Annual meetings of the national TB control programme (NTP) managers provide a strategic forum for exchange of information on existing and new, innovative approaches being applied in countries, for discussions on technical issues, and to follow up on actions taken on the recommendations of previous meetings, resulting in valuable advice for developing policies, strategies and plans for implementation of TB control interventions in Member countries. In November 2014, NTP managers from all 11 Member countries of the South-East Asia Region and representatives from donors, partners, as well as WHO regional and country staff met and discussed extensively on various issues including the future actions in the respective countries specifically for effective adaptation and implementation of the Global TB Strategy post-2015 now labelled as “End TB Strategy”.

The meeting made important recommendations to Member States, technical and financial partners and civil society for future action to ensure universal access to quality-assured diagnosis and treatment for all persons with TB, scale-up of PMDT, strengthened surveillance and impact measurement, and enhanced resource mobilization, through close multisectoral collaboration and engagement of diverse stakeholders ranging from relevant ministries to affected communities.
Tuberculosis control

Report of a meeting of national programme managers and partners
New Delhi, India, 10–14 November 2014
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## Annexes

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Acronyms

ACSM  advocacy, communication and social mobilization
CCM  country coordination mechanism
CDC  Centers for Disease Control, Atlanta, USA
CN  concept note(s)
DR-TB  drug-resistant TB
DST  drug susceptibility testing
FLD  first-line (anti-TB) drugs
GDF  global TB drug facility
GDI  Global Drug-resistant TB Initiative
GF  Global Fund (to fight HIV/AIDS, TB and Malaria)
GLC  Green Light Committee
rGLC  regional Green Light Committee
GLI  Global Laboratory Initiative
HBC  high-burden countries
HR  human resources
HSS  health system strengthening
IC  infection control
JICA  Japan International Cooperation Agency
MDG  Millennium Development Goal(s)
MDR-TB  multidrug-resistant tuberculosis
M&E monitoring and evaluation
NFM New Funding Model
NSP national strategic plan
NTP national tuberculosis programme(s)
PMDT programmatic management of drug-resistant tuberculosis
PWID people who inject drugs
PR principal recipient
QA quality assurance
RR-TB rifampicin-resistant TB
SEA South-East Asia
SEAR WHO South-East Asia Region
SLD second-line (anti-TB) drugs
SSF single stream funding (GF)
TA technical assistance
TB tuberculosis
TRP technical review panel (GF)
TS technical support
TBTEAM TB technical assistance mechanism
UHC universal health coverage
USAID United States Agency for International Development
WHA World Health Assembly
WHO World Health Organization
XDR-TB extensively drug-resistant TB
1. Introduction

In 2013, 2.1 million people with tuberculosis (TB) were notified to national tuberculosis programmes (NTP) in Member States in the South-East Asia Region (SEAR) and reported to the World Health Organization (WHO). Of these, over 40,000 were diagnosed with multidrug-resistant TB (MDR-TB). In 2013 there were an estimated 3.4 million cases with an estimated 89,000 cases of MDR-TB and an estimated 170,000 cases of HIV-associated TB. While progress is being made, these numbers indicate that TB remains a major public health problem in the Region. Five of the 11 Member States in the South-East Asia Region are among the 22 TB high-burden countries (HBC); Bangladesh, India, Indonesia, Myanmar and Thailand. Four Member States in the Region are also among the 27 HBC for MDR-TB: Bangladesh, India, Indonesia and Myanmar.

The treatment success rate continues to be high at 86% among all new TB cases in the Region. However, major efforts are needed to ensure all cases are detected, notified and treated. Increased use of new diagnostics is ensuring that significantly more TB patients are correctly diagnosed, but major treatment gaps remain and funding is insufficient. Of the 403,335 laboratory-confirmed DR-/MDR-TB cases in 2013, only 237,666 (59%) were started on treatment.

From a global perspective, the target of reducing the TB incidence rate has been achieved in all six WHO regions. The target of halving the TB mortality rate has already been achieved in three regions: the Region of the Americas, the South-East Asia Region and the Western Pacific Region. The other three regions are not on track to achieve the target. The target of halving the 1990 level of TB prevalence has already been achieved in the regions of the Americas and the Western Pacific. The currently available data suggest that SEAR is on track to meet the target by the end of 2015; however, a reassessment will be made towards the end of 2014 or early 2015 based on the findings from the 2013–2014 national TB prevalence survey in Indonesia, and again towards the end of 2015 when a national TB prevalence survey is scheduled to be completed in Bangladesh.
While the achievements over the past two decades are substantial, they are far from enough to ensure progress towards elimination of TB: inadequate coverage and weak performance of health services limit access to high-quality TB care. Many public and private health providers remain delinked from national TB control efforts. Absence of universal health coverage (UHC) aggravates the economic burden on the poor. This hardship is compounded by a lack of social protection mechanisms to address associated income loss and non-medical costs. Regulatory mechanisms essential to ensure effective infection control, rational use of TB diagnostics and medicines, mandatory disease notification, functioning vital registration systems, and protection of the legal rights of people with TB remain weak. Data collection, quality and use need to be improved at all levels. The weaknesses in health systems have limited the linkages that are required across social sectors in order to address poverty, undernutrition and risk factors that adversely influence vulnerability to TB, and the health outcomes of people with TB.

Against this background, during the Sixty-seventh World Health Assembly (WHA) in May 2014, Member States expressed concern that there are inequities in the progress made towards current targets, and that some regions, Member States, communities and vulnerable groups required specific strategies and support to accelerate progress in preventing disease and deaths, and expand access to needed interventions and new tools. The World Health Assembly subsequently adopted the Global strategy and targets for TB prevention care and control after 2015, now called “the End TB strategy”.

The annual meetings of NTP managers and partners provide a strategic forum to renew contact with existing partners, meet with new partners, share experiences and build on the discussions for future actions in the respective countries specifically the Global TB Strategy-post 2015.

2. Opening session

The acting WHO Director for Programme Management at the Regional Office, Dr Arun Bhadra Thapa, opened the meeting on behalf of the Regional Director, Dr Poonam Khetrapal Singh, welcomed the participants and delivered the address of the Regional Director.
In her address, Dr Singh commended NTP managers and partners for their achievements; she also stressed the need for a renewed commitment to intensify TB control efforts in both the public and private sectors. The Regional Director reinforced the message that successful TB control activities needed support from all partners and stakeholders in both the short-and-long term and that effective interventions against TB could be successful only through universal access to effective prevention, early diagnosis, and prompt treatment of all forms of TB including drug-resistant TB (DR-TB). (See text of address in Annex 1)

Dr Md Khurshid Alam Hyder, Regional Adviser Tuberculosis, WHO Regional Office for South-East Asia highlighted the objectives of the meeting. The general objective of the meeting was to organize a consultation involving the national TB control programmes, development partners, bilateral organizations, donors, civil society and other stakeholders in the development of country targets and relevant strategies in line with the new global post-2015 strategy and strengthen the implementation of TB control interventions in the Region.

The specific objectives were:

- to review progress towards the achievements of TB-related MDG targets;
- to provide guidance to Member States in adopting and adapting the new strategy including the development of national targets based on global targets;
- to review progress on achieving universal access to high-quality care for all people with TB;
- to share experiences in scaling up of the programmatic management of drug-resistant TB (PMDT);
- to review progress in national strategic plan revision, concept note (CN) of the new funding model (NFM) of the Global Fund; and
- to identify steps to strengthen country capacity to plan, implement and monitor TB control activities.

See Annexes 2 and 3 for agenda and the list of participants.
3. Progress in and challenges for TB control

3.1 Global update

TB remains a major global health problem, responsible for ill health among millions of people each year. TB ranks as the second leading cause of death from an infectious disease worldwide, after HIV. The latest estimates included in the 2014 global report on TB are that there were 9.0 million new TB cases in 2013 and 1.5 million TB deaths: 1.1 million among HIV-negative people and 0.4 million among HIV-positive people (see Figure 1).

*Figure 1: TB cases and deaths, 1990–2013*

9 million incident cases in 2013

1.5 million deaths in 2013

Globally, the TB mortality rate (deaths per 100 000 population per year) has fallen by 45% since 1990 and TB incidence rates (new cases per 100 000 population per year) are decreasing in most parts of the world. Between 2000 and 2013, an estimated 37 million lives were saved through effective diagnosis and treatment.

Though most TB cases and deaths occur among men, the burden of disease among women is also high. In 2013, there were an estimated 3.3 million cases and 510 000 TB deaths among women, as well as an estimated 550 000 cases and 80 000 deaths among children. TB mortality...
is unacceptably high, given that most deaths are preventable if people can access health care for a diagnosis and the correct treatment is provided. Short-course regimens of first-line drugs that can cure around 90% of cases have been available for decades.

The MDG target that the TB incidence rate should be falling by 2015 has already been met globally. Worldwide, the TB incidence rate has been falling for about a decade. Globally however, the targets of halving TB prevalence and TB mortality rates by 2015 compared with a baseline of 1990 are not on track. This is in line with previous assessments for TB prevalence, which fell by a best estimate of 41% between 1990 and 2013. However, the latest assessment that the TB mortality target is not on track to be met is more recent. This follows new evidence about the level of TB disease burden in Nigeria from the country’s first ever national survey of the prevalence of TB disease, which led to an upward revision of levels of TB incidence, prevalence and mortality. The size of Nigeria’s population and share of the regional and global TB burden mean that this change to burden estimates in Nigeria affects both regional and global assessments of progress. Nonetheless, the global TB mortality rate is estimated to have fallen by 45% between 1990 and 2013, demonstrating that major progress has been made (Figures 2, 3 and 4).

Figure 2: Global incidence, prevalence and mortality rates vs 2015 targets

Source: Global TB report 2014
Figure 3: Prevalence targets: three regions on track

Shaded areas represent uncertainty bands. The horizontal dashed lines represent the Stop TB Partnership target of a 50% reduction in the prevalence rate by 2015 compared with 1990. The other dashed lines show projections up to 2015.

Source: Global TB report 2014

Figure 4: Mortality targets: three regions on track

Estimated TB mortality excludes TB deaths among HIV-positive people. Shaded areas represent uncertainty bands. The width of an uncertainty band narrows as the proportion of regional mortality estimated using vital registration data increases and the quality and completeness of the vital registration data improves. The horizontal dashed lines represent the Stop TB Partnership target of a 50% reduction in the mortality rate by 2015 compared with 1990. The other dashed lines show projections up to 2015.

Source: Global TB report 2014

3.2 Regional update

The South-East Asia Region is home to 26% of the world’s population, but 38% of the estimated prevalent TB cases. In 2013, 2.1 million cases (all forms) of TB were reported to NTP. Out of those 40,335 were MDR-TB and almost 60,000 of the TB cases were positive for HIV. The full set of data illustrating the situation in the Region is found in Figure 5. While progress is being made, an estimated 1.3 million cases of TB are still not notified, clearly illustrating that universal access to quality assured diagnosis and treatment for all persons with TB is not yet achieved in the Region.

Progress is being made in ensuring that paediatric TB receives more attention and higher visibility in Member States. This is evident from the following examples:

- Guidelines for diagnosis and treatment of paediatric TB have been widely disseminated in Indonesia.
- Guidelines have been disseminated and patient-wise drug boxes for children are available under the programme in India.
- National guidelines for the management of childhood TB have also been finalized in Bangladesh and Myanmar.
- Bangladesh has conducted several batches of TOT and training on childhood TB since 2012.
- Myanmar included paediatricians in the expert committee on drug-resistant TB.
- In the Democratic People’s Republic of Korea, training material on paediatric TB treatment has been developed and training conducted. An orientation meeting on childhood TB with children-related facilities at central and provincial levels was held to improve TB service in 2012.
- In Nepal, a Childhood TB Management section was introduced in the NTP General Manual.
- Bangladesh, Democratic People’s Republic of Korea and Myanmar received grants/exceptional donor funding for anti-TB paediatric formulations through the Global Drug Facility (GDF) in 2014.
Progress in TB prevention, diagnosis and treatment requires adequate funding sustained over many years. The national NTP budget in the Member States in the Region for 2014 was US$ 551 million of which 41% was from domestic funding, 35% from international donors. However, 23% was unfunded (Figure 5).

Figure 5: WHO SEA Region TB update

WHO South-East Asia Region

WHO MEMBER STATES 11

Estimates of TB burden* 2013

<table>
<thead>
<tr>
<th>WHO SOUTH-EAST ASIA REGION</th>
<th>NUMBER (thousands)</th>
<th>RATE (per 100,000 population)*</th>
</tr>
</thead>
</table>

Mortality (exclude HIV+TB) 401 (312-966) 25.5 (3-30)  
Mortality (HIV+TB only) 4 (1-10) 3 (1-5)  
Prevalence (include HIV+TB) 4 500 (3 500-5 500) 244 (188-307)  
Incidence (exclude HIV+TB) 3 480 (3 300-3 480) 383 (276-490)  
Incidence (HIV+TB only) 170 (150-190) 9 (8-10)  
Case detection (all forms TB) 41 (34-48)  

Estimates of MDR-TB burden* 2013

<table>
<thead>
<tr>
<th>WHO SOUTH-EAST ASIA REGION</th>
<th>NEW</th>
<th>RETREATMENT</th>
</tr>
</thead>
</table>

% of TB cases with MDR-TB 2.1 (2.0-2.3) 15 (12-20)  
MDR-TB cases among notified pulmonary TB cases 36 000 (26 000-44 000) 51 000 (44 000-66 000)  

TB case notifications 2013

<table>
<thead>
<tr>
<th>WHO SOUTH-EAST ASIA REGION</th>
<th>NEW</th>
<th>RELAPSE</th>
</tr>
</thead>
</table>

Pulmonary, bacteriologically confirmed 1 504 316 129 256  
Pulmonary, clinically diagnosed 58 314 1 368  
Extrapulmonary 3 324 64  

Total new and relapse 2 066 178  
Previously treated, including relapses 293 983  
Total cases notified 2 260 384  

Among 1 681 034 reported new and relapse* cases disaggregated by age, 302 168 (18%) cases were aged 15 years or below, 986 325 (58%) new and relapse* cases disaggregated by sex, male to female ratio = 1.5  

Reported cases of RR, (MDR-TB) 2013

<table>
<thead>
<tr>
<th>WHO SOUTH-EAST ASIA REGION</th>
<th>NEW</th>
<th>RETREATMENT</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

Cases tested for RR, (MDR-TB) 12 333 (12.7%) 19 518 (2.0%) 29 851  
Laboratory confirmed RR, (MDR-TB) cases 4 305  
Patients started on RR, (MDR-TB) treatment 23 704  

TB/HIV 2013

<table>
<thead>
<tr>
<th>WHO SOUTH-EAST ASIA REGION</th>
<th>NUMBER</th>
<th>RETREATMENT</th>
</tr>
</thead>
</table>

TB patients with known HIV status 360 509 (93)  
HIV positive TB patients 19 682 (60)  
HIV positive TB patients in co-trimoxazole preventive therapy (CPT) 92 440 (86)  
HIV positive TB patients on antiretroviral therapy (ART) 48 263 (80)  
HIV positive patients screened for TB 1 149 574  
HIV positive people provided with IPT 1 142  

Treatment success rate (%)

Cases tested in 2012 89  
Previously treated cases, excluding relapse, registered in 2012 75  
HIV positive TB cases, all types, registrar in 2012 76  
RR, (MDR-TB) cases registered started on second line treatment in 2011 50  
EDR-TB cases started on second line treatment in 2011 39  

Laboratories 2013

<table>
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<tr>
<th>WHO SOUTH-EAST ASIA REGION</th>
<th>NUMBER</th>
<th>RETREATMENT</th>
</tr>
</thead>
</table>

Sputum smear microscopy for TB diagnosis 11  
Chest X-ray smear microscopy 3  
Drug susceptibility testing (per 5 million population) 2  
Drug resistance testing (per 5 million population) 2  

Financing TB control (low- and middle-income countries)*2014

<table>
<thead>
<tr>
<th>WHO SOUTH-EAST ASIA REGION</th>
<th>NUMBER</th>
<th>RETREATMENT</th>
</tr>
</thead>
</table>

Funding TB programme budget (US$ millions) 55  
% Funded domestically 61  
% Funded internationally 36  
% Unfunded 23  

Data as reported in WHO. Estimates of TB and RR/TB burden are produced by WHO in consultation with countries.  
HIV positive TB cases includes co-infected TB with treatment history.  
All percentages calculated excluding cases with missing or unknown information.  
Data are not collected from all Member States.  
Funding indicators exclude funding for general healthcare services provided outside the TB service.

(Source: Global TB report 2014)
Domestic funding increased in 2014 as compared to 2013. However, the variation between countries is considerable. In the five TB HBCs in the Region, the share of available funding from domestic sources ranges from 13–66% (Figure 6). The Global Fund (GF) accounts for almost 45% of the funding for TB activities in Member States. Ten Member States currently benefit from funds mobilized through the GF from the previous rounds of GF grants and through the single streaming funding (SSF), transitional funding mechanism and NFM. Maldives is planning to apply for the new funding mechanism of the Global Fund grant for 2015. In addition, nine Member States benefit from funds from other development partners and donor governments with the exception of Bhutan and Maldives, where the only external funds are provided through WHO country budgets.

**Figure 6:** Reported NTP budget, available funding for NTP budget from domestic and international donor sources, funding gap and share of NTP budget provided by domestic and international donor funding (5 TB HBC SEAR) (US$ millions)

<table>
<thead>
<tr>
<th>Country</th>
<th>Total budget</th>
<th>Domestic funding (a)</th>
<th>International donor funding (b)</th>
<th>Share of available NTP funding (a+b) provided from domestic sources (%)</th>
<th>Share of available NTP funding (a+b) provided by international donors (%)</th>
<th>Funding gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>57</td>
<td>2.9</td>
<td>19.0</td>
<td>13</td>
<td>87</td>
<td>35.0</td>
</tr>
<tr>
<td>India</td>
<td>252</td>
<td>165.0</td>
<td>86.0</td>
<td>66</td>
<td>34</td>
<td>0</td>
</tr>
<tr>
<td>Indonesia</td>
<td>127</td>
<td>17.0</td>
<td>38.0</td>
<td>30</td>
<td>70</td>
<td>72.0</td>
</tr>
<tr>
<td>Myanmar</td>
<td>36</td>
<td>5.5</td>
<td>18.0</td>
<td>24</td>
<td>76</td>
<td>13.0</td>
</tr>
<tr>
<td>Thailand (*)</td>
<td>16</td>
<td>8.6</td>
<td>5.2</td>
<td>62</td>
<td>38</td>
<td>2.1</td>
</tr>
</tbody>
</table>

(*)Data reported are only national level budgets for the Bureau of TB and the National Health Security Office, and do not include provincial and local, private sector, etc. It was not possible for Thailand to report funding for other levels in 2014. However, given the policy of UHC, it is estimated that other resources required for TB prevention, diagnosis and treatment are financed from domestic sources.

Source: Global TB Report 2014

Major challenges for TB prevention, care and control in the Region include:

- **Ensuring access to quality diagnostic and treatment services for all people with TB:** Though progress is being made, the SEA Region continues to carry 38% of the global TB burden. There is:
- slow progress in scaling up programmatic management of DR-TB (PMDT);
- slow progress in scaling up TB–HIV collaborative activities;
- inadequate laboratory capacity;
- overstretched health systems including major challenges related to the quality of the health workforce;
- insufficient resource mobilization and remaining funding gap;
- insufficient involvement of big hospitals and private providers; and
- limited involvement of NTP in decision-making related to the health sector reform processes. However, NTP are affected by changes made.

➤ **The underlying determinants:** Specifically, effective tuberculosis prevention will require actions resulting in poverty reduction, improved nutrition, and better living and working conditions as well as strategies to mitigate the impact of migration, ageing populations and chronic diseases such as diabetes that are risk factors for tuberculosis.

➤ **Noncommunicable diseases and tuberculosis co-morbidities:** Risk factors of tuberculosis such as diabetes, tobacco smoking, silicosis, alcohol and drug misuse, and under-nutrition hamper TB control, especially in low- and middle-income countries.

### 4. Technical sessions

#### 4.1 The End TB Strategy and the Global Plan 2016–2020

*The End TB Strategy: developing guidance on its implementation*

The Sixty-seventh World Health Assembly unanimously adopted a resolution on the “Global strategy and targets for TB prevention, care and control after 2015” (Figure 7). The post-2015 global TB strategy, now labelled as “End TB Strategy” was developed through an inclusive process that engaged the whole range of stakeholders, from programme managers to partners and from activists to academics. The core principles of the new
strategy are: government stewardship and accountability, with monitoring and evaluation; strong coalition with civil society organizations and communities; protection and promotion of human rights, ethics and equity; and the adaptation of the strategy and targets at country level, with global collaboration.

**Figure 7: The End TB Strategy**

<table>
<thead>
<tr>
<th>Vision:</th>
<th>A world free of TB</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Zero deaths, disease and suffering due to TB</td>
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</table>

| Goal:  | End the global TB epidemic |

**Milestones for 2025**
- 75% reduction in TB deaths (compared with 2015)
- 50% reduction in TB incidence rate (less than 55 TB cases per 100,000 population)
- No affected families facing catastrophic costs due to TB

**Targets for 2035**
- 95% reduction in TB deaths (compared with 2015)
- 90% reduction in TB incidence rate (less than 10 TB cases per 100,000 population)
- No affected families facing catastrophic costs due to TB

**Principles**
- Government stewardship and accountability, with monitoring and evaluation
- Strong coalition with civil society organizations and communities
- Protection and promotion of human rights, ethics and equity
- Adaptation of the strategy and targets at country level, with global collaboration

**Pillars and components**

1. **Integrated, patient-centred care and prevention**
   - Early diagnosis of TB including universal drug susceptibility testing; and systematic screening of contacts and high-risk groups
   - Treatment of all people with TB including drug-resistant TB; and patient support
   - Collaborative TB/HIV activities and management of co-morbidities
   - Preventive treatment of persons at high-risk; and vaccination against TB

2. **Bold policies and supportive systems**
   - Political commitment with adequate resources for TB care and prevention
   - Engagement of communities, civil society organizations, and public and private care providers
   - Universal health coverage policy and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control
   - Social protection, poverty alleviation and actions on other determinants of TB

3. **Intensified research and innovation**
   - Discovery, development and rapid uptake of new tools, interventions and strategies
   - Research to optimize implementation and impact, and promote innovations.
The WHO Secretariat, at all levels of the Organization, will provide support to Member States in reviewing, adopting, adapting and implementing their post-2015 TB strategies, and in building on the framework provided in the draft strategy. WHO will draw on its comparative advantages in areas of the core functions outlined below and use its Strategic and Technical Advisory Group for Tuberculosis and regional advisory bodies, as well as the Organization’s governing bodies, to guide, support and evaluate its work.

WHO is currently developing guidance on adapting and implementing the End TB Strategy. The objective of the implementation guidance document is to describe key considerations and steps for operationalizing the End TB Strategy. The document would be a link between the official strategy document and numerous current and future WHO guidelines and tools.

For the overall strategy, there will be guidance on how to adapt the strategy and the targets to the country contexts and a list of indicators to measure and monitor progress and impact. For each pillar and component, the document will outline the following: the policies that should be in place to facilitate implementation; the key actors to be engaged; the requirements from the health systems and general health services; and the key implementation steps. The document will offer practical working examples from the ground related to implementation. Links to all available technical guidelines and tools and citations of useful and relevant resource material will also be provided. The document is expected to be available in early 2015.

The Global Plan 2016–2020

Since 2001, the Stop TB partnership has coordinated the development of the global plans to Stop TB:

- First Global Plan to Stop TB: 2001–2005
- Five year Global Plan: 2011–2015

With the current five-year plan approaching its end and with the endorsement by the Sixty-seventh World Health Assembly in May 2014 of the End TB Strategy, the Stop TB Partnership as initiated work on the development of the Global Plan 2016–2020. In May 2014, a task force consisting of 10 TB experts was created. The group includes partners from
TB-Mycobacterium avium complex/The London School of Hygiene & Tropical Medicine, Institute for Health Metrics and Evaluation, United States Agency for International Development, new tool working groups, Brazil/South Africa country programme representative, RESULTS UK, UNSGO/UNAIDS, Global Coalition of TB Activists, WHO Global TB Programme, and the Stop TB Partnership Secretariat. The task force has organized two meetings to date. The first meeting was organized in July 2014 in Seattle, USA where agreement was reached on the general approach. The second meeting took place in October in Barcelona, Spain where the group reached consensus on country groupings and investment packages.

The Global Plan 2016–2020 will aim at reaching the milestones set for 2020: 35% reduction in TB deaths (compared to 2015); 20% reduction in TB incidence rate (<85/100 000), and no affected families to face catastrophic costs due to TB. The main features of the plan will be country grouping based on epidemiology, health systems and socioeconomic and political characteristics (16 indicators used for groupings), and investment packages, consisting of interventions appropriate for each country group, will be modelled for cost and impact. The plan will indicate the:

- Funding requirement for accelerated TB response for the period 2016–2020
  - implementation (investment packages)
  - research and development
- Impact of funding on the TB epidemic
  - Modelling of incidence, prevalence and mortality globally and by country groups

The plan is expected to be launched in October 2015.

4.2 Review of activities to scale up the programmatic management of drug-resistant TB (PMDT)

Drug-resistant TB and PMDT

DR-TB poses a major threat to the control of TB worldwide. By the end of 2013, data on anti-TB drug resistance were available for 144 countries, accounting for 95% of the world’s population and estimated TB cases.
Globally, an estimated 3.5% (95% CI: 2.2–4.7%) of new cases and 20.5% (95% CI: 13.6–27.5%) of previously treated cases have MDR-TB. In 2013, there were an estimated 480,000 (range: 350,000–610,000) new cases of MDR-TB worldwide, and approximately 210,000 (range: 130,000–290,000) deaths from MDR-TB. Among patients with pulmonary TB who were notified in 2013, an estimated 300,000 (range: 230,000–380,000) had MDR-TB. More than half of these patients were in India, China and the Russian Federation. A new analysis of trends focusing on the years 2008–2013 shows that, at the global level, the proportion of new cases with MDR-TB remains unchanged. However, serious MDR-TB epidemics in a number of countries jeopardize progress. Extensively drug-resistant TB (XDR-TB) has been reported by 100 countries.

A total of 136,412 people with MDR-TB or rifampicin-resistant TB (RR-TB) who were eligible for MDR-TB treatment were notified globally in 2013, mostly by India, South Africa and countries in the European Region. Despite progress in the detection of MDR/RR-TB cases, a major diagnostic gap remains: 55% of reported TB patients estimated to have MDR-TB were not detected in 2013. Almost 97,000 patients were started on MDR-TB treatment in 2013. Between 2012 and 2013, gaps between numbers diagnosed and numbers started on treatment widened in several countries. The ratio of enrolled to diagnosed cases was lower than 60% in 10 high MDR-TB burden countries in 2013 and the lowest in Myanmar (34%), South Africa (41%), and Tajikistan (30%).

Five high MDR-TB burden countries (Ethiopia, Kazakhstan, Myanmar, Pakistan and Viet Nam) achieved treatment success rates of ≥70%. However, overall only 48% of patients with MDR-TB were successfully treated, largely as a result of high mortality and loss to follow-up (Figure 8). Of 1269 XDR-TB patients reported in 40 countries in the 2011 cohort overall, only 284 (22%) completed their treatment successfully and 438 (35%) patients died.

Considerable progress in the global and national response to the MDR-TB epidemic is evident, particularly since 2009, when the Sixty-second World Health Assembly called for universal access to diagnosis and treatment of MDR-TB. However, it remains far from sufficient. While the percentage of new TB cases that have MDR-TB globally remains unchanged, some countries have severe epidemics and in many settings, the treatment success rate is alarmingly low. Five priority actions, from
prevention to cure, are required. Health system barriers, diagnostic and treatment challenges and inadequate funding for care and research must be urgently addressed.

**Figure 8: Treatment outcomes for patients with MDR-TB**

![Graph showing treatment outcomes for patients with MDR-TB](image)

Source: Global TB Report 2014

**The Global Drug-resistant TB Initiative**

A landmark resolution adopted by all Member States at the Sixty-second World Health Assembly demonstrated strong national and international commitment to scale up efforts to address the challenge of DR-TB through achieving universal access to MDR-TB diagnosis and care. To support these efforts, the previous Green Light Committee Initiative has been substantially reformed and today regional Green Light Committees (rGLC) in all six WHO regions, with secretariats hosted by WHO regional offices, have been established. A new Global Framework was launched in 2011, with a focus on increased technical support to countries through decentralized structures. Since then, this structure has been reinforced. At a global MDR-TB stakeholders meeting held in October 2013, the Global Drug-resistant TB Initiative

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TB Initiative (GDI) was established to coordinate global MDR-TB activities, with the following strategic areas of work: (1) develop targeted advocacy strategies and resource mobilization for DR-TB management scale-up; (2) facilitate integration and coordination of efforts to align diagnostic services for patients with access to high-quality care; (3) build global consensus on the management of DR-TB for patient-centred care delivery (“care for cure”); (4) promote strategies to facilitate patient access to high-quality DR-TB care, through a long-term, in-country capacity-building approach targeting both the public and private sector; and (5) support prioritization of research to generate evidence for PMDT scale-up. The GDI Core Group was formed in February 2014, and held its first and second meetings in May and October 2014 respectively. The procedures of GDI will be aligned to those of the Global Laboratory Initiative (GLI), an analogous structure which has provided global guidance to and coordination of TB diagnostic activities since its creation in 2008. Further information about the GDI and the GLI is available online.2

4.3 The new strategy including the development of national targets based on global targets

The vision of the post-2015 TB strategy is “a world free of TB”; also expressed as “zero deaths, disease and suffering due to TB”. This vision is defined to represent the ultimate achievement in TB prevention, care and control. Progress during the 2015–2035 period covered by the strategy should represent a substantial step towards achievement of this vision.

The goal of the post-2015 global TB strategy is to end the global TB epidemic. This goal is in line with broader post-2015 development goals, including those for HIV, malaria and neglected tropical diseases. It is considered feasible within a 20-year time period (by 2035), and can be defined as reducing the global burden of TB (incidence and mortality) to levels already reached in low-burden countries, which are considered to have “ended” their TB epidemics and can instead aim for TB elimination.

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2 Global Laboratory Initiative, http://www.stoptb.org/wg/gli/
The two principal global targets of the post-2015 global TB strategy are for reduction in TB cases and deaths. The targets are defined to correspond to the 2035 goal of ending the TB epidemic. They are:

- 95% reduction in deaths due to TB by 2035, compared with a baseline of 2015 (equivalent to about 65 000 TB deaths – approximately 0.8 per 100 000 population – globally in 2035, compared with approximately 1.3 million in 2015); and

- 90% reduction in the incidence of TB (i.e. the number of new cases developing each year) by 2035, compared with a baseline of 2015, (reducing the number of new cases per year to 10 per 100 000 globally by 2035, a level similar to that already reached in North America, several countries in Western Europe and parts of the Western Pacific Region.)

The global milestones along the way to reaching these 2035 targets, which correspond to the projected trajectories of TB incidence and mortality that are considered feasible, are shown in Table 1 and Figure 9.

Achievement of 2035 targets requires two things.

1. The 2025 milestones are reached.

2. New tools, in particular an effective post-exposure vaccine or equivalent treatment for latent TB infection, become available around 2025 and are subsequently scaled up. For such new tools to be available for introduction by 2025, greatly enhanced and immediate investments in research and development will be required throughout the period 2015−2025.

### Table 1: The two global targets for 2035 that correspond to the goal of ending the tuberculosis epidemic, and associated global milestones for 2020, 2025 and 2030 (%)

<table>
<thead>
<tr>
<th>Indicators with estimated baseline values for 2015</th>
<th>Milestones</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2020</td>
<td>2025</td>
</tr>
<tr>
<td>Percentage reduction in tuberculosis deaths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(projected 2015 baseline: 1.3 million deaths)</td>
<td>35</td>
<td>75</td>
</tr>
<tr>
<td>Percentage and absolute reduction in tuberculosis incidence rate (projected 2015 baseline 110/100 000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 (&lt;85/100 000)</td>
<td>50 (&lt;55/100 000)</td>
</tr>
</tbody>
</table>

Note: Numbers in brackets show absolute value
Figure 9: Projected global trajectory of tuberculosis incidence rate 2015–2035 required to reach 2035 targets

Source: Global TB Programme

Vision and goal: adaptation at country level

The global vision of “a world free of TB”, also expressed as “zero deaths, disease and suffering due to TB”, could be adopted with no need for adaptation at country level. It is a long-term vision relevant to all countries. Nonetheless, the wording could be adapted to use wording considered most appropriate at country level.

The global goal of ending the TB epidemic by 2035 could be adopted with no need for adaptation in all countries that have not yet reached the corresponding targets of a TB incidence rate of ≤10 per 100 000 population and a mortality rate of <0.8 per 100 000 population. Alternatively, in countries that are already close to or at these levels, a more ambitious goal such as TB pre-elimination (with a corresponding target of less than 10 cases per million population) or TB elimination (with a corresponding target of less than one case per million population) could be set.

The two global targets for 2035 – a 95% reduction in the number of TB deaths and a 90% reduction in TB incidence – could be adopted in any
country for which the goal of “ending the TB epidemic” is appropriate. This means they could be appropriate in any country that has not yet reached the absolute targets of ≤10 incident cases per 100 000 population and <0.8 TB deaths per 100 000 population. These are targets for 20 years into the future that, in all countries that have not yet reduced the burden of TB to such levels, will depend on new tools becoming available around 2025.

It is the three global milestones set for 2025 and 2020 that are likely to need the most thought and adaptation at country level. The 2025 global milestones are a 75% reduction in TB deaths and a 55% reduction in TB incidence compared with 2015 levels, and no families of TB patients facing catastrophic costs as a result of the disease. The 2020 global milestones are a 35% reduction in TB deaths, a 20% reduction in TB deaths compared with 2015, and no families of TB patients facing catastrophic costs as a result of the disease. It should also be kept in mind that if some countries set less ambitious targets for 2020 and 2025, global milestones for these years and subsequent targets for 2025 can only be met if other countries set targets for 2020 and 2025 that are more ambitious than the global targets.

In addition, while at global level, the term “milestones” is used for the levels of TB deaths and incidence to be reached in 2020 and 2025, at country level, the levels aimed for in 2020 and 2025 could be referred to as “targets”, for example in national strategic plans covering a five or ten-year period.

To define country-specific targets for reductions in TB incidence and deaths for 2020 and 2025 (or other years between 2015 and 2035), the starting point should be a thorough epidemiological analysis of the baseline situation, recent trends in incidence and mortality and the major determinants of the TB epidemic, combined with an assessment of planned actions to improve TB prevention, care and control in line with the three pillars of the global TB strategy, with particular attention to a national strategy for achieving UHC as outlined below.

The key steps in setting country-specific targets for 2020 and 2025 (and/or other years 2015−2025) are:
**Targets for reductions in TB deaths and TB incidence**

1. Conduct a baseline epidemiological analysis of current and recent trends and drivers of the TB epidemic alongside assessment of planned actions to improve TB prevention, care and control, with particular attention to the national strategy for achieving UHC (if this is not already in place).

2. Set targets for the case-fatality rate and the rate at which incidence should be falling *for the year in which UHC is expected to be achieved*; if UHC has already been achieved, set targets for these two indicators based on current levels and trends alongside assessment of capacity to further lower the case-fatality rate and the annual rate at which incidence is falling.

3. Develop projections of trends in TB incidence and mortality based on the targets set (in step 2) for the case-fatality rate and the annual reduction in incidence, assuming progressive acceleration of progress towards these targets.

4. Define targets for reductions in TB mortality and incidence for specific years based on projections (produced in step 3). These targets can be expressed as absolute numbers (annual number of deaths and incident cases per year), as rates (number of deaths and incident cases per 100,000 population per year) and/or as relative reductions by the target year compared with a 2015 baseline.

**Target for catastrophic costs**

The target year in which no families of TB patients face catastrophic costs as a result of the disease should be set to be the same as the year in which the goal is to achieve UHC. If UHC has already been achieved, then the target should apply for all future years.

**Measuring progress and impact**

Key indicators of monitoring the burden of TB and for which short-and long-term targets should be set in all countries are TB mortality and TB incidence, alongside the prevalence of TB in some countries with baseline survey measurements around 2015.
The number of TB deaths per year should be the principal indicator used to monitor reductions in TB disease burden. This is because the number of TB deaths can be directly measured at country level via national vital registration systems in which causes of death are recorded using standard international coding systems. By 2011, 121 countries that accounted for >50% of estimated global TB deaths had such systems and they can and should be introduced elsewhere. The case-fatality rate (the number of TB deaths divided by TB incidence) is also an indicator that should be monitored; this is a key variable that influences the setting of targets for reductions in TB deaths, and subsequent achievement of these targets. In addition, it is also a good equity indicator, since whatever the number of incident cases, all countries can aim to reach the same low case-fatality rate based on achievement of UHC.

Incidence is currently not directly measured in most countries. However, measurement is possible in all countries with substantial strengthening of surveillance and wider health-care systems. The performance of information systems should regularly be formally assessed to ensure that TB notification data meet the standards required for notifications to provide a good proxy of incidence.

**Epidemiological projections and review**

It is important to distinguish between short-term and long term projections: short-term projections are needed to evaluate future needs; long-term projections are needed to set ambitious targets. Short-term projections should be based on a carefully evaluated epidemiological situation. It is also essential to evaluate and upgrade TB information systems. Short-term projections could for example be made for all cases: percentage bacteriologically confirmed; percentage of extra-pulmonary cases; number of retreatment cases and/or MDR detection and treatment. Long-term projections would address incidence and mortality.

This highlights the importance of surveillance as:

- estimates of TB burden based on weak data are very uncertain;
- eligibility for funding should be based on measurable criteria and accurate measurements;
planning, targeting and budgeting should match actual needs; and

- evaluation of programme performance should be based on accurate assessments.

TB epidemiological review is the baseline for setting country-level targets. The review offers a unique opportunity to conduct a baseline assessment of the strengths and weaknesses of the surveillance system; understand, use and improve the quality of TB, and other relevant, data; identify data gaps for direct measurement of TB burden and to set targets on improving: (i) quality and coverage of surveillance, and (ii) direct measurement of disease burden. The reviews can also inform programme reviews, the "epidemiological stage" of CN submission to GF and target-setting (at least short-, but also longer-term). Standardized terms of reference are available since early 2013, including four objectives, with suggested analytical tasks per objective.

### 4.4 National strategic planning and the Global Fund New Funding Model (GF-NFM)

**Status of national strategic plans in SEAR**

Global, regional and national strategic plans are today key documents for NTP and partners to strengthen programme management. The SEA Regional Strategic Plan for TB Care and Control 2006–2015 was updated to cover the time period 2012–2015. It is based on the Stop TB Strategy and focuses on five key strategies:

- ensure universal access to quality TB diagnosis and treatment services for all persons with TB including children;
- scale up PMDT;
- scale up TB–HIV collaborative activities;
- strengthen laboratory capacity; and
- contribute to health system strengthening.

Following the adaptation of the End TB strategy, the regional plan will be updated to support Member States in ongoing planning for the
reduction in TB mortality and incidence in line with the global targets set in resolution WHA67.1 and guiding the countries in addressing the persisting and emerging epidemiological and demographic challenges and in advancing UHC and robust health systems.

In the past year, a number of Member States in the SEA Region have revised their NTP strategic plans, partially taking the End TB strategy into consideration. The status of the plans can be seen in Table 2 below:

**Table 2: Status of NSP TB in SEA Region**

<table>
<thead>
<tr>
<th>Member States</th>
<th>Period of current NSP</th>
<th>Plans for update</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>2012–2016</td>
<td>Although the current plan is up to 2016, the National Strategic Plan for TB Control has been revised, 2015–2020 incorporating post–2015 Global WHO Strategy</td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td>2012–2016</td>
<td></td>
<td>The country is planning a midterm review of NSP probably by end of 2015 and it will be revised accordingly based on the review findings</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>2015–2018</td>
<td>Recently updated</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>2012–2017</td>
<td>No</td>
<td>NSP period is in line with nation’s five-year plan. However, with the new strategies being developed by the programme, there could be some substantial revisions in 2015.</td>
</tr>
<tr>
<td>Member States</td>
<td>Period of current NSP</td>
<td>Plans for update</td>
<td>Remarks</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------</td>
<td>------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2010–2014 (However, this was revised up to 2016 mainly to incorporate the Global Fund grant Phase II period)</td>
<td>Work on 2015–2019 period NSP has started. Expected to be completed soon</td>
<td>Although the current plan is up to 2016, NSP is being updated for 2015-2019 period to incorporate post-2015 and revised disease burden estimates (initial NSP results are available now). WHO country office is providing core support to NSP development.</td>
</tr>
<tr>
<td>Maldives</td>
<td>2014–2019</td>
<td>Mid-term review to be undertaken in 2016</td>
<td>The plan and costing part was done with the assistance of WHO external and local consultants.</td>
</tr>
</tbody>
</table>
| Myanmar       | • 2011–2015  
• 2012–2015 supplement  
• Has been extended till 2016 to incorporate NFM | Next NSP will cover 2016–2020 | Development of next NSP will start after JMM (Dec 2014) and should be completed during 2015. |
<p>| Nepal         | Jul 2010–Jul 2015    | Draft NSP Jul 2015–Jul 2020 produced by NTP with support from WHO consultant in May-June 2014 | NSP to be finalized shortly (before CN development and submission) by NTP and WCO. Recent change of NTP leadership has somehow delayed the process. |</p>
<table>
<thead>
<tr>
<th>Member States</th>
<th>Period of current NSP</th>
<th>Plans for update</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>2015–2020</td>
<td>The previous NSP was for the period 2012–2016. This was updated and costed during Aug–Sep 2014 by an external consultant funded through WHO-TGF TA Agreement</td>
<td>Draft Doc attached. Finalization workshop held on 6–7 October 2014. Final changes in NSP need to be made by the Bureau of TB and endorsed by MoPH</td>
</tr>
</tbody>
</table>

**Experiences in revising and updating NSP – Sri Lanka**

The existing National Strategic Plan on TB control has been updated for the period 2015–2020. Several factors contributed to the highlight need for this update:

- a sharp decline in TB case-finding (9.4%) in 2012;
- the epi-analysis highlighted the decline as a system weakness rather than an epidemiological phenomenon;
- the external evaluation team (Joint Monitoring Mission) identified several gaps that need urgent attention;
- to improve case detection and case holding (thereby treatment success) new interventions were needed—including decentralization;
- the need to change the diagnostic algorithm due to new diagnostics;
The need to base the CN to the GF NFM on an updated NSP; and

to be in line with the post-2015 WHO TB control targets.

The process for the revision consisted of the following steps.

(1) Gap analysis for the following major areas:
   - case detection – active / passive
   - quality-assured laboratory network
   - drug management/treatment including DOTS, patient support, other supplies
   - recording, reporting
   - monitoring/evaluation and supervision
   - TB in children
   - TB–HIV, TB/NCD and among other vulnerable groups,
   - MDR-TB
   - involving all care providers including private–public, public–public partnership
   - infection control
   - community and civil society engagement through advocacy, communication and social mobilization
   - programme management
   - operational research, and
   - health system response to TB control.

(2) Identification of priorities

(3) Development of goals, objectives and interventions

The goal of the revised NSP is to decrease the prevalence of TB by 10% by 2020 based on re-assessment of TB burden figures to be conducted in 2014. The key five objectives are:

(1) Detect at least 80% of incident TB cases (all forms) by 2017 and 90% of incident cases by 2020;
(2) Increase the treatment success rate of the enrolled patients (all forms of non-MDR TB) to 90% by 2017; successfully treat 75% of MDR-TB cases;

(3) Integrate TB diagnostic and treatment services to include 40% of all divisional hospitals (up to Type B) by 2017 and 80% by 2020;

(4) Engage 30% of all private health-care providers (hospitals and general practitioners) in TB control by 2017, and 50% by 2020; and

(5) Ensure that quality TB services in line with current international standards are provided by qualified and regularly supervised personnel at 100% of all implementation sites by 2017.

The revision process faced several challenges, for example, the non-availability of actual disease burden of TB in the country – only estimates were available; addressing concerns regarding decentralization / engaging PHC workers in TB care and prevention; prioritization of activities to meet the demands of financing, and the limited time and lack of adequate technical expertise.

The key lessons learned in the process include:

- The importance of the country dialogue to get views and ideas of different stakeholders and to negotiate / get the acceptance;
- The challenge in prioritization – to ensure a balance between the need and cost effectiveness;
- The need to strengthen counterpart funding; and
- The challenge in planning the implementation – how to prioritize activities within the given time-frame including for process and outcome monitoring.

Global Fund New Funding Model – update and experiences from the Global Fund perspective

The principles of NFM were established by the Board of the GF as part of its strategy for 2012–2016. It is based on feedback from countries and partners about how the GF could better help them.
All share a vision of a world free of the burden of HIV/AIDS, TB and malaria, and in a world of limited resources, investments need to go further in order to achieve this.

Therefore, NFM was established to make a bigger impact, with more reliable results, reward ambitious vision, and work on more flexible timings with a more streamlined approach.

- **The bigger impact** principle is delivered by establishing which countries have the highest disease burden and lowest ability to pay, and focusing more resources on this group.

- By introducing the idea of an ‘allocation’ for each country, and by supporting each country as they develop their intervention plan, the GF will be able to ensure a more reliable result, with predictable financing levels and a higher success rate of applications.

- **Rewarding ambitious vision** is achieved by developing a picture, based on national strategic plans or investment cases, of what each country would ideally like to do, over and above their funding allocation. By eliciting the full expression of demand and having a pool of ‘incentive’ funding available, the GF is able to allocate additional funds to the most compelling investment cases.

- Another big change is to move away from the rounds-based competition with a set application date, and allow countries to apply at a time that meets their own national schedules, within the 2014–2016 time-frame.

- Finally, by including much of the implementation plans up front in the initial proposal, and with greater support from GF country teams in the early stages, it has become simpler for countries to navigate the new process. By reducing complexity a lengthy process that used to take two years has been cut down to an average of 11 months.

An estimated 113 CN (all components) reviewed in 2014 representing US$ 8.5 billion in allocated funding. In Window 1-3, 69 new CN were reviewed, of which 80% are currently in grant-making and 20% are working
on iterations. A total of 44 TB and TB–HIV submissions were made in the first four TRP windows (Table 3).

**Table 3: NFM summary: TB and TB–HIV submissions to date**

<table>
<thead>
<tr>
<th>May</th>
<th>June</th>
<th>August</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haiti</td>
<td>Bangladesh</td>
<td>Thailand</td>
<td>Afghanistan</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Ukraine</td>
<td>Armenia</td>
<td>DRC*</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Zambia</td>
<td>Bhutan</td>
<td>Comoros</td>
</tr>
<tr>
<td></td>
<td>Moldova</td>
<td>Nigeria</td>
<td>Lao PDR</td>
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<tr>
<td></td>
<td>Myanmar</td>
<td>Panama</td>
<td>Romania</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Rwanda</td>
<td>Sao Tome &amp; Principe</td>
<td>Swaziland</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>Viet Nam</td>
<td>South Sudan</td>
<td>Tanzania</td>
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<td></td>
<td>Sudan</td>
<td>Sri Lanka</td>
<td>Togo</td>
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<tr>
<td></td>
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<td></td>
<td>Uganda</td>
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<tr>
<td>1</td>
<td>3</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td></td>
<td>17</td>
</tr>
</tbody>
</table>

* Democratic Republic of Congo

**Global Fund New Funding Model – update and experiences from the WHO perspective**

WHO provides support to countries in all processes leading to CN submission e.g. epidemiological data analysis, programme review, NSP development, planning of technical assistance (TA) and CN development. WHO also facilitates coordination and mobilization of TA. Overall key lessons learned with the NFM include:

1. The NFM CN process is working and has positive outcomes.
   - An intensive engagement with GF country teams is helpful during the CN development process.
- Partners’ technical support time and country resources are not being wasted on unsuccessful applications. Previously 50% of proposals were being approved, now all are being approved and much more successfully.

- TB–HIV single proposals are encouraging engagement at country level. There is some concern with global TB–HIV funding monitoring, but in general, single TB–HIV CN are reflect improved collaboration and demonstrating much more understanding between the two programmes.

- Allocation model benefits low-resourced countries and counterweighs the demand-and performance-driven process which tends to favour countries with better infrastructure, but not necessarily those in greatest need.

- SEAR is doing well, as resources are flowing in from Europe and America to Asia and Africa due to the disease burden. The applications are also well justified in asking for what is needed and therefore, funding is coming through (as opposed to some countries where they are poor at asking full demand, and therefore not receiving adequate funding).

(2) Early country engagement with prioritization of interventions to be funded is essential.

- Early prioritization needs to start with epi analysis, Joint Monitoring Mission and early country dialogue and be reflected in the NSP to facilitate identification of interventions to be included in the concept note.

- Prioritization is important and starts very early – during JMM and NSP development.

- Above allocation can disrupt some prioritization – as it is not a sure thing – makes it a gamble for the countries to prioritize in above allocation and risk not receiving funding for it.

(3) CN development is a complex endeavour, requiring time and effort of all players.

- CN is a process that can take months.
- CN templates very long documents, sections appear repetitive, encourage summaries.
- Prioritization may cut across modules.
- Online platform, though useful, is proving difficult for countries with poor internet access.
- Training of TA providers and writing teams is essential by those who have gone through the process.

(4) There is a need to review current tools using TA provider’s feedback:
- learn from the consultants and partners working at country level;
- streamline the modular tool, as it is difficult to harmonize with NSP;
- partners providing feedback to GF; and
- existing budgeting tools not yet harmonized with modular tool and allocation and above allocation.

In conclusion, experience to date has demonstrated that NFM is a lengthy, complex and expensive process which require extensive travels by consultants and workshops engaging many stakeholders. The work has also highlighted that the planning processes in TB and HIV programmes are not aligned. It is essential when exploring timelines with GF that all aspects of both programmes are discussed. A third essential aspect is the crucial importance of assessing the country’s preparedness to start work on the CN, before the formal TA request is processed (i.e., staff or consultant identified, travel arranged, etc.). Lastly, many countries are applying to multiple TA providers (such as WHO, the FEI 5%, USAID, UNAIDS, etc.). This needs good coordination at country level and a good mapping of country-based TA, which could address many needs in a more efficient and timely manner.
4.5 Preparing for the Global Fund New Funding Model

Introduction to key issues in CN preparation: country dialogue and engagement, prioritization of funding needs; TB–HIV joint planning – GF perspective

Recognizing the importance of collaborative TB–HIV services and the need for TB and HIV programmes to work jointly, the GF Board’s Strategy, Investment and Impact Committee has decided that countries with high co-infection burden of TB and HIV shall submit a single CN that presents integrated and joint programming for the two diseases. The joint CN refers to all necessary programme areas for TB and HIV programmes as well as to the areas where these two programmes overlap, including collaborative activities. HSS and community services/cross-cutting areas are particularly important to address.

The critical areas for joint TB and HIV programming are illustrated in Figure 9.

To strengthen CN, TRP offers the following recommendations to CCM, country teams and technical partners:

**General:**

The following should be borne in mind:

1. provide clear description and justification of prioritized interventions in above allocation vs. allocation;
2. match appropriate programmes and activities to situational analysis;
3. include gender-sensitive programmes and activities in CN;
4. provide information on key donor investments and impact on programmes;
5. strengthen sustainability through more deliberate transition plans; and
6. build health system capacity.
Figure 9: Critical areas for joint TB and HIV programming

Issues in TB care and prevention:

(1) Prioritization of interventions is still a challenge:
   - NSP and CN;
   - basic services and scale-up;
   - case detection for drug sensitive and MDR-TB scale-up; and
   - laboratory services and new diagnostics.

(2) Case-detection targets are still not ambitious:
   - flattening/decreasing trends;
   - TB estimates versus prevalence survey results; and
   - allocation and other sources including domestic funding.

(3) Innovative approaches to improve TB case detection not used:
   - PPM, inclusive of NGO and private sector, community TB care etc, and
   - experience from pilot projects e.g., TB REACH.
(4) Childhood TB:
   - most interventions for children proposed as pilot or as operational research – no nationwide strategy for scale-up; and
   - in most cases, contact tracing for children included, but no clear strategy on how to do/strengthen this.

(5) Limited linkages and integration with other health programmes such as RMNCH, diabetes etc.

**Issues in MDR-TB:**

(1) integrated approach to MDR-TB care: a challenge
   - balance between case-detection strategies, treatment capacity and quality of treatment and ambitious case detection targets not matched with testing and treatment capacity;

(2) Gene-Xpert expansion not linked to comprehensive laboratory plan

(3) appropriate model of MDR-TB care is still a challenge: decentralization of MDR-TB treatment;

(4) quality of MDR-TB care: poor treatment outcomes;

(5) prevention of MDR-TB is not well addressed; and

(6) countries requesting or considering using shorter regimen and new drugs.

**Issues in TB–HIV:**

(1) requires the full involvement of both TB and HIV programmes in the development of joint CN;

(2) some CN HIV-dominated, with more data and epidemiological context than TB;

(3) not simply TB–HIV activities, but joint programming should leverage both TB and HIV to harmonize intervention to increase efficiency and impact (look holistically);
(4) TB–HIV joint programming not reflected in budgeting of activities with concrete plans beyond the narrative. Further alignment in short-, medium-, and long-term TB and HIV strategies, policies and interventions; and

(5) screening PLHIV for TB and provision of isoniazid preventive therapy for weaker components.

**Cross-cutting issues:**

(1) Community-based approaches:
   - pilots, stand-alone projects
   - limited link with HSS and HIV
   - not yet optimized focus, more on improving treatment outcomes
   - focus more on service delivery, limited CSS.

(2) Key affected populations:
   - well described in most CN but the targeting of interventions is often too vague.

(3) Health system strengthening:
   - not strategically focused in most CN; and
   - countries to look for ways to share HSS costs across diseases by using cross-cutting HSS to help maximize impact. (For example, coordinated monitoring and evaluation systems, sharing procurement and supply chains).

**Ensuring an inclusive ongoing country dialogue in CN preparation – experience from the NTP perspective – Timor-Leste**

NTP has developed a detailed “Engagement Plan” for the development of the CN. The first phase of the engagement plan is the development of the NSP (June to October 2014) followed by the second phase, the preparation of the CN (October 2014–April 2015). The deadline for CN submission is 15 April 2015.
Based on identified gaps, NSP was developed after several consultations among various sectors in the government, NGOs, civil society organizations, key partners as well as bilateral and multilateral representatives. Several dialogues with partners were also held prior to the development of NSP.

Key challenges and lessons learned are as follows:

**Challenges:**

- The key challenge in having a dialogue with multiple partners is the time factor and not all partners are available at a given time.
- There are difficulties in getting full commitment (civil society and key affected population).
- High GF expectations should be tailored, depending on country situation and context.

**Lessons learned:**

- While the consultative process is good for enriching the CN, a clear timeline on consultative meetings and feedback is necessary.
- Consultative dialogue needs to be optimal in target and should be more productive.

*Ensuring an inclusive ongoing country dialogue in CN preparation – experience from a NGO PR - BRAC*

Bangladesh Rural and Advancement Committee is leading a group of 42 local NGO, who are sub-recipients (SR) of the GF grants. BRAC supervises and monitors the performance of the SR and provides technical assistance and guidance. The CN was developed by a proposal committee formed under country coordinating mechanism (CCM). Consultation meetings were held during the proposal development with stakeholders (e.g. government, NGOs and development partners), people/community affected by disease, technical experts, academicians, researchers, the private sector, and the business community. The draft CN was shared with partners as well as a web advertisement (call for public comments). The draft CN was finally
endorsed by the technical sub-committee and CCM for submission to the GF.

The strength of the process for developing the CN includes:

- participation and inclusiveness of stakeholders, early planning, decision-making and leadership role of CCM;
- GF emphasis on a costed national strategic plan;
- strong motivation and government commitment;
- recognition by GF of the country’s past performance;
- proposed higher domestic contribution for the programmes;
- good composition of CN development group;
- technically skilled and highly committed consultants for writing the CN;
- close involvement and continuous support from technical (WHO, USAID etc) and other partners; and
- support and guidance provided by the GF Secretariat through a strong country team.

Key challenges:

- completing all prerequisites within the timeframe;
- prioritizing the activities and fitting them within the allocated budget;
- difficulty in sharing technical content of CN share at all levels;
- intensive and heavier process because of the new modular templates; and
- technical barriers/issues related to web-based application.

Ensuring joint TB–HIV planning for CN preparation – experiences from an NTP perspective (India)

The process for developing the joint CN was initiated by a series of workshops with various stakeholders facilitated by the GF country team.
Subsequent meetings between the Central TB Division and the Department of AIDS Control reviewed priority areas, overlaps and areas for greater collaboration and a strategy was developed for the development of the joint proposal.

The development of the TB proposal was coordinated by the Central TB Division and the HIV proposal was developed in Department of AIDS Control. This was followed by four joint meetings to review areas for stronger collaboration. A team of external consultants facilitated by UNAIDS wrote the final proposal following two consultations.

The RNTCP NSP covers the period 2012–2017 and is aligned to the Twelfth National Five Year plan. The NSP of the National AIDS Control Programme was developed in 2013. Both NSP clearly spell out a strong collaboration between the two programmes. During the course of proposal development additional gaps were identified and were addressed in the NFM proposal.

The main challenges are:

- first-experience-challenges of coordinated planning for the development process;
- intrusive facilitations;
- challenges in alignment of programme priorities/partner priorities/donor priorities caused wasting of precious time and resources;
- lack of experience of external consultants in TB programming imposed challenges in developing the final consolidated proposal;
- failure of template to capture detailed technical components of individual programmes. Inflexible and inaccurate indicators; and
- development of joint proposal wherein both the programmes are in maturity stage and where the TB–HIV component is a miniscule component in each programme.

**Lessons learned:**

- analyse your NSP targets and achievements over last 2–3 years;
Identify critical gaps in programme;
Identify critical financial gaps;
Prepare a roadmap with key stakeholders;
Present to your CCM well in advance; and
Be ready for possible TRP queries.

Ensuring joint TB–HIV planning for CN preparation – experiences from an NTP perspective (Thailand)

Thailand was informed in March 2014 that it should submit a joint TB and HIV CN. The total allocation for TB–HIV was US$ 39 million. The Joint Concept note was submitted on 15 June for the 2015–2016 period, with transition to full domestic funding.

An intensive joint epi-analysis at provincial level was undertaken to identify high-burden HIV, TB and TB–HIV sites. The prioritization process was based on disease burden (based on mapping of new infections, prevalence, absolute numbers of key affected populations and existence of previous interventions), as well as on cost benefit analysis modelling.

Key populations and technical areas for collaboration were identified as: populations for joint action; prisoners, people who inject drugs (PWID), high-risk migrants, PLHIV; key areas for collaboration: community-based service delivery; M&E; guideline and policy development.

While the CN was submitted on time, a number of challenges and lessons learned have been identified:

- Limited time for consultation at sub-national levels on collaboration between HIV and TB – in the context of decentralized systems;
- Unbalanced representation and engagement between TB and HIV CSO;
- Budgeting of joint activities i.e. what should go to HIV budget and what should go to TB;
- Negotiation of disease funding split in the context of joint CN;
lack of consensus on IPT; relevance of IPT in the context of ART irrespective of CD4 questioned;

very time intensive process, with template of CN problematic (CN must read as a stand-alone document as excel spreadsheets for programme gaps and modular template are very difficult to navigate); and bugs in the system.

Prioritization: Issues, challenges and solutions – Sri Lanka

The process of setting priorities was started during the revision of NSP and an identification of gaps/strengths in all key programmatic areas was undertaken. The prioritization within NTP was based on the following criteria:

- disease burden/disease outcomes;
- equity of prioritization between TB/HIV/malaria programmes distribution of curative, preventive and diagnostic services throughout the country;
- key affected populations;
- quality of services; and
- cost-effectiveness.

There was also a prioritization between TB/HIV/malaria programmes based on disease burden, cost-effectiveness, gaps in current functioning capacity of programmes as well as the funding gap.

The key issues and challenges in this process are listed below, as well as the solutions identified during the process:

- Non-availability of actual disease burden of TB in the country – only estimates were available
  
  Solution: Plan to reassess the burden using indirect methods – who requested for technical assistance.

- Financing
  
  Solution: Some activities were budgeted under incentive funding and other budgetary sources.
Inconsistency of opinion on expansion of new diagnostic methods among clinicians

Solutions: Repeated discussions were held with clinicians to get their consensus on new plan of expansion of diagnosis by GeneXpert. The use of GeneXpert methodology in sputum-negative patients, in EPTB, in paediatric TB and suspects of MDR-TB were discussed in detail.

Involving family health workers in community screening.

Solutions: It was agreed during the country dialogue that family health workers will be used in referral of TB suspects and in promoting community awareness in limited capacity

Decentralization of curative and diagnostics services to other health care institutions.

Solutions: Concerns were expressed on anti-TB drug supply, patient registration, monitoring, diagnosis and sustainability of services in a decentralized system. Lengthy discussions were held with different stakeholders on having a successful integration of services and innovative approaches were developed.

Lessons learned:

- balancing of priority needs between allocated funding and cost effectiveness;
- importance of country dialogue and negotiation; and
- need to strengthen counterpart funding.

Prioritization: How do we prioritize activities, without compromising on scale up (in view of limited funding)? – Issues, challenges and solutions - Bangladesh

The prioritization process was started during the revision of the NSP based on the epi-analysis and the joint monitoring mission. The CN development was based on the strategic directives for the NTP described in the revised NSP 2015–2020. Its strategic approach focused on the achievement of universal access to TB control. Central to the plan is the expansion of diagnostic services through the establishment of additional smear-
microscopy centres and the provision of facilities for the diagnosis of smear-negative and extra-pulmonary TB. The plan contained strategies and interventions based on the components of the WHO post-2015 strategy.

**Issues and challenges:**

GF allocated US$ 50 million (including US$ 7 million savings) for 30 months (July 2015–December 2017), while NSP costed budget for 30 months was US$ 105 million.

This led to difficulties to accommodate the activities, even important ones. The challenges were overcome through a variety of approaches and support systems, e.g.:

- excellent and timely guidance and support from the NTP, partners, GF country team and technical partners;
- admirable mentoring from Bangladesh country coordinating mechanism (CCM)
- good cooperation from all partners and stakeholders
- outstanding team spirit in the motivated and committed team from NTP and its partners
- support from technical partners.

To accommodate activities within the given budget, a series of workshops and meetings were organized to prioritize a robust list of activities. Top priority was given for case detection and case-holding, scaling up of diagnostic facilities with special attention to DR-TB, ensuring drugs and diagnostic logistics, continuing social support for poor patients and incentive for DOT providers. There was no compromising with monitoring and supervision.

All the top priority activities were kept under the allocated budget. Second-priority activities were kept below the allocated budget. To manage the other activities, government’s contribution has been increased and resources will be mobilized from other donor agencies. Considering efficiency gains, some HR positions have been reduced.
Lessons learned:

- Frequent and rapid change of ideas always creates some worries in the beginning.
- Good guidance, team work with motivation and commitment are the keys to overcome the challenges.
- To sustain programme performance and achieve the goal, government’s contribution needs to be increased.
- Resources from multiple donors need to be explored.

Prioritization:– Issues, challenges and solutions – Democratic People’s Republic of Korea

The main criteria for the prioritization process was generally to contribute towards achieving the objectives of the NSP. The specific criteria were to: maintain the achievements made so far; reach all TB patients, including M/XDR-TB; and to contribute to HSS including the health information system. A series of country dialogues with partners including CCM members, KAP, academia, people with disease, UN partners and others were organized.

Issues:

- Indicative allocation not matching requirement
  - only 1050 MDR-TB could be covered under NFM
  - estimated cases during the same period: 11700
- Democratic People’s Republic of Korea has the second highest TB burden in SEAR; however, for allocation, TB is clubbed with malaria (low burden) and put in Band 2, affecting allocation.
- PR and SR are UN agencies; thus grant management cost is high (30%).
- HSS interventions were limited due to allocation.
- Incentive funding possibilities were not clear.
Lessons learned:

- Starting the process early gave ample time for wide consultations.
- Inclusive consultations with wide range of partners and key stakeholders at different stages of NSP and CN development helped in reaching national consensus and ownership.
- Strong national leadership kept the process smooth and harmonious.
- GF could explore approaches to decrease transaction cost, considering that it provides 30% of the funding to the country.

Panel discussion – Making a smooth transition from Stop TB to End TB

Based on useful reflections by representatives of technical and financial partners and programme managers on achieving a smooth transition from the Stop TB Strategy to the End TB Strategy and inputs from almost all country programmes, the participants concluded that the End TB Strategy 2016–2035 envisages country-specific adaptation of the strategy and implementation of several new interventions that have not been implemented routinely by national TB programmes so far. Some countries e.g. India have already changed from “control mode” to “elimination mode” based on which targets are re-set through a wide consultative process to be followed by budget calculation.

The End TB Strategy will require close multisectoral collaboration and engagement of diverse stakeholders ranging from relevant ministries to affected communities. To address social determinants, advocacy will be essential not only with the central level, but also with provincial and district levels, particularly in decentralized systems.

Implementing the comprehensive End TB Strategy will be greatly facilitated by elevating the leadership of national TB programmes and widening in-country ownership of TB care, control and prevention. TB elimination should be everybody’s business. Strong advocacy is required to reach outside the TB community including developing specific strategies for private sector involvement.
In preparation for the adaptation and roll-out of the End TB Strategy, countries need to prepare advocacy product(s) such as, for example, information brochures to help present the new strategy to diverse stakeholders and facilitate their engagement. New interventions envisaged in the End TB Strategy that are applicable to their settings need to be identified, for example, systematic screening of contacts and high-risk groups; preventive treatment for latent TB infection; the status of UHC and social protection schemes and how services for TB care and prevention are addressed within; any existing regulatory framework for TB control for mandatory TB case notification, and rational use of TB drugs. In addition to baseline epidemiological assessments, countries also need to undertake assessments to understand the baseline situation, design interventions and measure progress with regard to the new areas and interventions expected in the End TB Strategy.

To ensure and facilitate broad “buy in” to the End TB strategy at all levels and sectors, countries need to explore and set up, or strengthen existing appropriate national high-level mechanisms to ensure and sustain high-level political commitment, advise NTP to adapt, launch and implement the End TB Strategy and oversee its implementation.

The global strategy and targets for TB prevention, care and control after 2015 – issues and challenges in funding - WHO

In planning for the implementation of the End TB Strategy it is imperative to analyse and address the specificity of each context and avoid a "one size fits all" approach. The role of in-country dialogue (beyond the NTP boundaries), especially on the approach to Pillar 2 implementation is essential as well as the importance of inter-country dialogue. Each country will learn by doing, but all can benefit from each other's experience. The planning and implementation should be informed by the four cross-cutting principles as outlined in the End TB Strategy (see Figure 7 above). Based on the four cross-cutting principles, the dialogue should lead to a description of how each element of Pillars 1, 2 and 3 will be operationalized in a specific national context as well as the identification of cost implications of each aspect of the operationalization.
How can the NTP interact with this complex landscape? All stakeholders need to be engaged in an ongoing dialogue on situation analysis, identification of options fitting the country context, advocacy for social sector reform (if need be), planning and implementation of change and corrective actions. Complementary perspectives add on realism and feasibility.

A tool that proved adequate in several countries is the creation of a coalition of all stakeholders engaged in all stages of NSP development and implementation as well as in initiatives to create a momentum for reform of the social sector along a continuum of steps towards UHC. NTP may have to work as a pathfinder (in some countries) in the interest of all: UHC and social protection can have an impact on TB detection and TB mortality only if applied to a range of essential health services, beyond the domain of TB care (no patient has a "TB label" when entering the health facility with generic symptoms).

The goal of ensuring that all people have access to the services they need without the risk of financial ruin has been called universal coverage -
sometimes universal health coverage (UHC) or social health protection. Countries will have to take steps to modify their health financing systems with the goal of moving closer to UHC. Health financing includes a number of inter-related functions:

- raising financial resources;
- spreading the financial risks of illness through prepayment and pooling (which also reduces financial barriers to access); and
- obtaining more value for money by reducing inefficiency and inequity in resource use.

What can countries do to move towards UHC? In general, countries will have to go through the following processes (though detailed work will differ in each context):

1. review where they are in terms of UHC and how their health financing systems currently function;
2. develop or revise their policies and strategies for the health financing system as appropriate, ideally as a multistakeholder process involving all key players - all ministries involved in the provision or financing of health services (including the ministries of finance), sub-national governments, civil society, the private sector etc.
3. implement policies and strategies; and
4. monitor and evaluate progress and revise policies and strategies as necessary.

In conclusion, funding the End TB Strategy will pose new challenges (beyond the issue of securing financial resources). Each country context will require a highly tailored approach. It is important to acknowledge that UHC is a journey as well as a destination. To start the journey, it is essential to have a clear vision about gaps and priorities in TB care and prevention and inherent interventions. NTP need to be familiar with the key issues/concepts of UHC. It is equally important to identify all stakeholders

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4 As defined in the resolution WHA 58.33 of 2005 and the subsequent 2010 WHR
and to develop or strengthen existing long-lasting mechanisms for multisectoral collaboration. It takes time to build engagement. A comprehensive situation analysis with the identification of options to move towards UHC must be undertaken. These steps are preliminary to contributing to possible change in policies and strategies across the social sector.

The Global strategy and targets for TB prevention, care and control after 2015 – issues and challenges in funding - GF

GF is currently providing around 75% of all international financial resources for TB prevention, care and control while the remaining 25% comes from other international partners. In the period 2002–2013, grants for a total of US$ 4.8 billion were signed and US$ 3.8 billion was disbursed to 109 country programmes, and one multi-country programme (Figure 11). The trends in disbursements are shown in Figure 12.

Figure 11: Global Fund TB grants - coverage by country
The key short- and medium-term funding challenges relate to the following:

(1) The reported funding gap of about US$ 2 billion per year (WHO 2014).

(2) The above allocation requests versus the incentive funding available. A total of US$ 716 million in above-allocation request versus the total incentive funding available of US$ 157.4 million.

(3) The need for successful replenishment. It is essential to:
   - invest for impact in the current replenishment 2014–2016
   - make smarter and better investment
   - strengthen advocacy for more resources
   - increase domestic resources
   - engage more partners to support TB
   - review and assess the global health and development landscape-post 2015.

(4) The split of financial resources between diseases. In the 2002 to 2013 period a total of US$ 4.8 billion were signed for TB while US$ 8.3 billion were signed for malaria and US$ 16.5 billion were signed for HIV-AIDS.
4.6 Implementation of grants

From grant agreement to implementation – challenges and solutions - Myanmar

Myanmar was one of the “early bird” applicants to NFM. The country was invited to apply to NFM in February 2013. A new CN was submitted in April 2013 covering the period 2013–2016, and feedback was received in May 2013. Grants were approved and signed in June 2013. For TB, US$ 82 million was approved and committed out of the US$ 106 million that were requested.

There were many challenges in the process; the list below illustrates key challenges and proposed solutions.

- Negotiation time was very short with short turn-around times between local funding agencies and start of grant negotiation.  
  Solution: Anticipation with strict timelines.
- Very late information about approval of additional funds.  
  Solution:
  - PR should proceed with development of budgets and plans, assuming that the additional funds would be approved.
  - Risk of missing deadlines for not having a Plan B.
- Some important components of grant-making are kept as parked, which are then decided unilaterally by GF in Geneva.
- Negotiation sometimes revolves around micro-budgets.  
  Solution: GF could publish such unit prices (or price ranges) in a catalogue and make available to all PR.
- Sometimes decisions are very generic and PR are asked to cut across budgets by certain percentages.  
  Solution: Negotiation should take care to allow fine-tuning of complex budgets instead of linear measures.
New NFM template is difficult to fill in, not user-friendly.

Solution: Request for clarification from GF country team must be made after careful study

PR provided with new M&E indicator definitions AFTER PF was submitted. New financial templates were provided after the budgets were developed by SR.
- Such changes pose additional challenges.
- They were overcome, but at the expense of rather inefficient work.

Limited time that GF country team could spend with each PR (two days).

Solution:
- Additional days would be ideal.
- One day for PF/M&E review was sufficient.

Key lessons learned from an early bird applicant include the bullet points below, illustrating key components and principles that have become key components of the NFM process.

Successful grant negotiation depends on ongoing dialogue with all stakeholders in the country.
- agreement on strategy and activities; and
- identification of implementing partners.

Ongoing dialogue with GF country team
- flexibility for changing rules.

Proper guidance and oversight by CCM through the Executive Working Group
- realistic timelines and strict adherence to deadlines; and
- inputs from CCM members.

Involvement of technical support group on TB
- regular/periodic feedback to technical support group on TB during process; and
- inputs from technical support group on TB incorporated.
From grant agreement to implementation – challenges and solutions - Indonesia

Indonesia currently is in Phase 2 of a SSF grant. The time frame leading up to grant negotiations is illustrated in Table 4 below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Invitation from TGF to CCM Indonesia</td>
<td>5-December 2012</td>
</tr>
<tr>
<td>2 PR self-risk assessment</td>
<td>December 2012</td>
</tr>
<tr>
<td>3 Developing proposal SSF Phase 2</td>
<td>6 December 2012 - 24 Mar 2013</td>
</tr>
<tr>
<td>5 Grant renewal CN preparation process (suggested include series of conference call with TGF)</td>
<td>January- March 2013</td>
</tr>
<tr>
<td>6 Partnership/stakeholder meeting</td>
<td>7 February 2013</td>
</tr>
<tr>
<td>7 Deadline for CCM submitting grant renewal</td>
<td>31 March 2013</td>
</tr>
<tr>
<td>8 Deadline for LFA to send the review report</td>
<td>30 April 2013</td>
</tr>
<tr>
<td>9 TGF review panel through Phase 2</td>
<td>June 2013</td>
</tr>
<tr>
<td>10 TGF Board decision</td>
<td>July 2013</td>
</tr>
<tr>
<td>11 Grant negotiations</td>
<td>July – September 2013</td>
</tr>
</tbody>
</table>

The bullet points below list key issues and challenges and illustrate how some of these challenges were addressed.

Key issues and challenges:

- limited time-frame for proposal development and grant-making;
- limitation of the financial management system;
- limitation of the procurement and logistics management system;
- complexity in the bureaucracy system; and
- low achievement on key indicators.
Solutions:

➢ negotiating with GF and explaining the matter to grants approval committee;

➢ deciding whether SR can continue or postpone involvement in the project until they are ready;

➢ utilizing TA to improve the financial, procurement and logistic system;

➢ implementing new strategy to achieve the target; and

➢ ensuring support from all technical partners.

Lessons learned:

➢ preparation of the requested mandatory documents could be started earlier than was the case (e.g. budget, PSM Plan);

➢ improvement of communication with SR to avoid SR either dropping out or getting late with project implementation; and

➢ better planning of the programme could increase the absorption rate and achievement of targets/indicators.

Experiences from technical partners’ support to the GF grants implementation - Partners

KNCV/ TB CARE I Indonesia

TBCARE I in Indonesia is providing support in eight technical areas: universal access, laboratory, infection control PMDT, TB–HIV, HSS, drug management, monitoring and evaluation, operational research and surveillance.

Technical support for planning consists of e.g. support to the development of NSP, action plans for all technical areas, development of GF proposals (R5, R8 and R10) including performance frameworks and monitoring and evaluation plans. It also consists of assistance in re-programmemeing of grants and as well as support to the TB-Technical Working Group (as part of CCM).
Support for implementation of strategic plans /GF grants consists of technical and managerial support to the PR, e.g.:

- capacity-building: training and coaching of key NTP staff, focal points and SRs at central and provincial levels;
- initiation of innovative approaches (e.g. HDL, initiation of PMDT, PCA, implementation of Xpert and TBCARE tools etc.)
- updating and developing guidelines and SOP (e.g. for all new initiatives and interventions);
- monitoring and evaluation of grant implementation (based on PFW and “dashboard”);
- translating “lessons learnt and best practices” in strategies and guidelines;
- reporting ;
- technical trouble-shooting and addressing bottlenecks in implementation;
- assisting PR in addressing managerial risks
  - relating to oversight (through TB-TWG of CCM),
  - relating to financial management
  - relating to logistic management including procurement
  - managerial trouble-shooting and tackling bottlenecks e.g GF management letters.

TA remains crucial to address bottlenecks and achieve the targets. TBCARE and GF support are strongly linked and both have been essential for the achievements of the NTP. Close coordination and collaboration between NTP and partners has resulted in achieving better outcomes and creating mutual trust.

**Aisyiyah community TB-Care in Indonesia**

Aisyiyah is a moslem women’s organization established in 1917. The organization initially focused on religious meetings for women and schools for girls. Today, the organization is present in all 33 provinces and is
operating 13 266 kindergartens, 218 MCH clinics, 62 midwifery schools and is involved in EPI, MCH, family planning, malaria and TB programmes. In the 12 main provinces where 67% of Indonesians live, Aisyiyah covers 94% of the areas with 8800 community groups and programmes including health.

Aisyiyah’s involvement with GF started in 2002; the organization became a SR in 2005 and since 2009, it is the PR for civil society organization doing “community TB-care” programme in 48 districts in the 12 main provinces. The work is focused on complementary/supportive community actions through the following activities:

- advocacy for TB in 48 districts (also at national level);
- media campaigns and public education on TB;
- active case-finding-holding for standard TB cases;
- TB-MDR → social care, transit house, transport etc;
- ensuring successful HIV test 4 for all new TB cases (TB–HIV);
- active case-holding to lower hospital DOs (HQ-DOTS); and
- bi-monthly planning/coordination at all levels to reduce potential duplication.

The organization has been successful in its work under the GF grant as illustrated by the GF ratings: one B1, two A2 and seven A1. Many lessons have been learned in the process.

Civil society organizations must:

- focus on non-health issues at community level and at point-of-contacts with health facilities e.g. education, communication, case-finding-holding to ensure treatment compliance;
- utilize social capital more to support patients non-health needs e.g. local fund raising, especially from non-health sources;
- strengthen advocacy to policy/decision-makers and groups beyond civil society e.g. business, politics and non-health government units and departments until they give concrete support; and
establish and nurture local TB support groups to develop a support network for burden-sharing within the locality, then expand the burden-sharing to government units and other areas.

Division of TB Elimination, Centers for Disease Control and Prevention (CDC), Atlanta, USA

CDC is providing TS to NTP in the areas of:

- CN development and review
- baseline assessments and epidemiologic surveys
- capacity-building for laboratory and programme
- operational research
- M&E and impact measurements
- development of policies, NSP-TB, NSP-lab.

The work is coordinated through NTP, CCM and the technical working group while in some countries, in-country staff work closely with NTP. Main issues and challenges include the following:

- It is essential for the technical partner to be involved early in the process of developing the CN, as well as being given sufficient time for review and comment.
- There is a lack of CDC staff in-country to provide assistance.
- With regard to coordination of efforts with partners and with HIV programmes, laboratory issues are not always considered in CN. Laboratory partners must be engaged, and it is strongly recommended to consult with SRL.

From this work, the following important lessons can be drawn:

- early engagement in CN process
- in-country staff
- close coordination and excellent communication between all partners
- robust M&E and impact measurements.
KNCV, Tuberculosis Foundation, the Netherlands

KNCV works at the global level on policy development and at country level to strengthen the local health systems through efficient and effective TB control programmes. In 2013, KNCV’s core countries were: Botswana, Ethiopia, Ghana, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Mozambique, Namibia, Netherlands, Nigeria, Pakistan, Rwanda, South Sudan, Tajikistan, Viet Nam, Zambia and Zimbabwe.

KNCV works through coordination and collaboration at international level, e.g. participation in Stop TB Partnership “Situation Room” discussions, TB TEAM for GF-related TA and coordination with donors and TBCARE / Challenge TB partners; and at national level, e.g. country presence and specialized missions working through governments in joint annual work planning, aligned with national priorities, long-term commitment to countries, and in-depth knowledge of country priorities and stakeholders, as well as responding to ad hoc requests.

The key areas of support provided by KNCV are:

- epidemiological assessments and analyses
- surveillance systems (E&M health)
- National programme reviews
- NSP
- CN development
- budget support
- implementation assistance in:
  - the basics
  - advanced packages
  - what is really new
  - evidence generation
  - scale up design.

Key challenges in the work include the difficulty in responding to ad hoc ‘request for the best’; managing requests when countries make
requests to multiple partners; ensuring the “best fit” between the country and the consultant; ensuring clear and precise terms of reference; matching requests with approved workplans; ensuring the balance between consultants specialized in one area and generalists; and ensuring smooth coordination with freelance consultants. The main challenge, however, is sustainability.

Key lessons learned include:

- share country experiences: implementing activities for TB prevention, care and control today is not business as usual;
- develop a prioritized TA plan and when requests are made ensure a consultant match - and not only technical; and
- anticipate delays and have a plan for follow-up: discuss engagement of stakeholders with NTP.

**Research Institute of TB (RIT), Tokyo, Japan**

The Research Institute of TB is a WHO Collaborating Centre for TB Research and Training. The international activities of RIT model system development in field projects, manpower development through international training courses and research contributing to new knowledge and technology.

RIT is organizing three types of training:

1. TB control course: targets TB programme managers at national and intermediate levels in resource-limited countries (with JICA and WHO) three months
2. TB laboratory course: targets TB laboratory managers at national level (with JICA and WHO) 2.5 months
3. Others: Individual and group training upon request.

A total of 636 participants from nine countries in South-East Asia Region have attended courses at RIT.

The field work includes technical support to prevalence surveys in Bangladesh, Cambodia, Democratic People's Republic of Korea, Indonesia Mongolia, Myanmar, Nepal, Thailand.
TA has also included:

- TA to NTP: Cambodia and Myanmar (JICA)
- Lab. EQA system development in Indonesia (JICA, TBCARE), Myanmar (JICA)
- Strengthening case-finding by PPM including referral system from pharmacy and community volunteer, and active case-finding by mobile teams in Myanmar (JICA)
- Programme reviews: Bangladesh, Cambodia, Indonesia, Nepal, Philippines, Thailand
- Technical support and research in urban TB in Dhaka, Lusaka and Manila
- Mobile seminars in Ethiopia, Kenya, Bangladesh (EQA) and Nepal (EQA, culture and chest X-ray interpretation)
- Research Unit: Chiang Rai, Thailand (TB–HIV), Kathmandu, Nepal (urban), Manila, Philippines (urban).

**Urban TB programme, Bangladesh**

The Urban Primary Health Care Services Delivery Project is an initiative of Government of Bangladesh under the Local Government Division with financial support from the Asian Development Bank, Swedish International Development Cooperation Agency and the United Nations Population Fund. The project delivers primary health-care services to the urban poor in partnership with urban local bodies and nongovernmental organizations. The project started in 1998 through the Urban Primary Health Care Project (1998–2005) and the Second Urban Primary Health Care Project (2005–2011). The project has been a successful innovative model and one of the largest public-private partnership interventions for urban PHC services in the South-East Asia Region. At present, the project covers more than 10 million urban population and has a PHC network of 25 comprehensive reproductive health care centres, 112 primary health care centres and 224 satellite clinics at community level.

UPHCSDP is one of the implementing partners of the GF grant in the NGO PR consortium and is collaborating in the following areas:
Tuberculosis control

- HSS and capacity-building;
- local training, strengthening laboratory services, civil society and professional association involvement;
- diagnosis, treatment and follow-up:
  - engaging community health workers and village doctors; and
  - expansion of peripheral labs and conducting outreach centre activities
- drug supply:
  - transportation, local storage, supply to the user
- external quality assessment:
  - training, infrastructure, implementation
- monitoring and supervision:
  - local monitoring/supervision reporting, annual data validation, audit.

Key challenges include the need for strong political commitment, translating policy change into implementation, resource mobilization, ensuring skilled human resource at the right place, coordination and information sharing.

Lessons learned to date include the need for a patient-centered approach for DOT and the need to strengthen the involvement of professionals. Special strategies are needed to provide TB control services to populations living in slum areas as well as to “floating populations”. Partnership creates and facilitates the process of synergy to fulfil the ultimate programme goal as well as helping to ensure efficient use of limited resources to avoid overlapping.

**USAID Bangladesh**

USAID supports Bangladesh’s national strategic plan for TB through multiple implementing mechanisms. The programmes are designed together with NTP in collaboration with other partners working in the field of TB to complement activities supported by other donors including the Global Fund. The programmes are managed by USAID/Bangladesh mission
with programmatic and technical support from USAID/Washington and in some cases CDC/Atlanta. Project staff and mission staff stay actively engaged in all areas within NTP to ensure USAID-supported programmes are complementary and not duplicative.

The current support mechanisms are:

(1) TB Care II implemented by URC (cPMDT, GeneXpert expansion, FAST, childhood TB, TB reference laboratory support and renovations;

(2) CDC TB-related research, ongoing MDR/XDR facility-based surveillance, EPTB, EQA for GeneXpert;

(3) National TB prevalence survey (WHO) SIAPS (MSH) eTB Manager, drug supply management;

(4) NGO health service delivery (Smiling Sun clinics) integrating TB screening and DOTS into MCH clinics; and

(5) TA MDR-TB adviser.

Beginning in January 2015, the support mechanism will transition TB Care II activities to Challenge TB. New activities such as support for nine month regimen operational research may be included. The transition is currently in the planning stage and activities will be designed in close collaboration with GF PR to ensure critical gaps are “filled”.

Issues and challenges include the following:

General:

- wide range of activities - numerous technical working groups
- transition of projects
- synchronizing work in the field with other partners
- existing public health infrastructure often in poor state (i.e. CDC and CDHs, HR)
- funding gap in national programme.
Specific programmatic challenges:

- childhood TB diagnosis
- IPT for children
- eTB Manager roll-out
- moving nine month MDR regimen forward
- PPM.

Lessons learned include:

- partners supporting NTP very effective at rolling-out and scaling up new programmes.
- strong working relationship with NTP needed with active involvement in national planning to ensure best use of limited resources; and
- coordination critical given the range of activities within the portfolio.

TB response in Bangladesh is still highly donor dependent. Ultimately, sustainability will be assured as the Government of Bangladesh begins to take on more domestic financing of critical TB activities.

5. Conclusions and recommendations

Conclusions:

(1) Progress continues to be made in the SEAR towards the MDG and Stop TB partnership goals and targets of reducing the prevalence and death rates compared with their levels in 1990. While the Region is home to 26% of the world’s population, it continues to carry a major share of the global TB burden with 38% of the global prevalent TB patients resulting in an estimated 4.5 million prevalent cases and 440,000 deaths in 2013.

(2) In 2013, Member States in the Region notified a total of 2.1 million cases of TB. While this represents an increase over cases
notified in 2012, an estimated 1.3 million TB cases are still not notified. These figures clearly illustrate that universal access to quality assured diagnosis and treatment for all persons with TB has not yet been achieved.

(3) In 2013, 43% of TB patients in the Region had a known HIV status and 59,462 (6.1%) were HIV-positive. Of these, 88% were on cotrimoxazole preventive therapy and 81% on ART. This represents an increase from 2012 when 56,093 HIV-positive TB cases were notified.

(4) Despite the proportions of MDR−TB amongst notified cases being lower in the Region than global averages, due to the large populations of the Member States in the Region, almost 30% of the global burden of MDR−TB exists in the Region (an estimated 89,000 out of the global 300,000 cases, with 62,000 cases of the cases in the Region reported from India alone). XDR-TB has also now been reported from five of the 11 Member States in the Region. However, much progress has been made in 2013, with 40,335 RR-TB and MDR-TB cases being detected although by the end of 2013

(5) Only 23,766 (59%) cases were enrolled on treatment, highlighting the widening gap between detection and enrolment on treatment observed both at the regional and at many national levels. Treatment success for RR-/MDR-TB cases started on second-line treatment in 2011 was only 54%, which together with the wide gap between patients diagnosed and patients put on treatment raises major concerns regarding the quality of care.

(6) Despite the impressive progress made by a number of Member States in scaling up PMDT services, there is an urgent need for significant further expansion in the scale and scope of the TB control activities to fully implement resolution WHA62.15 on “Prevention and control of multidrug-resistant TB and extensively drug-resistant TB” by the end of 2015. Even if most TB patients in the Region are not drug-resistant, the burden of MDR-TB in the Region poses a formidable challenge to the prospect of controlling TB. More resources are needed to ensure that targets are reached. Successful TB control activities need support from all partners and stakeholders in both the short-and long-term.
(7) The Sixty-seventh World Health Assembly in May 2014 adopted a resolution on “Global strategy and targets for TB prevention, care and control after 2015”. The post-2015 global TB strategy, now labelled as “End TB Strategy” sets very ambitious post-2015 global targets. The short-term target in the context of national strategic plans emphasizes the need to base targets on directly measurable indicators to ensure that performance rating is grounded on solid evidence.

(8) The End TB Strategy 2016–2035 envisages country-specific adaptation of the strategy and implementation of several new interventions that have not been implemented routinely by national TB programmes so far. It will require close multisectoral collaboration and engagement of diverse stakeholders ranging from relevant ministries to affected communities. The implementation of the comprehensive End TB Strategy will be greatly facilitated by elevating the leadership of national TB programmes, widening in-country ownership of TB care, control and prevention and ensuring that NSP are updated with budgets to redefine funding gaps and mobilize resources.

(9) Accurate estimates of the size of the TB burden remains a challenge in countries that have not conducted prevalence surveys. However, major progress in strengthening TB surveillance in the Region has been made in recent years. Indonesia and Myanmar conducted nationwide disease prevalence surveys that allowed a vastly improved understanding of programme performance gaps, with direct implications for policy changes. India is rolling-out a case-based recording and reporting system and recently updated a legal framework making TB reporting mandatory. Thailand is taking steps to improve the efficiency of TB reporting in a context where universal access to health care has been achieved. Other countries in the Region are taking steps to further improve case reporting. TB case notification is recognized to suffer from a significant problem of under-reporting from the private sector in several countries including India and Indonesia. While country reporting of surveillance and monitoring data continues to improve, efforts are needed to take better advantage of available information and communication technologies to collect data efficiently and enable timely action.
(10) Major progress has been made in 2014 in the Region in strategic planning and resource mobilization. In 2014, Bangladesh, Bhutan, Democratic People’s Republic of Korea and Sri Lanka have conducted comprehensive joint monitoring missions. Several countries have already developed multiyear strategic plans, with various levels of consideration of the End TB strategy.

(11) Based on them, they have submitted or are in the process of submitting CN to the GF as well as to other financial partners in the Region, e.g USAID.

Recommendations:

Recommendations for Member States:

Universal access to quality assured diagnosis and treatment for all persons with TB

In light of the gap between estimated and notified cases of TB in the Region, the long-term character of the recommendations made during the 2013 meeting to contribute to ensuring universal access to quality-assured diagnosis and treatment for all persons with TB, remain valid e.g.:

(1) continue to address the considerable gap between estimated and notified TB cases:

- Further intensify efforts to strengthen the capacity of the public health system to provide high quality services for early and increased case detection, including but not limited to: revision of the definition of symptomatic TB; broadening screening indications based on additional symptoms; and using risk factors profile: e.g. contacts of a person diagnosed with TB, especially children under five, HIV-infected persons, poor people, slum-dwellers, homeless, alcoholics, smokers, diabetics, elderly, infants, previously treated patients, prisoners, migrant workers and malnourished children;

- revise diagnostic algorithms to enhance their sensitivity with introduction of newer diagnostics;
- strengthen and improve community involvement, awareness and early care-seeking behaviour and the empowerment of patients and key affected populations; and
- further scale up PPM approaches, including adopting new approaches, and engage all care providers.

(2) continue to develop capacity at all levels to analyse and use locally available data to strengthen programme management at different levels;

(3) strengthen the level of collaboration for planning, guidance, oversight and implementation of TB–HIV collaborative activities through the establishment/strengthening of TB–HIV coordinating/technical committees/working groups and relevant mechanisms for implementation at all levels;

(4) continue efforts to scale up and strengthen community and civil society engagement in TB control and develop mechanisms to reflect their contribution;

(5) develop/update and implement operational plans for airborne infection control in all health facilities;

(6) Reinforce and accelerate efforts to develop/strengthen clear linkages in strategic plans for TB control with health policies, health system strengthening strategies and plans to ensure:
  - access to health-care services for poor and vulnerable populations;
  - strategic allocation of resources for supporting priority health programmes including TB control services in a sustainable manner;
  - availability of sufficient, competent health workers at all levels of the health system including programme planning, implementation, monitoring and evaluation;
  - establishment of sufficient number of diagnostic facilities and storage space for drugs and supplies of necessary quality assured drugs and consumables to ensure UHC;
- integration and upgrading of TB information systems in the general health management information systems and use data to identify strategic issues;
- governance (leadership, policy, planning and organizational support);
- full integration of TB control activities into all health system strengthening efforts; and
- inclusion of research on implementation and health systems.

Scale up PMDT

(1) ensure a re-invigorated high-level political commitment to accelerate the prevention and combating of M/XDR-TB as agreed upon by Members States in line with resolution WHA62.15;

(2) to ensure that up-to-date national drug resistance surveillance data is available – at least those countries with a significant DR–TB problem; however, data on drug resistance should rapidly become available via routine surveillance activities amongst the diagnosed cases;

(3) With only one year left before the end of 2015, efforts to achieve universal access to diagnosis and treatment of M/XDR-TB as laid out under the Resolution WHA62.15 need to be accelerated, in particular:

- as a first priority, prevent the development of drug resistance by ensuring the early and increased case-detection of all drug susceptible TB cases followed by high quality treatment and care to cure;

- ensure that a complete comprehensive planning exercise is conducted prior to scale up of PMDT services in order that the diagnostic and management capacities, including the availability of adequate and trained human resource capacity, are aligned during any scale up of services. Field assessments should be conducted against pre-defined criteria to assess readiness of services prior to actual implementation of services;
Tuberculosis control

- scale up rapid testing and detection of all MDR-TB cases by strengthening and expanding laboratory networks, including referral or sputum transportation systems, introduction of new rapid molecular diagnostic tools and utilizing revised diagnostic algorithms, and implementing quality assurance systems;

- ensure introduction of an electronic comprehensive and integrated information system, which links diagnostic, clinical and programmatic services for PMDT;

- strengthen collaboration and coordination between the different components of the public health services, and between public and private health-care providers;

- continue to ensure the uninterrupted availability of sufficient amounts of FLD and SLD free of charge to patients;

- strictly promote and enforce the rational use of anti-TB drugs, and strengthen pharmacovigilance in both the public and private sectors, especially as new drugs are now available;

- ensure that a patient-centred care approach is at the core of all treatment of cases, including community-based interventions to address DR-TB care and prevention; and

- ensure that the appropriate infection control measures are in place and implemented at the different levels in order to prevent further transmission of MDR-TB.

(4) actively encourage implementation of research promoting new interventions in diagnostics and treatment such as shorter drug regimens for the treatment of MDR−TB and where appropriate the introduction of bedaquiline and/or delamanid; and

(5) underpin and sustain the MDR-TB response through high-level political commitment, strong leadership across multiple governmental sectors, ever-broadening partnerships including the community and civil society, and financing for care and research.
TB surveillance, monitoring and targeting

(1) strengthen investments to improve the measurement of TB burden and to monitor the implementation of the End TB Strategy:

- ensure that TB case-notification systems operate within a legal framework making reporting of cases mandatory by all health providers, including appropriate law enforcement mechanisms to avoid under-reporting;

- regularly assess the performance of TB surveillance based on the WHO standards and benchmarks;

- implement appropriate surveys to quantify under-reporting of the magnitude of TB prevalence, so as to address performance gaps;

- implement an online case-based reporting (that is now the standard of modern TB surveillance), allowing rapid identification of at-risk populations so as to tailor a more effective response. Countries using paper-based TB surveillance are encouraged to take steps towards the transition to electronic case-based reporting along recent guidelines for electronic TB surveillance available from WHO.

- ensure improved clarity and guidance on criteria for the selection of indicators to set targets.

(2) while improving the surveillance systems towards a capacity to measure impact of interventions in terms of prevalence, incidence and mortality, continue to continue collecting and utilizing the traditional data and indicators being aware of their limitations;

(3) ensure results from recent prevalence surveys (e.g. Indonesia and Thailand) are disseminated and used for action; including the necessary policy changes to improve detection and surveillance and effective engagement with the private sector and consider a nationwide prevalence survey in India to allow more precise quantification of programme performance gaps and accurate updating of estimates of the burden of disease;
(4) monitor data on causes of death through national vital registration systems or sample vital registration systems as an interim measure; this is an essential source of information to assist in public health prioritization of resources and to TB programmes in particular. (TB mortality measured from VR systems are an invaluable source of data on time trends in TB burden and on gaps in the performance of care programmes in sub-populations where mortality is higher relative to case notifications.)

(5) consider the opportunity to request funding support from the GF and other donor agencies to accelerate implementation of vital registration systems; and

(6) continue dialogue with the GF on the inclusion and use of impact indicators within the CN, addressing in particular the challenge of measuring impact indicators for interventions implemented within the limited timeframe of three years.

**National strategic plans and the GF NFM**

(1) Following new guidance that will be provided to implement the End TB strategy, countries should tailor their own current or future NSP to adopt the relevant elements of the strategy.

(2) ensure early preparations for the transition to the new End TB strategy including:

- high-level advocacy and preparation of advocacy product(s) such as, for example, information brochures to help present the new strategy to diverse stakeholders and facilitate their engagement;

- identify new interventions envisaged in the End TB Strategy that are applicable to their settings such as, systematic screening of contacts and high-risk groups; preventive treatment for latent TB infection; the status of UHC and social protection schemes and how services for TB care and prevention are addressed within; any existing regulatory framework for TB control for mandatory TB case notification and rational use of TB drugs etc.;
- undertake assessments to understand the baseline situation, design interventions and measure progress with regard to the new areas and interventions expected in the End TB Strategy;

- set up/strengthen the existing national high-level mechanism to guide the implementation of the End TB Strategy to ensure and sustain high-level political commitment, advise the NTP to adapt, launch and implement the End TB Strategy and oversee its implementation; and

- short-term targeting in the context of national strategic plans and GF CN, emphasizing the need to base targets on directly measurable indicators to ensure that performance rating is grounded on solid evidence.

(3) ensure experience gained in the management of the ongoing country dialogue for the preparation of CN for the GF NFM are used for advocacy and coordination in preparation for a phased transition to the new End TB Strategy.

**Recommendations for WHO, technical and financial partners and civil society**

(1) continue high-level advocacy to ensure Member States sustain and increase their commitment and actions to meet the targets set out under resolution WHA62.15 and the End TB Strategy and targets for TB care and control;

(2) provide technical support to Member States to develop and set up plans and mechanisms for the transition from the Stop TB Strategy to the End TB Strategy;

(3) provide the appropriate technical support to Member States to develop and implement updated comprehensive national strategic plans by which universal access to diagnosis and treatment of TB including M/XDR-TB in the public and private sectors can be ensured;

(4) advocate for and provide need-based assistance for resource mobilization for Member States in the Region;
(5) advocate that funding decisions of external funding agencies are based on a comprehensive analysis of the burden of the disease, including M/XDR-TB, is need-based and realistic and allows for appropriate re-programming for combating all forms of TB;

(6) strengthen technical support and provide further guidance to implement epidemiological reviews, assessments of TB surveillance, including through the implementation of inventory studies and prevalence surveys;

(7) provide technical support to Member States for the development and implementation of DRS surveys, analyses and dissemination of results, and to the gradual introduction of routine surveillance amongst the diagnosed TB patients;

(8) provide appropriate TS to Member States to scale up and strengthen community and civil society engagement to develop and implement NSP for TB prevention, care and control;

(9) provide the required specific TS on all aspects related to PMDT to Member States for the development and implementation plans to support scaling up of PMDT and care and control services, and continue the coordination and provision of the required TA via the rGLC Secretariat and regional TBTEAM mechanism;

(10) provide support to Member States and organizations to conduct relevant operational / health system research, including piloting of the shorter treatment regimen for MDR-TB patients and introduction of new drugs such as bedaquiline and/or delamanid, under the appropriate conditions, including active pharmacovigilance; and

(11) ensure timely supply of quality assured SLD by GDF and other partners.
Annex 1

Address by Dr Poonam Khetrapal Singh, WHO Regional Director, for South-East Asia

“This meeting is important, as WHO South-East Asia Region alone accounts for almost 38% of the global burden of TB. The Region has a pool of 4.5 million TB cases, to which 3.4 million cases are added each year with almost half a million people dying annually due to TB. It is also estimated that nearly 89,000 cases of multidrug-resistant TB are occurring in our Region annually.

However, I would like to commend our TB programme managers and partners in the South-East Asia Region for their tremendous efforts in sustaining countrywide access to DOTS services and achieving more than 88% of treatment success rate among new smear-positive pulmonary TB cases since 2009. There is a decline in the prevalence rate of TB in all Member States and the Region, as a whole, is on track to achieve the global target of 50% reduction of TB mortality by 2015. Some countries, in fact, have achieved over 50% reduction compared to 1990 levels.

The national TB control programmes, in collaboration with technical partners, are making good progress in scaling up management of drug resistant TB; it is urgent to address the problem of MDR-TB. In 2012, the Regional Advisory Committee on MDR-TB was formed to provide strategic and policy guidance on addressing the problem of drug-resistant TB in the countries of the Region. This Committee is providing technical support to the countries through organization of regular meetings and country monitoring missions.

National TB and AIDS control programme managers in most countries are well aware of the urgent need to address the dual epidemic of TB–HIV co-infection and are jointly implementing a comprehensive package of interventions against TB-HIV co-infection.

While attempting to address all of these issues in the TB control programme, we must also understand the constraints and challenges in TB control in the Region. In many countries, the health systems infrastructure is
weak, under-financed, and, therefore, overstretched. These constraints must be addressed if we are to ensure universal access to critical interventions in TB control. Primary health care infrastructure and quality of primary health care need improvement, including intensified community actions if we are to reach the hard-to-reach.

In recognition of TB as a disease of poverty, effective TB control has to go far beyond DOTS to encompass, among other things, nutrition and environmental factors.

Along with medical interventions, related social and economic issues have to be simultaneously tackled. These non-medical aspects of TB control are important indeed in the prevention and control of TB for achieving long-term results.

While highlighting the global and regional problem of TB, including drug-resistant TB and TB–HIV co-infection, I would like to see that we renew our commitment to intensify TB control efforts in both the public and private sectors during this meeting. Successful TB control activities indeed need support from all partners and stakeholders in both the short and long terms. Effective interventions against TB can be achieved only through universal access to effective prevention, early diagnosis, and prompt treatment of all forms of TB including drug-resistant TB.

WHO has now released a new global TB control strategy through WHA67.1 endorsed by the Sixty-seventh World Health Assembly in May 2014. The new strategy aims to achieve elimination of TB by 2035. This is an ambitious target, but with strong commitment, concerted efforts and actions, I am sure we would achieve this goal.

Opportunities during this meeting should be used to learn from the experiences in our Region and elsewhere which will be useful for more effective planning of the next steps in addressing TB in the Region. I would like to reiterate that our efforts in TB prevention and control are contributions to global health security.
Annex 2

Agenda

- Global situation: progress and challenges for TB control
- Regional situation: progress and challenges in TB care and control
- Update on childhood TB resources and activities in SEAR
- The End TB Strategy: developing guidance on its implementation
- The Global Plan 2016 – 2020
- Update on PMDT including work of the GLC and rGLC
- Country poster presentations on progress towards universal access
- Overview of TB burden monitoring, global post-2015 projections
- Country specific projections, rational for selection of key performance indicators, target setting
- Next steps including regional targets
- Current disease burden estimation methods
- Status of national strategic plans in SEAR (including plans for updating the Regional Strategic Plan)
- Experiences in revising and updating NSP
- Global Fund New Funding Model – update and experiences
  - Global Fund perspective
  - WHO perspective
- Introduction to key issues in concept note preparation: country dialogue and engagement, prioritization of funding needs; TB-HIV joint planning
- Ensuring an inclusive on-going country dialogue in CN preparation
  - NTP perspective
  - NGO PR perspective
- Ensuring joint TB–HIV planning for concept note preparation – experiences from an NTP perspective
- Prioritization: issues, challenges and solutions
- The global strategy and targets for TB prevention, care and control after 2015 – issues and challenges in funding
- Experiences from technical partners’ support to GF grants implementation.
Annex 3

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Annual meetings of the national TB control programme (NTP) managers provide a strategic forum for exchange of information on existing and new, innovative approaches being applied in countries, for discussions on technical issues, and to follow up on actions taken on the recommendations of previous meetings, resulting in valuable advice for developing policies, strategies and plans for implementation of TB control interventions in Member countries. In November 2014, NTP managers from all 11 Member countries of the South-East Asia Region and representatives from donors, partners, as well as WHO regional and country staff met and discussed extensively on various issues including the future actions in the respective countries specifically for effective adaptation and implementation of the Global TB Strategy post-2015 now labelled as “End TB Strategy”.

The meeting made important recommendations to Member States, technical and financial partners and civil society for future action to ensure universal access to quality-assured diagnosis and treatment for all persons with TB, scale-up of PMDT, strengthened surveillance and impact measurement, and enhanced resource mobilization, through close multisectoral collaboration and engagement of diverse stakeholders ranging from relevant ministries to affected communities.