NGOs working with key vulnerable populations • Support was provided to countries with challenging operating environments to maintain Global Fund support for essential services, advocate for more resources to address high disease burdens, and collaborate with humanitarian response services to deliver care to populations in conflict/crisis zones

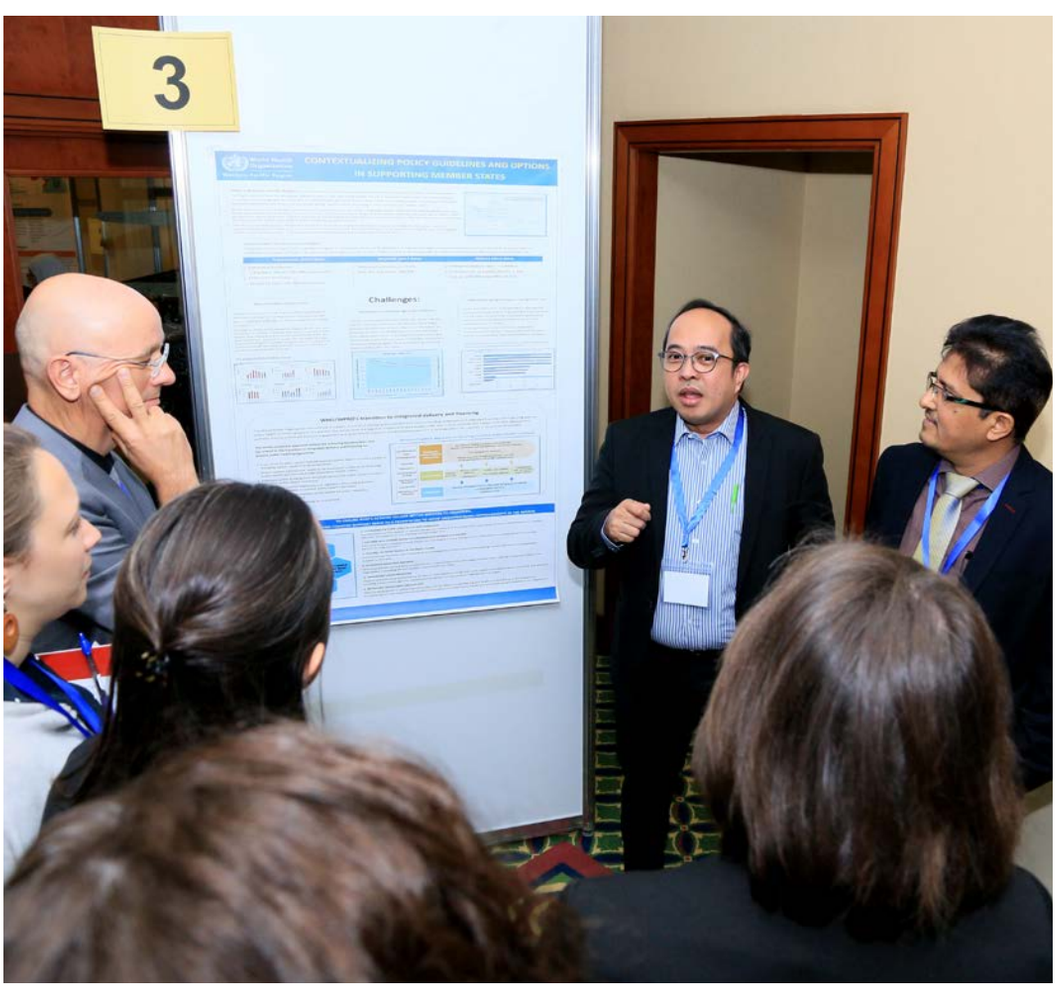

Table 1. *contnd.*

PAHO/WHO	• The Pan American Health Organization (PAHO)/WHO is supporting countries with the pooled procurement of quality, safe and efficacious essential medicines and strategic health supplies to improve access to these in the WHO Region of the Americas, while ensuring the efficiency and sustainability of health systems, including technical assistance to plan for demand and avoid country stock-outs • In 2015 PAHO/WHO and the Global Fund signed an agreement to strengthen supply chain systems and reduce the risk of medicine shortages. During the 2016–2017 period, Bolivia, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua and Paraguay received direct support for supply chain management strengthening under this agreement • In June 2018 the Global Fund and the Ministry of Health and Secretariat of Foreign Affairs of Mexico, in collaboration with PAHO/WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other partners, organized a regional forum, Public financing of CSOs for the provision of health services, to share best practices with representatives from 20 countries in the Region. Mexico provided substantial evidence of successful collaboration and implementation of public financing for CSO service delivery.
WHO Regional Office for the Western Pacific	• Funding for national HIV responses, especially for care and treatment, is a major challenge faced by many countries in the WHO Western Pacific Region face. Political and financial commitments by government are required to sustain HIV services • The WHO Regional Office for the Western Pacific is taking a whole-systems approach to securing essential health functions during transition, including the following: ensuring clearly defined health functions; assessing the public health architecture; securing domestic funding; using regulatory mechanisms at government level; training a fit-for-purpose workforce; and promoting equity to make sure none are left behind • Viet Nam is demonstrating effective transition to government funding of HIV services through the national health insurance scheme to achieve UHC

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4. Core themes to be addressed during transition

This section presents four core themes to be addressed to specifically overcome transition-related issues, but also more generally to strengthen health systems by making health services people-centred and cost-effective, increasing coverage for key populations, and ensuring access to high-quality and effective medicines and health products. One plenary and one working group session took place for each of the four thematic areas:

1. towards integrated, people-centred and efficient health services for impactful and sustainable responses to TB, HIV and malaria;

2. health financing: incentivizing people-centredness, encouraging efficiency and allocating sustainable domestic resources;

3. strategies for scaling up and sustaining effective and evidence-based services for key and vulnerable populations; and

4. challenges and opportunities in improving access to health products through efficient public procurement.

THEMATIC AREA 1. TOWARDS INTEGRATED, PEOPLE-CENTRED AND EFFICIENT HEALTH SERVICES FOR IMPACTFUL AND SUSTAINABLE RESPONSES TO TB, HIV AND MALARIA

Key messages of the plenary session

Previous experiences have shown that challenges related to service delivery can be a barrier to sustainable epidemic responses: service delivery is often inadequate or too costly to scale up and sustain during and after transition. Moreover, some disease responses are developed vertically. Building and

maintaining effective and efficient people-centred approaches[5] to prevention, treatment and care are important components of transition and sustainability planning for countries as their HIV, TB and malaria programmes transition from Global Fund and other donor support.

Transition readiness assessments have highlighted additional risks linked to service delivery and service uptake during transition. Less priority is given to preventive interventions following transition, thereby risking the discontinuation of these services. Moreover, two commonly reported programmatic risks during and after transition are: (i) failure to sustain and institutionalize investments in human resource training; and (ii) the persistence of stigma for key vulnerable[6] and criminalized populations, including through a punitive legal environment. Together, stigma and punitive legal environments limit access to essential services such as prevention, treatment and care, which may result in the ongoing transmission of these diseases and/or continued poor social conditions which increase vulnerability to infection.

Integrated people-centred services are essential for donor transition and financial sustainability of the epidemic response; they allow an upstream approach to health service provision[7] and empower affected people and communities to take up services, while increasing the opportunities to scale up. They also improve efficiency in the use of limited human, financial and other resources, including optimized integration and the coordination of disease responses with other parts of the health system.

Reorienting the service delivery model (such as moving from hospitalization based approaches, as characterized by high hospitalization rates and durations, to a more outpatient-care oriented model) requires alignment with other health system building blocks,[8] such as health workforce, and might involve or have implications for task shifting, health information systems, access to essential medicines and health products , health system financing and leadership and governance.

WHO and other agencies produce general and differentiated guidance to help services become more people-centred, including specific technical guidance related to HIV, TB and malaria and guidance on reducing donor support for disease responses *(18)*. One example of differentiated guidance is the document, *A people-centred model of tb care*, developed through a broad partnership led by the WHO Regional Office for Europe *(19)*. This document provides policy options and practical approaches to reform the TB care across eastern Europe and central Asia. Countries in the Region still benefit substantially from international support, most notably the Global Fund. Similarly, WHO Regional Office for the Western Pacific's *Regional Framework for Action on Transitioning to Integrated Financing of Priority Public Health Services in the Western Pacific* provides guidance to Members States on actions to help secure essential public health functions to ensure the sustainability and resilience of their health systems, including in the area of HIV, TB and malaria *(20)*. It specifically outlines the steps (with practical examples from countries) to identify core programme elements and service delivery arrangements needed to strengthen financial institutions to optimize use of resources, increase domestic financing and govern the change. The WHO Regional Office for the Eastern Mediterranean also produced guidance on assessment and planning of actions needed for better interaction and coordination between HIV programmes and health systems *(21)*.

Working group session outcomes

- **Task shifting and institutionalizing engagement with community and peer workers:** revise legal frameworks, referral and surveillance systems accordingly, build standardized cost packages for CSOs, and build capacity in a sustainable way.

- **Sustain the capacity of human resources during and after transition:** have advance agreement with government, integrate services and capacity-building (including on programme management) with national systems, and align salaries with government scales.

[5] People-centred health services is an approach to care that is focused and organized around the health needs and expectations of people and communities rather than on diseases (15).

[6] For the key populations for HIV, see footnote 5. Key populations for TB include people living with HIV, people who inject drugs, prisoners, urban and rural populations, children, miners, and migrants (16).

[7] That is, early intervention to address the social, economic, political and environmental factors contributing to health problems.

[8] In a previous report, WHO suggests six building blocks for building better health systems (17).

- **Integrate programmes into the health system and financing strategies and schemes:** encourage national ownership of the programmes, engage various government bodies across sectors, ensure consistency in disease-specific needle and syringe programmes (NSPs) and national health strategies, and improve donor coordination. Integration should be progressive and respond to the contexts and changing situation in the country.

- **Integrate with private sector,** including as a large health service provider in some countries (where relevant).

- **Design incentives for people-centred services** considering the context (intrinsic and extrinsic[9]), demand and supply side incentives, and capitalize on efficiency gains from increased outpatient and community services.

- **Seek technical assistance from partners** for evidence-based approaches, data analysis, country-specific social contracting, legislation, capacity-building, and development of quality NSPs and integrated disease surveillance and response systems.

- **Establish and maintain** regional and government-to-government mechanisms for knowledge sharing and capacity-building.

THEMATIC AREA 2. HEALTH FINANCING: INCENTIVIZING PEOPLE-CENTREDNESS, ENCOURAGING EFFICIENCY AND ALLOCATING SUSTAINABLE DOMESTIC RESOURCES

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Key messages of the plenary session

As external donor financing for health reduces and countries move towards domestically funded systems, it is increasingly important to design health financing strategies that improve efficiency and support the building of sustainable, integrated people-centred services.

Levels of domestic public expenditure in health vary depending on the local context and are insufficient in many lower-income settings, which highlights the need to assess the fiscal space for health *(22)* against epidemiologically demonstrated need from a comprehensive health system perspective.

Although it may be effective in supporting the improvement of disease outcomes, vertical financing for HIV, TB, malaria contributes to the segmentation and fragmentation of services in many country and local contexts. Several financing schemes cover different population groups with important differences in service coverage, per capita resources and geographical presence, which may in turn contribute to fragmentation of care (disease-centredness and lack of continuity) and the organization of health service delivery (including having several uncoordinated providers). Lack of universal pooling prevents the application of strategic purchasing and efficient resource allocation from a health system perspective. This vertical organization of priority programmes needs to be made more sustainable (through successful transition) and efficient (by avoiding duplications and perverse incentives) while strengthening health system capacity and ensuring sufficient financing for specific interventions that are often highly donor dependent, including services for key and vulnerable populations.

Further, vertical programmes need to optimize the use of available resources through efficient spending that reflects the existing health priorities and care model in the local context, with payment mechanisms based on outcomes (such as the number of patients treated), not inputs (such as the number of beds, stay in hospital). See Boxes 1 and 2 for examples of assessments (inputs versus outputs) in different countries.

[9] That is, factors related to the health system and non-health systems (other sectors), respectively.

Box. 1. Transition preparedness assessment

According to the 2015 transition preparedness assessment for Belarus, "[T]he legislative framework provides perverse incentives for TB patients to stay longer in hospitals" [and] "Current payment methods promote suboptimal quality in the provision of TB services as hospitals budgets are based on fixed volumes" *(23)*.

Box 2. Transition readiness assessment

According to the 2015 transition readiness assessment for Panama, "[T]he parallel organization of service provision and financing is problematic (…) as it creates significant waste in the health system. The cost sharing agreements neither seem to adequately reflect actually incurred cost by the respective provider, nor do they introduce incentives to achieve better coordination or lower costs" *(24)*.

Working group session outcomes

- **Assess fiscal space for health** from a comprehensive health system perspective (but including priority areas for health sector).

- **Progressively integrate vertical programme financing into national health financing** strategies and plans as part of comprehensive pooling to stimulate a reduction in the fragmentation of resource allocation and management.

- **Reform and streamline payment mechanisms** in order to (i) incentivize technical efficiency (pay for outcomes not inputs); (ii) incentivize people-centredness and continuity of care (avoid fee-for-service when possible, reward coordination); and (iii) incentivize integrated health service delivery networks (mixed payment mechanisms within network according to provider, including capitation, diagnosis-related groups).

Enhance public procurement mechanisms, including access to joint intercountry procurement strategies and programmes (e.g. the Pan American Health Organization Strategic Fund).

Thematic area 3. Strategies for scaling up and sustaining effective and evidence-based services for KVPs

THEMATIC AREA 3. STRATEGIES FOR SCALING UP AND SUSTAINING EFFECTIVE AND EVIDENCE-BASED SERVICES FOR KVPS

Key messages of the plenary session

Key populations are population groups that are disproportionately affected by a disease, isolated from services, criminalized or excluded by other legal barriers; experience stigma, discrimination and human rights abuses; and have high rates of incarceration and detention. Key populations are often the hardest-to-reach population groups when trying to respond completely to an epidemic. Models of care can also be adapted to increase access for key populations through further integration of disease services, providing more people-centred and community-based services, and task shifting.

For example, although there are 179 countries with evidence of injecting drug use, NSPs are available in only 93 (33 needles/person/year) and only 86 have access to opioid substitution therapy (with only about 16% of all people who inject drugs receiving opioid substitution therapy) *(25)*.

Currently, essential interventions for key populations are highly donor dependent and special attention needs to be given to how programmes will be sustained and expanded during and after transition to

ensure sustainability of the response. Interrupted delivery of these essential services risks backsliding on the quality, coverage and equity of HIV, TB and malaria service delivery. Addressing structural barriers that affect all key and vulnerable populations, such as inadequate laws and policies, stigma and discrimination, lack of community involvement and violence against key populations, is crucial in the response to HIV and TB.

Involving communities of key populations in planning, monitoring and implementing services is essential for ensuring that health services are inclusive of these population groups. One of the proposed and recognized mechanisms for the sustainable involvement of community and civil society is social contracting, the process by which government resources are used to fund entities which are not part of government (i.e. non-state actors) to provide services to assure the good health of its citizenry. Therefore, key elements of social contracting need to be considered.

Working group session outcomes

- **Reform legislation and policy** to enable the provision and scaling up of services for all key populations.
- **Coordinate governmental sector, CSOs and communities** in the design, delivery and oversight of services for key populations.
- **Sensitize stakeholders, including governmental and non-governmental, internal and external donors and partner organizations,** on the critical role of civil society organisations and communities in the TB and HIV and Malaria response.
- **Ensure the availability and use of disaggregated key strategic information** through integrating data and indicators into health management information systems and national monitoring and evaluation frameworks.
- **Institutionalize the social contracting of CSOs** with incorporation of key elements, such as (i) creating a conducive political environment; (ii) defining the activities/package of services to be carried out by CSOs; (iii) ensuring transparency in the selection of CSOs and tendering for contracts; (iv) building the human capacity of governments and CSOs; (v) establishing frameworks for management and accountability and a mechanism for monitoring and evaluation; and (vi) ensuring sufficient, appropriate and predictable funding is available to finance services.
- **Build and communicate evidence through research and economic analyses around the cost–effectiveness** of reforming policy environments, human rights and anti-stigma programmes for achieving better health outcomes.
- **Continue the engagement of governments and donors to guarantee the inclusion of all key populations,** including establishing and continuing support for a safety net fund for key population programmes and diversifying sources: even when public funding is available for services for key populations, the funding level is expected to be sufficient, appropriate and predictable. Therefore, exploring alternative financing mechanisms is recommended.

THEMATIC AREA 4. ENSURING ACCESS TO QUALITY HEALTH PRODUCTS AND MEDICINES FOR TB, HIV AND MALARIA

Key messages of the plenary session

Effective procurement systems ensure the complete availability of the right medicines, in the right quantities, at a recognized standard of quality and at an affordable price. Key challenges include the cost and delay of registration and market authorization, aligning national essential medicines lists and nation-

al treatment guidelines with international guidelines, and implementing quality assurance and to have functioning pharmacovigilance programmes (including the introduction of new medicines). WHO recommends that countries use, for WHO pre-qualified products, the WHO Collaborative Registration Procedure (CRP) to speed up registration process, implementing a harmonized global benchmarking tool/national regulatory authority assessment to ensure, strengthening pharmacovigilance systems and limiting procurement to WHO pre-qualified products.

Countries should have the capacity at all levels (central, regional and periphery) to do proper quantification and forecasting of needs. That needs trainings of all staff involved in PSM. Early warning systems should be in place to ensure that appropriate quantities of drugs are procured to avoid stock-outs or over-stocks. This can be achieved by introducing or enhancing the logistics management information system to collect information at each level of the supply chain. Market and product intelligence should guide procurement strategies to ensure a healthy market and supplier security. Before to procure any medicine, it is essential to consider the product life-cycle, how many suppliers are in the market, the market production capacity, the level of demand for the product, and the plans for its use in the future. It may be necessary to contract multiple suppliers for the same product to prevent dependence on a single supplier/ monopoly situation. National rules and practices should be updated to make procurement more efficient and cost-effective, for example by implementing policies that accelerate the rates that public funds for procurement are disbursed and suppliers are contracted. Countries may consider voluntary collaboration to share lessons learned about procurement or to engage in joint procurement to increase their negotiating power to drive down prices.

Working group session outcomes

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- Revise market authorization regulations (in the medium term).
- **Streamline registration process and fees:** introduce fast-track registration and use one-time waivers as a short-term measure.
- **Streamline regulations** for revision procedures and the national essential medicines list based on the WHO latest EML.
- Join the WHO collaborative registration procedure to speed up registration of WHO PQ products.
- Promote direct procurement from international procurement agencies as the United Nations Children's Fund (UNICEF), UNDP, UNFPA, Global Drug Facility etc
- Assess the feasibility of pooled forecasting and procurement (regional, selected countries).
- **Use reference pricing** for the procurement of medicines and other health products.
- **Encourage CSOs to serve as "watchdogs"** to ensure transparency in procurement and hold governments accountable.
- **Enhance the national procurement and supply management system at all level of the chain,** including quantification and forecasting capacities.
- **Use development partners and donors to support the integration** and streamlining of public warehousing, transportation, stock maintenance and distribution/redistribution capabilities.

5. Addressing challenges and follow-up actions

IN DIALOGUE BETWEEN COMMUNITIES AND CIVIL SOCIETY

A talk show style panel discussion between representatives from communities and civil society was organized to discuss the role of CSOs in the process of building sustainability and present recommendations on how to make greater progress in the sustainability of HIV, TB and malaria programmes. Participating in the discussion were representatives from the Developing Country NGO delegation to the Board of the Global Fund, the Asia Pacific Council of AIDS Service Organizations, the Association de Lutte Contre le SIDA (ALCS), the Botswana Network on Ethics, Law and HIV/AIDS, Global Network of People living with HIV (GNP+) Indonesia, the Institute for Global Health Sciences at University of California, Médecins Sans Frontières, the Center for Health Policies and Studies and the TB Europe Coalition.

Key take-away messages

To ensure that countries continue to fund CSOs after transition, ministries and partners need to understand the vital role of CSOs in programme development and implementation. The capabilities and accountability of CSOs must be clearly defined, especially regarding service provision for key populations. Furthermore, CSOs will need to boost the accountability of their organizations if they are to support health service provision after donors exit. CSOs should continue to put pressure on governments to allocate funding for prevention services in countries where the value of these interventions is not recognized.

IN DIALOGUE WITH PARTNERS

A talk show style panel discussion between representatives from donor and partner organizations was organized to share their experiences and discuss their role in assisting countries in overcoming barriers during transition. Participating in the discussion were representatives from the GAVI Alliance, the German Society for International Cooperation (GIZ), the Global Fund, the Stop TB Partnership, UNAIDS, USAID and WHO.

Key take-away messages

- The GAVI Alliance stated that most countries were transitioning successfully and that all transitioned countries have continued to fund their vaccines with domestic resources after transition. However, in a few countries, a number of remaining institutional capacity gaps had been identified and these were being tackled through targeted and tailored support. This underlines the importance to address these issues early before a country begins the transition phase. The GAVI Alliance additionally stressed the importance of adequately prioritizing health expenditures to the most cost-efficient interventions based on/tailored to specific needs.

- UNICEF has experienced constant challenges during transitions in the quantification, costing, provision of funds, delays in procurement and stock-outs. UNICEF provides procurement services and can procure medicines, equipment, educational materials, and other items. UNICEF should also be able to assist countries in identifying the technical assistance needed in the areas such as sustaining supply chain management, system design and data management.

- The Global Drug Facility has developed a risk dashboard to assess which countries are most at risk of TB medicine stock-outs and develop short- and long-term solutions. In the short-term, stockpiling/ buffer stock is recommended. The Global Drug Facility also offers a flexible procurement fund for countries that cannot prepay. Assistance with quantification tools and early warning systems are also available.

- UNAIDS has experience in supporting many transitions, including with technical assistance for transition readiness assessments and analysis, and is providing technical assistance for specific strategies. UNAIDS Country Offices should be contacted.

- GIZ works closely with the Global Fund. GIZ provides countries with technical assistance to address existing health system gaps and bottlenecks for an effective disease response, including preparation for transition, as well as support in the management of grants and CCMs.

6. Summary outcomes of the meeting and next steps

The meeting participants agreed that addressing transition-related challenges and successfully preparing for transition from external financing will require better coordination between national governments, civil society, international technical partners and external financiers, including the Global Fund. The following set of high-level outcomes were discussed by participants and proposed.

- Countries should use transition as an opportunity to assess the challenges and gaps in their governance, financing and service delivery that could be barriers to the sustainable scaling up of effective coverage for priority interventions and successful transitions. Health system strengthening towards sustainable UHC is the cornerstone of effective transitions.

- Successful transitions will require sustained governmental commitment, as well as efforts to support the ownership and leadership of the transition process, including the support of technical partners, bilateral and multilateral agencies, civil society, and health advocates.

- Policy-makers in countries, development partners and other stakeholders such as the private sector and civil society groups should **work in coordination and synergy** to address key transition-related challenges including:

  – early and proactive planning, perhaps at the regional project level, to strengthen sustainability and prepare for transition (including analysing or continuing to analyse transition readiness where applicable, assessing major sustainability gaps and using grant financing to specifically address transition and sustainability challenges);

  – reforming systems to deliver integrated and people-centred models of care/services while embedding disease-specific programmes and interventions into a system-wide approach to include financing and service delivery;

  – reforming towards an integrated and people-centred model of care to ensure adequate coverage of all key and vulnerable population with priority intervention and services;

  – adopting health outcome-oriented financing mechanisms and payment schemes to improve efficiency and evaluate both outputs and health outcomes (examples include case-based financing for hospitals (outputs), capitation for primary care (outputs) and social impact bonds (outcomes));

  – making efforts to engage country stakeholders across all relevant sectors, (for example, including ministries of finance) and strengthen domestic resource mobilization for health as a whole, as well as for priority interventions that are heavily dependent on donor financing, through using resources efficiently;

  – supporting efforts by civil society to play more active role in communicating and advocating for resource mobilization and accountability;

  – early preparation and proper planning to address challenges related to country ownership of the procurement and supply of quality-assured and affordable TB, HIV and malaria medicines and health products;

  – revising and improving legal frameworks that hinder the provision of high-quality of care for all, and especially for all key and vulnerable populations, such as restrictive or absent regulatory policies and standards within pharmaceuticals (including procurement policies); policies that forbid the social contracting of service implementation by CSOs; and policies that increase the

vulnerability of key populations in the response, including but not limited to human rights violations and the criminalization of behaviours, stigma and discrimination, travel bans for people living with HIV, HIV non-disclosure laws, and others which may impact access to prevention, testing, treatment and care of the three diseases; and

– task shifting for health-care professionals and institutionalizing the engagement of communities and CSOs.

- Appropriate interventions to strengthen sustainability and address transition-related challenges should be specifically adapted to the country context to ensure an effective response, while encouraging countries to continue to seek technical guidance where needed.

- Ensure that transition processes are effectively monitored, with the engagement of communities and people affected by the diseases, including key and vulnerable populations.

- Support cross-country learning on transition and ensure that expertise is available and applied in addressing health system challenges and in strengthening national and subnational capacities.

- Development partners at the global and national levels should work in synergy to support well-coordinated national transition plans, harmonize assessment tools where possible to avoid duplication, and ensure the flexibility to address changing environments.

The primary outcome document has been developing and consists of main principles and technical recommendations which should guide countries and stakeholders throughout the transition and sustainability process. The document is based on the outcomes of the Workshop and includes challenges and lesson learned by countries and partners.

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Annex 1. Workshop programme

DAY 1. 17 OCTOBER

9.30–10.30	Registration of participants and welcome coffee/tea	
10.30–10.40	Welcome by the Georgian health ministry	Maia Lagvilava, *Deputy Minister, Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, Georgia*
10.40–10.50	Welcome by WHO headquarters and the WHO Regional Office for Europe	Mubashar Riaz Sheikh, *Director, Strategic Partnerships and Cross-Cutting Coordination, WHO headquarters* Masoud Dara, *Coordinator, Communicable Diseases, Division of Health Emergencies and Communicable Diseases, WHO Regional Office for Europe*
10.50–11.00	Opening Remarks by the Global Fund and USAID	Osamu Kunii, *Head, Strategic Investment and Impact Division, Global Fund* Sevim Ahmedov, *Senior TB advisor, USAID headquarters*
11.00–11.15	Overview of the scope and purpose of the workshop Introductions	Sayohat Hasanova, *Technical officer, Joint TB, HIV and Viral Hepatitis programme, WHO Regional Office for Europe* Jost Wagner, *The Change Initiative (Lead Facilitator)*

Session 1. Conceptualizing sustainability and transition under the UHC framework		
11.15–11.40	Achieving UHC – challenges and opportunities for transition Presentation	Ihor Perehinets, *Technical Advisor, Division of Health Systems and Public Health, WHO Regional Office for Europe*
11.40–12.00	The Global Fund's approach to sustainability, transitioning and co-financing – key thematic areas and identified challenges Presentation	Matthew MacGregor, *Senior Project Lead, Sustainability, Transition and Co-Financing, Global Fund*
12.00–12.15	Group photo	
12.15–13.30	Lunch break	
Session 2. Past, present and future of the TB, HIV and malaria response – a snapshot		
13.30–13.45	A global overview on HIV, TB and malaria trends Presentation	Mubashar Riaz Sheikh, *Director, Strategic Partnerships and Cross-Cutting Coordination, WHO headquarters*

13.45–13.55	Perspectives from the United Nations General Assembly high-level meeting on ending TB and next steps Presentation	Lucica Ditiu, *Executive Director, Stop TB Partnership*
13.55–15:05	Regional gallery walk WHO regional offices Poster presentations	WHO regional offices
15.05–15.30	Coffee/tea break	
15:30–15:50	Transition from a donor: common barriers, challenges and lessons learned Presentation	George Gotsadze, *President, Curatio International Foundation*
15:50–16:20	Experience on transitioning: the stories of North Macedonia and Mexico Method: storytelling	Andrej Senih, *Director, NGO Stronger Together, Association for Support of People Living with HIV, North Macedonia* and Augustín López González, *Director, Prevention and Social Participation, Mexico*
16:20–16:50	The future of sustainable health systems (Participants discuss in mixed groups at their tables the guiding questions they want to address during the workshop.) Method: World Café	Jost Wagner, *The Change Initiative (Lead Facilitator)*
16:50– 17:00	Introduction to the workshops on Day 2 Conclusions for Day 1	*WHO Lead Facilitator*
18.00	Reception	

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DAY 2. 18 OCTOBER

9.00–9.10	Introduction to Day 2	*Lead Facilitator*
Session 3.Thematic introduction to essentials – core theme that needs to be addressed in transition		
09.10–09.50	Key thematic areas **Thematic area 1.** Towards integrated, people-centred and efficient health services for impactful and sustainable responses to TB, HIV, and malaria Method: presentation and table discussion	Speaker: Alexandre Lourenço, *WHO Advisor*
09.50–10.30	**Thematic area 2.** Health financing: incentivizing people-centredness, encouraging efficiency and allocating sustainable domestic resources Method: presentation and table discussion	Speaker: Juan Pablo Pagano, *Health System Strengthening, WHO AMRO/Pan American Health Organization*
10.30–11.00	Coffee/tea break	

11:00–11:40	**Thematic area 3.** Strategies for scaling up and sustaining effective and evidence-based services for key and vulnerable populations Method: presentation and table discussion	Speakers: Virginia Macdonald, *HIV Department, WHO* Carmen Gonzalez, *Sustainability and Transition Specialist, Latin American and Caribbean, Global Fund*
11:40–12:20	**Thematic area 4.** Ensuring access to quality key health products and TB, HIV and malaria medicines: challenges, opportunities and the need to develop reliable and efficient systems for procurement and supply chain management Method: presentation and table discussion	Speaker: Tifenn Lucile Marie Humbert, *Technical Advisor, Health Technologies and Pharmaceuticals Programme, WHO Regional Office for Europe*
12.20–12.30	Introduction into parallel workshops	*Lead Facilitator*
12:30–13:20	Lunch	

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Session 4. Deepening our knowledge and working on solution		
13:20–15:00	Three parallel workshops on presenting country experiences and facilitated discussions by thematic areas Participants choose one out of the three workshops **Workshop 1.** Strategies for scaling up and sustaining effective and evidence-based services for key and vulnerable populations **Workshop 2.** Integrated, people-centred services and health financing **Workshop 3.** Ensuring access to quality key health products and TB, HIV and malaria medicines Method: technical clinics (mini workshops)	Each workshop has a designated moderator for the thematic area
15:00–15:30	Coffee/tea break	

15:30–17:10	Participants choose a second workshop out of three options **Workshop 1.** Strategies for scaling up and sustaining effective and evidence-based services for key and vulnerable populations **Workshop 2.** Integrated, people-centred services and health financing Workshop 3. Ensuring access to quality key health products and TB, HIV and malaria medicines	Each workshop has a designated moderator for the thematic area

DAY 3. 19 OCTOBER

08.45–9.00	Introduction to Day 3	*Lead Facilitator*
Session 5. Addressing challenges and follow-up actions		
09:00–10:00	In dialogue with communities and civil society Panel discussion Method: talk show style panel discussion	Moderator: Raminta Stuikyte *WHO temporary consultant*
10:00–11:00	In dialogue with partners Panel discussion (WHO, Global Fund, USAID, GAVI Alliance, Stop TB Partnership, UNAIDS, GIZ) Method: talk show style panel discussion	Moderator: George Gotsadze, *President, Curatio International Foundation* Jost Wagner, *The Change Initiative*
11.00–11.20	Coffee/tea break	
11.20–12.20	Country gallery walk Method: poster presentations by countries on lessons learned	*Lead Facilitator*
12:20–13:20	Lunch break	
13:20–14:50	Dialogue on solutions and the way forward Method: adapted open space and world café method	*Lead Facilitator*
14:50–15:50	Feedback from breakout working groups of the session, Dialogue on solutions and the way forward	*Lead Facilitator*
15:50–16:30	Next Steps, Conclusions and Closing Remarks	WHO, Global Fund and USAID
16:30–17:00	End of workshop/Farewell coffee	

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Annex 3. Member State posters

Countries	Key findings
Armenia	• Advances in the domestic take-over of drug procurement included (i) completing the registration of TB medicines in 2016 with technical support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and Stop TB Partnership; (ii) the allocation of state funds for procurement of pharmaceuticals; (iii) changing regulatory policies to ensure that successful bidders are automatically given pre-registration status, with the state covering registration fees; and (iv) from 2017 to 2018, initiating/completing the process of revising regulations on pharmaceutical procurement to grant procurement from internationally recognized suppliers. • Revision of procurement procedures and quality assurance requirements was dependent on strong partnerships, requiring intense discussions and strong political commitment from the Ministry of Health as a prerequisite, along with the National Drug Regulatory authority, Ministry of Finance, higher level of governance and strong ties with civil society. • In this context, establishing partnership and collaboration needed to take place **at least three years** ahead of the completion of grant programmes to ensure the continuity of quality drug supplies to patients.
Bhutan	• WHO and Global Fund assistance have resulted in a large reduction of malaria in the country. Massive deployment of artemisinin-based combination therapy and rapid diagnostic testing down to the community level and a large-scale, long-lasting insecticidal net campaign with two rounds of focal indoor residual spraying, along with enhanced malaria surveillance contributed to the reduction. • In this context, transition is dependent on the engagement of relevant sectors (including CSOs and NGOs) in health promotion, involvement of political leaders/decision-makers for enhanced policy stewardship, enhanced dialogues with neighbouring countries to make joint efforts to respond to all three diseases, and the development of a transition plan. • The way forward includes revision of the National Strategic Plan for preventing the re-introduction of malaria foci, strengthening surveillance in parasitology and entomology through real-time reporting, extensive screening of migrant workers and mobile populations, and strengthening quality control/assurance of diagnosis and treatment to achieve malaria elimination and WHO certification.
Botswana	• Although the Government of Botswana has assumed the primary funding role for the national malaria elimination strategy since 1950, engagement of community structures and a public–private partnership with a key role for the private sector in resource mobilization was critical to support the country strategy and response to Malaria. • The Government is actively engaged in cross-border meetings to plan for effective provision of services to mobile and migrant key populations. • The CATTEM (Community Acting Together to Eliminate Malaria) approach intensified community ownership of and involvement in malaria elimination activities. This included a bottom-up approach to stimulate the community to engage in vector control interventions/improved health-seeking behaviour and used community structures such as local leadership to drive the demand for malaria services among local communities and migrant populations.

Dominican Republic	• TB/HIV coinfection is a serious concern in the Dominican Republic, with one quarter of all TB patients being HIV-positive. However, the Puerto Plata province has a TB/HIV coinfection rate of 64%. The Puerto Plata Integrated Model Pilot project strengthens joint coordination of TB/HIV coinfection management through the integration of care efforts. • If patient satisfaction of TB/HIV-coinfected patients increases, adherence to treatment improves; therefore, mechanisms should be provided for obtaining feedback from patients on the quality of services received. • The National Health Service has committed to expanding the model to the 17 remaining provinces with a TB/HIV coinfection rate of 11%. National coverage is expected by 2022.
Estonia	• Transition planning needs to begin at the same time as grant implementation. • Services must be developed as part of the national health and/or social system, not as stand-alone programmes. Quality of services needs to be the focused, not just quantity. • During the next three years, Estonia will guarantee funding for mobile harm reduction units (November 2018), expanding the number of harm reduction sites and take-home naloxone programmes for overdose prevention, pharmacy-based harm reduction services (from 2019), and social programmes as alternatives to coercive sanctions.
Georgia	• Procurement of antiretrovirals (ARVs) and anti-TB drugs by the Government through the usual tendering process without setting standards in line with those adopted elsewhere may lead to the procurement of lower-quality pharmaceuticals (due to a large number of generics with uncertain origin and lower prices worldwide). • Expanding eligibility for antiretroviral therapy (ART) based on the new WHO test-and-treat recommendations increased the coverage of patients starting ART for prevention compared with the existing practice of starting treatment only in the case of viral load measurement. • Over the 2016–2020 period, Government funding for first-line ARVs increased: funding was US$403 000 in 2016; $441 947 in 2017; $530 000 in 2018; and $817 337 in 2019. For second-line ARVs, government funding began in 2017 at 25% and will be increased to 100% between 2019 and 2022.
Kazakhstan	• Kazakhstan is the only country in central Asia in which all ARVs are procured using state funding (since 2009) within the scope of state-guaranteed free medical care and in which HIV treatment is provided entirely at the expense of the state. • Since 2017 all people living with HIV have received ART in line with the WHO recommendation to treat all. As a result the number of people receiving ART increased 11-fold between 2009 and 2017. • In the country, the cost of ART was 10 times higher than the global median price, including the Global Fund price. This was due to many factors, such as the small amount of drugs ordered, the fragmentation of regional centres that require significant funding for logistics services, and a strict requirement for registration of drugs. • International procurement through UNICEF (since 2016) enabled a substantial reduction in the price of ARVs and the introduction of new medicines/regimens.

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Malaysia	• Malaysia recommends the three P's as integral to sustaining the domestic response to ensure services for people who inject drugs and key populations: **political** support, **policy** based on evidence and **partnership** with CSOs, including for social contracting of service implementation. • Linkage between the key performance indicators for all partners involved in fund disbursement was crucial. • The country uses a health-care model to link people who inject drugs to care in order to improve HIV outcomes and narrow the gaps in the HIV care cascade.
Morocco	• Success factors in the transition context included anticipating transition preparation and speeding up the process by involving senior Ministry of Health officials and direct actors, in particular CSOs/NGOs; developing a budgeted action plan describing the steps, interventions and responsibilities; and early support for international partners (Global Fund, UNAIDS and WHO). • Challenges in the transition of HIV and TB programmes include the risk of losing gains and the role of NGO in responce; the risk of losing representativeness from community and key populations in execution, planning and monitoring processes; increasing stigma and discrimination, especially among key populations; the complexity of drug purchase procedures/ weaknesses in the management of the supply system; and the financial situation.
North Macedonia	• The country transitioned to full domestic funding for all key populations in the HIV response by January 2018. Discussions on the transition with the CCM and stakeholder task force were initiated four years prior in 2014. • CSOs established their own platform to coordinate advocacy and service delivery, but could contribute to the most substantial outcomes in the transition process only after receiving political support to allocate adequate human resources and pursue specific advocacy interventions. • Key factors in facilitating the transition included early actions by the CCM and a strong CCM Secretariat; early/independent advocacy work through CSOs; diversification of advocacy approaches (including working with the Ministry of Health, members of parliament and political parties; and street activism, mobilizing communities and campaigning); and Global Fund support for studies to generate reliable evidence for coordination with the Government. Continued support from international donors is still critical to ensure the quality of services provided.
Panama	• The country has a dual, comprehensive HIV and TB transition plan in place alongside the National health policy of Panama and strategic guidelines 2016–2025 and the Panama multisectoral strategic plan for HIV 2014–2019 and the National strategic plan for tuberculosis 2017–2021. • Partnership between government and civil society for social contracting is an essential strategy for sustainable health and development programmes because coordinating the response may help ensure successful financial transitions. • Over 90% of notified TB cases have been treated.

Paraguay	• Paraguay was declared malaria free in June 2018, so a transition plan comprising only HIV and TB programmes has been adopted: The Sustainability and Transition Plan for Global Fund-Supported Programmes (TB and HIV) for 2019–2024. • The government has gradually taken over responsibility for purchasing supplies, reagents and drugs and for the recruitment of staff for National HIV and TB programmes. Although anti-TB drugs and ARVs are purchased through public funds, the Pan American Health Organization Strategic Fund plays a critical role in supporting the procurement of these drugs in the country. • Options for public financing of CSOs for service implementation/social contracting are still being explored because high levels of stigma and discrimination are associated with HIV infection, TB and key populations in the country.
Sri Lanka	• The malaria epidemic in Sri Lanka has been substantial. In the 20th century, more than half of public health funds have been spent on the response to malaria in the country. However, Sri Lanka achieved malaria elimination in 2012 and WHO certification in 2016. • Additional funding is still required for activities proposed under the initiative in "building resilient and sustainable systems of health for sustainability of people-oriented research", including strengthening regional health and development offices, procuring vehicles and upgrading information technology facilities. • In the future, the country plans to incorporate malaria into the essential service care package in primary care through a restructuring initiative; introduce multitasking laboratory staff for five diseases, including malaria; and introduce comprehensive community screening for foreign labour groups and other TB and HIV risk groups.
Suriname	• The country has strong diversification of funding for the malaria response that includes funding from the private sector, including a US$60 000 investment to develop services. • Innovative and collaborative regional approaches were vital to address malaria in migrant key population(s) that are moving across borders, and international funding is still required to support this key and vulnerable population. • A largely undocumented migrant key population complicates government support for involving migrants in prevention and response efforts, which drives the need for external funding. Registration of migrant populations would be a key achievement in the response to malaria and provide a path towards increased domestic funding.
Ukraine	• Remodelled delivery of directly observed treatment jointly by health-care and social services has led to the reform of both general health-care and TB services. This was achieved through strengthening the coordination role of the primary care provider while ensuring the meaningful involvement of nonmedical staff/social workers in service provision. • This required a combination of state budget funding, local budgets and technical assistance funding (extra services and incentives as a social support). Additional services include directly observed treatment, treatment adherence, TB prevention in the family, infection control, side-effect monitoring and referral for extra services. • Results-based funding improves treatment effectiveness. A new national financing mechanism allowed the development of new service delivery models, procurement reform, and optimized patients' expenses (covering other TB-related needs), and the TB patient community played an active role in reform and advocacy.

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The WHO Regional Office for Europe

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

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