



**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**

# Intercountry high-level meeting on health systems strengthening for enhanced tuberculosis prevention and care

**Regional Eastern European and Central Asian  
project (TB-REP)**

**Copenhagen, Denmark, 26–28 April 2016**

## ABSTRACT

Despite notable progress being made in the past decade, tuberculosis (TB) is still a public health concern in most Member States of the WHO European Region. Many countries in the Region currently are in transition to more integrated outpatient- and patient-centred services with a strong focus on primary health care. Within this context, the overall goal of the three-year multipartner TB Regional Eastern European and Central Asian project (TB-REP) is to contribute to decreasing the burden of TB and halting the spread of drug resistance in 11 project countries through increasing political commitment and translating evidence into implementation of patient-centred TB models of care adapted to country contexts. This intercountry high-level meeting was organized by the WHO Regional Office for Europe in collaboration with project partners and aimed to increase high-level political commitment to halt TB, familiarize participants with the structure and content of TB-REP, transfer knowledge and skills on how roadmaps for TB-REP can be developed at country level, discuss and finalize baseline TB-REP country profiles, and provide good practice examples.

### Keywords

TUBERCULOSIS – PREVENTION AND CONTROL  
DELIVERY OF HEALTH CARE  
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## Acronyms and abbreviations

CCM	country coordinating mechanism
CSO	civil society organization
EU	European Union
GDP	gross domestic product
HR	human resources
MDR-TB	multidrug-resistant tuberculosis
NGO	nongovernmental organization
PHC	primary health care
SDGs	Sustainable Development Goals
SWOT	strengths, weaknesses, opportunities, threats
TB	tuberculosis
TB-REP	TB Regional Eastern European and Central Asian project
TWG	technical working group
USAID	United States Agency for International Development
V-DOT	video directly observed therapy
XDR-TB	extensively drug-resistant tuberculosis

## Introduction and background

Despite notable progress being made in the past decade, tuberculosis (TB) is still a public health concern in most Member States of the WHO European Region. While the European Region accounts for less than 4% of the global TB burden, the incidence rate of multidrug-resistant tuberculosis (MDR-TB) is more than twice as high as any other WHO region, with 25% of global MDR-TB cases.

Many countries in the Region currently are in transition from somewhat overhospitalized vertical TB systems to more integrated outpatient- and patient-centred services with a strong focus on primary health care (PHC). Those driving the transition must nevertheless overcome the legacy of fragmented governance, service delivery and finance systems, lack of modern equipment, understaffing, low motivation and/or inequitable distribution of staff (especially in rural areas), and few incentives for health workers to stay or further develop their skills.

Within this context, the overall goal of the three-year multipartner TB Regional Eastern European and Central Asian project (TB-REP) is to contribute to decreasing the burden of TB and halting the spread of drug resistance in 11 project countries – Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan – through increasing political commitment and translating evidence into implementation of patient-centred TB models of care adapted to country contexts.

TB-REP also purports to foster fundamental transformation of health systems delivery and financing mechanisms by aligning financial reforms with transformation of service delivery. This is supported by quality technical support and high-level advocacy to project countries, addressing intersectoral and governance aspects of TB and strengthening links.

## The meeting

This intercountry high-level meeting was organized by the WHO Regional Office for Europe in collaboration with project partners. The first day of the meeting provided high-level decision-makers from the 11 countries with information about the project and the strategic benefits for countries, while illustrating the vital importance of high-level political commitment. Technical project-related aspects, including health financing, TB prevention, service delivery and human resources (HR) development, were addressed on the second and third days.

### *Objectives*

The objectives were to:

- increase high-level political commitment to halt TB through strengthened regional and intercountry cooperation and evidence-sharing for effective and sustainable transformation of health systems;
- familiarize participants with the structure and content of TB-REP, stressing the potential country benefits stemming from its successful and sustainable implementation;
- transfer knowledge and skills on how roadmaps for TB-REP can be developed at country level;

- discuss and finalize the baseline TB-REP country profiles, which provide a base for the upcoming country roadmap, and reform development and implementation; and
- provide participants with good practice examples of models of care, TB-relevant health financing and HR development.

### ***Expected outcomes***

It was anticipated that the expected outcomes of the consultation would be:

- baseline country profiles being finalized;
- participants becoming familiar with the purpose, structure and key content of TB-REP;
- participants becoming familiar with country experiences and good practices in relation to TB-REP, from TB-related health financing through models of care to HR development; and
- participants being guided in developing and implementing roadmaps for TB-REP in their own country contexts.

### ***Participants***

Participants comprised high-level representatives delegated by ministers of health and up to two additional nominees from the 11 TB-REP Member States. Nominees included national TB programme managers and representatives of national health insurance funds, state penitentiary services, TB research institutes and schools of public health. Project partners were the Global Fund Against AIDS, TB & Malaria, the London School of Economics, the London School of Hygiene and Tropical Medicine, the European Respiratory Society, the TB Europe Coalition, the Centre for Health Policies and Studies, nongovernmental organizations (NGOs), the Regional Office and WHO headquarters. Participants are listed in Annex 1.

### **Key terms**

Annex 2 provides a list of key terms that may be helpful to readers.

## Day 1. Raising political commitment

Time	Topic	Speaker	Chairperson/facilitator
08:30– 09:00	Registration		
09:00– 09:30	Welcome and opening	Dr Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe Dr Masoud Dara, Acting Programme Manager, Tuberculosis & M/XDR-TB, Joint Tuberculosis, HIV/AIDS and Hepatitis Programme, WHO Regional Office for Europe Mr Uldis Mitensbergs, Fund Portfolio Manager, Global Fund	Chairperson: Dr Stela Bivol, Centre for Health Policies and Studies (PAS Centre)
09:30– 09:50	Key health system components linked to TB and overview of TB in the WHO European Region	Dr Hans Kluge, Dr Masoud Dara	Chairperson: Dr Masoud Dara

### Session 1

#### *Welcome and opening*

Dr Stela Bivol (PAS Centre) officially welcomed participants and introduced TB-REP. She lauded the project as the first regional approach to health systems strengthening that has a TB focus. It will allow countries to build on previously demonstrated national commitments to health systems strengthening. TB-REP, she said, aims to provide a broad set of concrete actions on how to improve health systems from the TB perspective. High-level legal and personal commitment from Member States is vital for project success, as are strong partnerships among project countries.

Dr Hans Kluge (Director, Division of Health Systems and Public Health, WHO Regional Office for Europe) cited TB-REP as a milestone that comes in the wake of international commitments to the Sustainable Development Goals (SDGs). He called for whole-of-society and whole-of-government approaches and welcomed the high-level representation from the ministries of finance of seven countries. The difference between the Millennium Development Goals and the SDGs, he explained, is that SDGs are designed to be led by countries, rather than the United Nations. He highlighted universal health coverage – a core priority of the WHO European policy framework and strategy for the 21<sup>st</sup> century, Health 2020, and the Tallinn Charter — but acknowledged the delivery challenges, which are largely caused by pressures on the finance sector. It is not the role of TB-REP, he said, to create new structures, but rather to embed and encourage good practice within current structures, where possible. He posed the same challenge to participants as had been offered by Professor Martin McKee in a preparatory meeting – how would TB-REP address and remedy the failures of past projects that have attempted to achieve similar goals?

Dr Masoud Dara, WHO Regional Office for Europe, highlighted to participants that we are living in an increasingly interconnected world and summarized TB and TB/HIV coinfection

epidemiology. He stressed the importance not only of allocation of resources, but also of *efficient use* of these resources and encouraged everyone to have as fruitful a meeting as possible.

Mr Uldis Mitenbergs (Global Fund), who attended in place of Mr Nicolas Cantau for Session 1, drew attention to the importance of recognizing TB as a vital aspect of health system reform in the countries chosen for TB-REP. He stressed the importance to the project of external expert partners and the need for effective internal and external communication to achieve success. Mr Mitenbergs viewed three key elements as being essential for project success: political will (buy-in); developing the necessary technical tools within countries; and communication.

### ***Key health system components linked to TB and an overview of TB in the WHO European Region***

Dr Masoud Dara explained the background and epidemiology of TB in the Region, highlighting the huge public health problem posed by MDR-TB. The Region has the greatest burden of MDR-TB relative to other WHO regions, with 340 000 new TB cases every year and 33 000 deaths. He illustrated two important trends: MDR-TB among new and retreatment cases; and TB/HIV coinfection. MDR-TB in new cases, in particular, is rising and HIV prevalence among new TB cases is also increasing greatly. Only 50% of MDR-TB cases are detected – an unacceptably low figure in arguably one of the most developed regions of the world. Dr Dara outlined the TB action plan for the Region and expressed the hope that all countries will develop their own national plans. Big differences in TB epidemiology exist among the Region's countries, he said.

Dr Dara drew attention to the economic benefits of investing in TB control activities, saying that for every US\$ 1 spent, US\$ 42 is saved, and outlined the epidemiological goals of the regional action plan, which he described as ambitious but realistic. He described the six next steps for improving the TB situation across the Region, with countries needing to:

- adapt national TB plans in line with the regional plan
- scale-up intersectoral collaboration in line with Health 2020
- continue and improve the exchange of good practice
- develop intercountry relationships
- improve interagency collaboration
- promote research and development.

Dr Hans Kluge spoke (in Russian) on health systems reform, reflecting on his work in the Russian Federation in the late 1990s. He saw how poor conditions facilitated the spread of TB in prisons. With time, determination and hope, however, it was possible to turn the situation around – people stopped contracting the disease and the cure rate improved dramatically. The first building block in health systems progress is leadership. All people attending this meeting, he said, are already showing leadership.

Dr Kluge said that waste within health systems, largely due to expenditure on medicines and hospital inefficiencies, is estimated to be around 10–20%. He touched on the problem of insufficient resources in primary care in many countries compared to those in secondary and tertiary centres, but highlighted one of the difficulties in redistributing resources to the primary care sector – vested interests in secondary and tertiary care systems. He stressed the importance of addressing the concerns of professionals in secondary and tertiary centres, who ask: “If we reform hospitals, what will happen to our jobs?” Innovative solutions must be provided for this



problem. Above all, Dr Kluge stressed, we need to be brave, open to new ideas and trusting of our staff, rather than commanding them.

## Session 2

Time	Topic	Speaker	Chairperson/facilitator
09:50 – 10:05	An introduction to the role of stewardship and governance in TB care and health systems	Ms Monika Kosinska, Programme Manager, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe	Chairperson: Dr Nicolas Cantau, Global Fund, Regional Manager EECA countries
10:05– 10:45	Panel discussion: Intersectoral collaboration between health systems and TB prevention and care programmes at country level	Dr Ihor Perehinets, Deputy Minister of Health, Ukraine Ms Aliona Serbulenco, Deputy Minister of Health, Republic of Moldova Dr Rafail Mehdiyev, Head of the Main Medical Department, Ministry of Justice, Azerbaijan Mr Karymshakow, Deputy Minister of Finance, Kyrgyzstan	Facilitator: Professor Martin McKee, London School of Hygiene and Tropical Medicine
10:45– 11:05	Questions and answers		

### *An introduction to the role of stewardship and governance in TB care and health systems*

Mr Nicolas Cantau (Global Fund) underlined the importance of TB-REP as a flagship for TB and health system reform and noted that donors will be assessing its implementation, taking into account the political will shown in reforming health systems. If successful, he was sure the Global Fund would contribute more support to tackling TB. He challenged participants to show willingness to make real the changes and scaling-up proposed by the project.

Ms Monika Kosinska (WHO Regional Office for Europe) highlighted two strategic objectives of her unit: addressing persistent inequalities that exist in the Region; and improving governance in health (see Annex 2). She stressed that health (and by extension universal health coverage) is a political choice and an indicator of development. Successful implementation of Health 2020 calls for:

- an intersectoral approach
- a whole-of-society approach
- the adoption of health in all policies
- improved governance for health.

Ms Kosinska welcomed Member States' commitment to adopt more systematic approaches to achieving the goals of Health 2020 and the SDGs, citing the example of reform to address noncommunicable diseases, in which the governance components of reform are still to be implemented in TB-REP countries.

### ***Panel discussion: intersectoral collaboration between health systems and TB prevention and care programmes at country level***

Professor McKee (London School of Hygiene and Tropical Medicine) introduced this discussion, inviting panellists to describe the big challenges to health systems reform in their countries.

Ms Aliona Serbulenco (Republic of Moldova) explained that the government has been developing five-yearly TB action plans since 1996, fostering good relationships between local government and medical facilities. HIV and TB programmes are separate but share a national coordination council that covers governmental agencies and NGOs/civil society, and expert groups allow for coordination of services between the programmes. Probed by Professor McKee on leadership for TB/HIV control in prisons and among post-release prisoners, Ms Serbulenco implied that the national coordination council, which acts under the Ministry of Health, takes on this role; on release, patients are transferred to the care of family physicians.

Dr Rafail Mehdiyev (Azerbaijan) discussed the interplay between the penitentiary system and health care sectors. He highlighted the importance of close collaboration with WHO colleagues and the successes of TB prevention and care in the prison system. On release, the penitentiary health service collaborates with civil society to ensure smooth transition to services provided under the Ministry of Health. NGOs in the civilian sector play a significant part in ensuring follow-up. The sense of ownership of TB patients who started treatment in prisons is high, even when they leave prison, creating an impetus for follow-up. Professor McKee asked about lessons learnt during health system reforms with regards to TB, prompting the interesting response that penitentiary medical services should not necessarily function under the penitentiary sector. When they act outside the prison sector, it was claimed, medical services have more freedom to interact with civil society and other sectors. Governmental organizations, civil society and departments of pulmonology have a special agreement on ensuring follow-up and support for treatment compliance of TB patients.

Professor McKee suggested Ukraine provided an interesting contrasting case study to the previous two countries, as it is larger and has a different political setup. Dr Ihor Perehinets identified two key challenges in Ukraine:

1. programme management is very fragmented between civilian and penitentiary sectors
2. financial resources are also fragmented.

Each creates problems for the provision of care and follow-up of TB patients. It is expected that the Ministry of Health will pick up released patients, but this sometimes is challenging. The overarching plan in Ukraine is to create an integrated resource to allow tracking of patients and sustainable follow-up. The issue of finite resources is neither new nor surprising, he said, but rational use, or reallocation, of resources could definitely be improved.

### ***Questions and answers***

Professor McKee asked about the patient's viewpoint: if you were a patient with TB, he asked, what one thing would you suggest to have the greatest impact on improving your treatment? Dr Perehinets (Ukraine) offered two responses: improved financing; and social support after completion of treatment, especially for vulnerable populations. Ms Serbulenco (Republic of Moldova) did not initially answer the question directly, but spoke of specific plans to address at-risk populations. Dr Mehdiyev (Azerbaijan) reported 100% treatment coverage in his country, but noted that some populations are more difficult to treat and retain in treatment. He stressed the

need for improved health education and awareness, particularly for patients in the penitentiary sector.

Professor McKee then asked the panellists how they would convince him to become a TB physician in their country? Dr Mehdiyev (Azerbaijan) highlighted opportunities to work in the prison sector, where pay and working conditions are good. Ms Serbulenco (Republic of Moldova) noted the differences in financial incentives throughout the medical professions and stressed the potential to take part in research, with arguably more international support in TB than in other medical specialties. Dr Perehinets (Ukraine) said it was difficult to encourage people to become doctors in Ukraine, full stop! The main incentive is to take part in the elimination of TB, which receives international recognition, and witness innovations in diagnosis and treatment.

The question of where the money for civil society engagement in TB control activities comes from was raised. Ms Serbulenco (Republic of Moldova) answered that civil society activities are largely funded via the Global Fund, which provides funds for activities in the civil and penitentiary sectors. Dr Mehdiyev (Azerbaijan) conceded that while civil society funding is very complex, the Global Fund finances NGO activity. In this context, and acknowledging the Global Fund's gradual withdrawal from the Region, Professor McKee posed a further question: what are countries doing to prepare for the eventuality of the Global Fund withdrawing from the Region and to account for declining oil prices, upon which the economies of some of the TB-REP countries depend? Panellists acknowledged the pending Global Fund withdrawal and provided some detail on their country's plans to increase government spending to fill the

Ms Serbulenco (Republic of Moldova) stated that the government currently meets 60% of expenditure on TB services and plans to transfer exclusively to national funding by 2018. It is also looking for other sources of funding, perhaps via alternative donors or the Global Fund, although to a lesser extent than before. Dr Perehinets (Ukraine) explained that Ukraine is reforming the health finance system to ensure long-term provision of TB service funding. It also plans to improve laboratory and social services and disease prevention.

Dr Hans Kluge's question, directed largely to the Republic of Moldova and Ukraine (countries that are undergoing significant health service delivery reform, including strengthening of primary care), was: what is the biggest challenge in delivering health service delivery reform, and how can partners help you?

Ms Serbulenco (Republic of Moldova) identified financing as the biggest challenge, while Dr Perehinets (Ukraine) drew attention to human resource challenges in his country, including an ageing workforce and the need to retrain health care workers in preparation for the move towards ambulatory treatment.

### Session 3

Time	Topic	Speaker	Chairperson/facilitator
11:35– 11:45	TB Regional EECA project on strengthening health systems for effective TB and drug-resistant TB control	Dr Martin van den Boom, Technical Officer, Division of Communicable Diseases and Health Security, WHO Regional Office for Europe	Chairperson: Dr Hans Kluge Facilitator: Mr Zlatko Nikoloski, London School of Economics and Political Science

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11:45– 12:00	An introduction to the economic benefit of investment in TB prevention and care and TB-relevant sustainable health financing	Mr Szabolcs Szigeti, National Professional Officer, WHO Regional Office for Europe  Mr Alexander Lourenço, WHO Temporary Advisor
12:00 – 12:45	Panel discussion: economic benefit of investments in TB prevention and care and into TB-relevant sustainable health financing	Ms Valentina Stratan, Vice- president, Committee on Social Protection, Health and Family, Member of Parliament, Republic of Moldova  Mr Saro Tsaturyan, Head of State Health Agency, Ministry of Health of Armenia  Ms Aida Abarbekova, Head of Financial Management, Ministry of Finance, Kyrgyzstan  Dr Alena Skrahina, Deputy Director, Republican Scientific and Practical Centre for Pulmonology and TB, Belarus
12:45- 13:00	Questions and answers	

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### ***TB-REP project on strengthening health systems for effective TB and drug-resistant TB control***

Dr Martin van den Boom (WHO Regional Office for Europe) provided an overview of the TB-REP project, emphasizing how it ties in with the SDGs (with SDG 3 being specific to health) and Health 2020. He outlined key health system challenges, particularly bottlenecks in health systems that include population- and individual-level service delivery mechanisms, resource generation (including HR and technology), health financing and governance.

He summarized overall TB-REP goals as the development of:

1. sustainable high-level advocacy for effective TB prevention and care
2. regional dialogue and capacity-building (see Annex 2) for sustainable health system transformation
3. tailored health system strengthening for TB prevention and care
4. efficient patient-centred TB models of care (see Annex 2).

Key expected outcomes include:

1. adopting key policies to address TB-REP strategic areas, such as improved models of care and health financing mechanisms;
2. ensuring cost-effectiveness and decreased reliance on donor funding; and
3. reducing hospitalization rates and hospital lengths of stay.

He highlighted the problems created by inequalities in the Region in relation to access to care and treatment outcomes. TB-REP aims to tackle these inequalities through improved models of care, TB-relevant health financing and effective HR development (see Annex 2). Country ownership is essential to success: Dr van den Boom urged delegates to try to strengthen governance in their countries not only in health care, but also in other vital sectors, such as justice and finance.

### ***An introduction to the economic benefit of investment in TB prevention and care and TB-relevant sustainable health financing***

Mr Szabolcs Szigeti (WHO Regional Office for Europe) detailed provider-payment methods and lessons learnt for TB control. He pointed to the targets of altering the configuration and alignment of TB service delivery models and health finance arrangements, briefly outlining commonly used provider-payment methods in use in the Region, which include fee-for-service, capitation, line-item budget, global budget and case-based payments. He then provided detail of the design of payment methods in TB control in the 11 TB-REP countries.

Mr Szigeti illustrated, by means of a pyramid/inverse-pyramid diagram, the overall goal of TB control activities –the reallocation of resources from secondary/tertiary to outpatient/primary care. This will hopefully be addressed by TB-REP and beyond. In summary, he stressed that the plan was to move from an inpatient-based financing system to one that is outpatient-based.

### ***Panel discussion: economic benefit of investment in TB prevention and care and TB-relevant sustainable health financing***

Dr Zlatko Nikoloski (London School of Economics and Political Science) asked panellists what, in their opinion, were the biggest challenges to the delivery of sustainable health systems financing in their countries?

Ms Valentina Stratan (Republic of Moldova) reiterated her government's intention to control TB. The government understands very well that funding from the Global Fund is decreasing, but hopes that this will be gradual. Governmental and health insurance foundation support for TB control is increasing: a meeting in February 2016 involving many parties interested in TB produced detailed information on the financing of civil society and health service financial needs for the short and long term. Health insurance coverage in the country is approximately 80%. The hope is that the government will soon pledge its support to a new law that will allow individuals to identify an NGO to which 2% of their taxes can be donated.

Dr Alena Skrahina (Belarus) explained that the Government of Belarus funds the treatment of sensitive and MDR-TB, while the Global Fund assists with procurement of drugs for extensively drug-resistant TB (XDR-TB). The model of financing, which is based on the number of inpatient beds and limited outpatient clinic facilities, presents a strong financing barrier for TB prevention and treatment. There is anecdotal evidence of project successes in outpatient services, not only in relation to medical treatment, but also to social support, but a truly effective payment mechanism is still to be developed. Many patients with MDR-TB have had to spend huge sums of money to be treated in hospitals. Dr Skrahina also touched on an initiative to provide outpatients in Belarus with food packages.

Mr Saro Tsaturyan (Armenia) said that financial reforms have been vital in improving the TB care delivery system in his country, but optimization of the service delivery infrastructure is needed to improve poorly equipped and staffed TB departments. TB clinics have been reduced

from 72 to 60 (none of those closed were in rural/peripheral areas – all were in the capital city). Health care financing is now performance-based with 30 indicators, some of which are designed to incentivize health care providers to improve TB detection and treatment rates. He noted a recent 28% increase in funding for outpatient services, compared to a 14% increase for inpatient services – this is progress, he said, but too much money is still directed towards inpatient (relative to outpatient) services.

Ms Aida Abarbekova (Kyrgyzstan) explained that in her country, roughly 52% of funds for TB are directed to inpatient services and 48% to outpatient, but it is well known that funds allocated to the inpatient sector can be redirected to outpatient services. The plan is to be fully self-sufficient in relation to TB treatment by 2018 – this has already begun, with the government procuring first-line drugs and various social services. Social contracting mechanisms are being sought in anticipation of Global Fund withdrawal. Civil society organizations (CSOs) that work with preventative services are concerned about what will happen when the Global Fund withdraws. They have proposed social contracting mechanisms, the potential for which is being explored. The Ministry of Health has developed an intersectoral working group (see Annex 2) that is aiming to ensure services continue during and after the switch from external to internal funding.

Dr Zlatko Nikoloski asked panellists: can you detail one or two key achievements that have been achieved by health financing reforms in TB care? General reforms and improvements in the health insurance system in the Republic of Moldova have benefited TB care, service delivery, and mortality and treatment success rates. Improved public resource allocation to laboratory services has also been seen. A pilot project to incentivize general practitioners in Belarus to treat TB patients in their catchment areas has improved social support.

While deficiencies in general health care financing in Armenia (1.6% of gross domestic product (GDP) for public health financing, 7% spent on health) were acknowledged, spending on outpatient services has increased in recent times. The importance of providing better financial incentives to treat patients in the outpatient setting was stressed. Armenia is considering reforming payment mechanisms in polyclinics to provide payment in cases of *successful* TB treatment.

The Ministry of Health of Kyrgyzstan ensures that a budget is provided for TB treatment and care expenses. Pilot projects are underway to incentivize TB treatment.

### ***Questions and answers***

In the ensuing discussion, Dr Masoud Dara stressed the importance of:

- publishing country findings in peer-reviewed journals
- qualitative, as well as quantitative, research
- ensuring good quality of medicines.

Key points from Dr Hans Kluge related to:

- the importance of a systems approach, rather than fragmented reform;
- the need for financing mechanism reforms to go further – PHC and social care need to be prepared for the switch; and
- the need to ensure a mechanism for improved and frequent communication between national TB programme managers.

## Session 4

Time	Topic	Speaker	Chairperson/facilitator
14:00– 14:10	Introduction to the importance of strong partnerships for the success of TB-REP	Mr Paul Sommerfeld, TB Europe Coalition	Chairperson: Dr Uldis Mitenbergs, The Global Fund, Fund Portfolio Manager, TB-REP
14:10– 14:40	Panel discussion: Beneficial impact of strong partnerships within the context of national working groups for health	Mr Safarov Sayvali, Head of the Main Department of the state budget, Ministry of Finance, Tajikistan Dr Zhumagali Ismailov, Director, National Centre for Problems of Tuberculosis, Kazakhstan Dr Oleg Gorin, Deputy Minister, Ministry of Health, Kyrgyzstan Dr George Kuchukidze, Monitoring and Evaluation Officer at the Global Fund, Georgia	Facilitator: Mr Gregory Paton, Advocacy Officer, Stop TB Partnership
14:40– 15:00	Questions and answers		

### ***Introduction to the importance of strong partnerships for the success of TB-REP***

Mr Uldis Mitenbergs (Global Fund) introduced the subject of the importance of partnerships to TB-REP, while also recognizing the challenges that will be posed by vested interests in health system structures.

Mr Paul Sommerfeld introduced the TB Europe Coalition, a large informal coalition of CSOs. He emphasized civil society's desire that TB care in the Region moves towards outpatient settings and stated that the biggest role for the TB Europe Coalition is advocacy – convincing people in positions of power that investment in TB control is worthwhile. He stressed the importance of following up on the pledges and promises made at high-level meetings and underlined the crucial role civil society will play in this. “We have many allies within TB-REP,” he said – “let's use each other”.

### ***Panel discussion: beneficial impact of strong partnerships within the context of national working groups for health***

Mr Gregory Paton (Stop TB Partnership) asked panellists if they could speak about the state of engagement between TB services and civil society in their country. What challenges does the country face?

Dr Zhumagali Ismailov (Kazakhstan) answered that TB care and the national TB action plan had been discussed in detail with all relevant organizations, including NGOs and CSOs. These groups have been particularly strong in facilitating the move towards outpatient TB care. The main challenge is the lack of intersectoral interaction, even between CSOs; this represents a significant impediment to the implementation of activities.

Dr Oleg Gorin (Kyrgyzstan) described the four main foci of health care delivery in his country: cardiovascular diseases, TB, HIV and maternity. The council for intersectoral action (see Annex

2), which is under the auspices of the Prime Minister, acts to improve collaboration between health care actors.

Dr George Kuchukhidze (Georgia) explained how working groups are created in the health system to accomplish particular tasks within a predefined time frame, one of which focuses on helping the country through the transition from donor to state funding. Key prerequisites for the success of the working groups include: agreement on group membership (including representatives of CSOs); clear terms of reference; clarity of leadership; and ensuring that all members have a good understanding of key objectives. The potential challenge of creating too many working groups is being addressed by mapping the groups to improve collective efficacy.

Mr Paton then asked how collaboration with civil society could be used to help tackle HIV and, by extension, TB/HIV coinfection in the countries.

One in four patients in Kazakhstan has a significant comorbidity (such as HIV or diabetes). The country is attempting to improve collaboration between agencies and working groups on individual conditions.

Separate programmes exist for TB and HIV in Kyrgyzstan. Levels of coinfection are quite low and diagnostic algorithms have been developed in conjunction with WHO.

There are relatively low levels of HIV infection in Georgia. Close collaboration between HIV and TB programmes is vital. There are also plans to integrate hepatitis C care with TB/HIV programmes. The vital role played by civil society in providing technical advice and assistance was stressed.

### *Questions and answers*

Tajik representative Dr Kurbonkhon Zakirova commented that implementation of the Tajik national action plan commenced in July 2015. Civil society played a significant role in the establishment of the plan, and the government-created coordination committee includes representatives from all key CSOs active in the country. Médecins Sans Frontières and the Global Fund were singled out for particular praise for their activities in Tajikistan. Civil society involvement in the development of a strategic plan to tackle TB/HIV coinfection has also been significant.

It was noted that there are some patients who cannot be reached by the system, or who get lost to follow-up or default from treatment. Civil society is central to efforts to minimize the numbers involved. Targeted financial support, including for CSOs, is vital; without this, it was claimed, the challenge of TB will not be overcome.

The Chair of the session concluded:

- the role of civil society is clear, and there is an obvious requirement for an intersectoral approach to tackle TB in the Region that goes beyond government–civil society links: it also requires government ministries to look inwards to ensure good interministerial collaboration; and
- sometimes, too many partnerships can be a negative thing, which poses the rhetorical question – how do we coordinate these actors?



## Session 5

Time	Topic	Speaker	Chairperson/facilitator
15:30-15:40	Introduction to the purpose and role of the national group mechanism for TB-REP	Ms Regina Winter, Consultant, Division of Health Systems and Public Health, WHO Regional Office for Europe	Chairperson: Ms Ieva Leimane, European Respiratory Society Facilitator: Ms Monika Kosinska
15:40-16:00	Questions and answers		
16:00-16:15	Closure of Day 1	Dr Hans Kluge, Dr Stela Bivol	

### *Introduction to the purpose and role of the national group mechanism for TB-REP*

Ms Regina Winter (WHO Regional Office for Europe) discussed the role of the national group mechanism for TB-REP. She reiterated TB-REP goals of increasing political commitment to the End-TB strategy and supporting countries in implementing effective and efficient TB service delivery systems with sustainable financing.

She discussed the potential structure of different types of technical/working groups in TB-REP, emphasizing the importance of not duplicating work. The structure of the working groups was outlined, including:

- the national TB-REP focal point (ideally Prime Ministerial or similar level official);
- the National High-Level Working Group (see Annex 2) on TB/health systems strengthening (chaired by the ministries of health and finance and a representative of the WHO country office, and including officials from the ministry of social protection, state penitentiary service, civil society, national TB programme, TB research institute, school of public health/economics and health insurance structures);
- National High-Level Working Group secretariat;
- thematic working groups;
- project partners.

The functions of the National High-level Working Group are to:

- act as an advisory body to the government;
- choose priority issues, items for discussion and work streams for the thematic working groups;
- advise on practical and feasible mechanisms for implementation of TB models of care at national, regional and local levels;
- support necessary legal changes; and
- oversee, monitor and guide the work of thematic working groups.

The role of the National High-Level Working Group secretariat was explained as:

- facilitating communication among technical working group (TWG) members, outreach to other TWGs and coordination of TWG meetings;
- drawing up an annual plan of work for the National High-level Working Group and TWGs and ensure its implementation; and
- providing information management.

Finally, the intended purpose of thematic working groups was described as:

- promoting broad understanding and acceptance of any technical and policy changes resulting from the working group;
- identifying key national advocacy targets; and
- supporting and identifying suitable individuals to participate at regional TB-REP events to provide technical assistance for the development and implementation of TB/health systems strengthening country roadmaps (see Annex 2).

Extensive discussion on the precise definitions of working groups and country roadmaps followed: definitions are provided in the list of key terms (Annex 2).

Discussion also focused on the need to create working groups in places where they already exist. It was clarified that if such structures already exist, there is no need to recreate them.

### *Questions and answers*

Mr Paul Sommerfeld (TB Europe Coalition) asked for clarification on the role of the National High-Level Working Groups. It was confirmed that their purpose will be to: 1) facilitate and coordinate TB-REP activity; and 2) integrate learning from TB-REP into practical aspects of TB control.

A delegate asked how sustainability of the project can be ensured when TB-REP ends? Country ownership and responsibility are prerequisites for successful TB-REP implementation, which is why the national group work mechanism has been suggested. Existing country-level groups are to be utilized as much as possible to avoid duplication and overburdening of the country (in relation to country coordinating mechanisms (CCMs), intersectoral health committees and existing health working groups).

Will the structure of the secretariat be supported by TB-REP or will it be down to the country, another delegate asked? Terms of reference detailing specific functions of the secretariat will be shared with delegates in due course.

In answer to a delegate question on how to ensure TB-REP works with CCMs, Dr Ihor Perehinets (Ukraine) said he wanted to ensure that a second CCM was not introduced to countries with an existing CCM already in place. If another was created, it should act under the existing structure and complement the work of existing groups. Another delegate who felt that it would be impossible for her government to create a further working/coordination mechanism reiterated this point. Clarification was provided by Ms Regina Winter, who said there was no need to establish additional structures where they already exist and function well. A thematic working group may be added, if appropriate.

Nicolas Cantau (Global Fund) supported the use of an interagency mechanism to inspire TB service reform and encouraged delegates to learn from neighbouring countries' good practice and take advantage of the potential for technical assistance that TB-REP provides.

### **Closure of Day 1**

Dr Stela Bivol and Dr Hans Kluge provided the following summary.

- There is need to maximize health gains from existing investments, make better choices from the restricted budgets available and address variation in total health expenditure of different countries.

- Some countries are making great improvements in health financing of TB care and in the general move from inpatient to outpatient care (see Annex 2)).
- There is good understanding of the need to move towards the goals of the regional action plan; TB-REP provides operational advice on how to do this.
- The role of intersectoral partnerships is vital.
- The overview of the steps required to implement National High-Level Working Groups suggests the need to use existing structures as well as create new ones.

In closing, Dr Kluge remarked:

- TB is an appropriate condition to use in generating health systems reform, as you can create and demonstrate concrete results;
- we have tools and strategies available – we just have to make best use of them; and
- the fight against TB is not only about TB – it reflects the SDGs and involves other reforms that will benefit general population health.

## Day 2. TB-REP applied

### Session 6

Time	Topic	Speaker	Chairperson/facilitator
08:45- 09:00	Recap of Day 1	Dr Hans Kluge, Dr Masoud Dara	Chairperson: Dr Juan Tello, Programme Manager, Health Services Delivery, Division of Health Systems and Public Health  Facilitator: Dr Stela Bivol
09:00– 09:15	The concept of patient-centred TB care, including an introduction to payment mechanisms	Dr Masoud Dara	
09:15 – 10:00	Panel discussion: what measures should be taken to improve TB relevant models of care within TB-REP?	Dr Alena Skrahina, Deputy Director, Republican Scientific and Practical Centre for Pulmonology and TB, Belarus  Ms Aelita Ibraeva, Chief Specialist on Tuberculosis, Ministry of Health, Kyrgyzstan  Dr Svitlana Ostashko, Director of the Department of Public Health, Ministry of Health, Ukraine	
10:00– 10:10	Questions and answers		

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10:10– 10:20	Introduction to the importance of adequate human resource management and development for TB prevention and care	Ms Ieva Leimane, European Respiratory Society	Chairperson: Dr Galina Perfilieva, Programme Manager, Human Resources for Health, Division of Health Systems and Public Health  Facilitator: Dr Masoud Dara
10:20– 11:00	Panel discussion: what measures should be taken to improve TB-related human resource development?	Mr Aram Manukyan, Deputy Director of the National Tuberculosis Control Centre, Armenia  Dr Alena Skrahina, Deputy Director, Republican Scientific and Practical Centre for Pulmonology and TB, Belarus  Dr Tamar Gabunia, Vice-Chair of Country Coordinating mechanism, Tblisi, Georgia  Dr Kurbonkhon Zakirova, Child TB Specialist of the MOHSPP, Dushanbe, Tajikistan	

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### *Recap of Day 1*

Dr Dara suggested the key messages to reinforce were that:

- country ownership is vital; and
- financing of the project is relatively minimal: the idea is for TB-REP to facilitate other Global Fund/partner agency projects to move towards reform rather than necessarily expecting all things to change over the three years of the project.

### *The concept of patient-centred TB care, including an introduction to payment mechanisms*

Dr Masoud Dara introduced the broad concepts behind people-centred care (see Annex 2) – that is, the term used to describe care that offers foremost consideration of the patient across all levels of health systems. He aimed to explore different models of care for TB, rational modification of care models and existing models of care, moving towards integrated care and next steps. He highlighted the differences in care delivery between WHO regions (such as the use of community models of care in Africa compared to Europe) and stressed that the aim of modifying models of care is to create more efficient use of resources and improved treatment adherence by ensuring quality, patient satisfaction and improved infection control. Dr Dara explained that there are many factors to consider when designing models of care for TB service delivery, including:

- the type and transmissibility of TB
- the length of suffering from disease
- the need to cater for all people who are affected
- the need to ensure state-of-the-art clinical care
- the need to address social determinants
- geographic and climate conditions
- cultural, social and psychological aspects of care.

He stressed the need to reorientate models of care (by, for example, standardizing practices), providers and settings (through a multidisciplinary approach) and find ways of ensuring service delivery (through financing mechanisms, for instance).

Dr Dara suggested the next steps should be to:

- assess the efficiency and efficacy of national models of care
- document lessons learnt from alternative models of care
- exchange good practices
- remove legal and financial barriers to scale-up of successful pilot projects
- monitor and evaluate all models of care
- use outcomes to add weight to evidence for scaling-up and adapting national policies.

In response to a question from the floor regarding definitions of models of care, Dr Dara agreed that models of *care* should look far beyond models of *treatment*. It is important to stress that models of care are not a one-size-fits-all entity.

***Panel discussion: what measures should be taken to improve TB-relevant models of care within TB-REP?***

Ms Aelita Ibraeva (Kyrgyzstan) explained her country's inpatient and outpatient models of care. She discussed the need to alter them, as they have remained largely unchanged since Soviet times. Ambulatory methods are not widely used at present. Outpatient care is being scaled up – a roadmap is being developed with the ultimate goal of delivering outpatient TB treatment from the day of diagnosis. Performance-based funding is being introduced to incentivize physicians to treat TB patients completely and to effect cure. Services in PHC are not prepared currently to take over all of the responsibility of TB diagnosis, treatment and care. At present, only 16% of TB patients are treated as outpatients; reportedly, the ministries of health and finance are committed to changing TB models of care. The need not to get caught up in defining care as inpatient or outpatient, but to ensure that emphasis is maintained on *quality* of care – that is, not to compromise quality purely in the name of adjusting models of care – was stressed.

A further issue surrounding TB care in Kyrgyzstan is that of stigmatization. The stigma surrounding TB makes treatment adherence more difficult. Ms Ibraeva called for the TB-REP project to provide technical assistance to tackle stigma.

Finally, details were provided on the subject of TB in vulnerable groups. With support from the Global Fund, projects have been developed to deal with vulnerable groups such as intravenous drug users, migrants (internally displaced people and migrants originating from outside the country) and TB/HIV coinfecting patients. No results are available at the present time to demonstrate the success or otherwise of these projects, but the work is being done.

A question was asked about clinical/regulatory documents in Kyrgyzstan. Ms Ibraeva responded that clinical protocols/guidelines have been created (including in PHC) in conjunction with WHO. Family doctors know how to diagnose and treat TB, but concern was voiced that ongoing stigmatization, even from doctors, may be hindering treatment success rates.

Dr Svitlana Ostashko (Ukraine) explained that provision of care to internally displaced people in his country has been difficult. In relation to outpatient models of care, pilot projects are taking place in eight regions. Developing political will within local government to embark on a path to significant reform remains an important challenge. It has been very difficult for local government to make the decision to decrease the number of hospital beds, as health care funding

is allocated per bed. Where outpatient models of care are being provided, agreements have been reached to keep money saved within TB services by allocating it to outpatient models of care. On a positive note, the multidisciplinary approach (involving TB and HIV programmes, for example) has improved in recent times.

Other challenges and obstacles in Ukraine are:

- the ongoing conflict;
- multidrug and extensively drug-resistant TB;
- procurement of anti-TB drugs (some of the newer drugs are not registered in the country); and
- health care worker training in TB (including at postgraduate level) needs to be adapted and improved.

Dr Alena Skrahina (Belarus) discussed primary care. PHC workers' interest and motivation to work in TB control has been limited. Reasons for this include lack of knowledge about TB and very low salaries in the sector. Roughly 80% of finance for TB goes to inpatient care (see Annex 2). For example, 186 XDR-TB patients receiving a combination of medications that included intravenous imipenem were unable to be discharged from hospital because administering imipenem at home or in an outpatient setting is prohibited. This has led to additional costs and inappropriate lengths of stay in hospital.

Despite Belarus being a relatively advanced country, TB treatment has much room for improvement. A mechanism to make TB models of care more successful needs to be developed.

Dr Skrahina drew attention to various pilot projects taking place in Belarus. In one, nine patients are taking part in video directly observed therapy (V-DOT); in another, patients will receive smart phones free of charge to encourage treatment adherence and follow-up. With help from the Red Cross, some patients receive US\$ 20 per month if they adhere to treatment. There are also plans to provide free transport for patients to attend treatment/clinic appointments. These projects will be assessed individually to decide which should be continued and which not. Dr Skrahina called on TB-REP to help in the development of a pilot mechanism for ensuring smooth transitions to patient-centred care.

The chair of the session asked presenters what the next steps in relation to evolving models of care in their country should be, and how would they like TB-REP to help. Dr Svitlana Ostashko (Ukraine) stressed the importance of political will, emphasizing that the Minister of Health must lead the process of reform in the country; the newly established Department of Public Health should also help. The new national TB programme, based on WHO's strategic plan, should be introduced in 2017. Good financial support and access to health care services will be an ongoing challenge, especially with the impending withdrawal of funding from the Global Fund. He stressed that support must be provided to regions that are piloting outpatient models of care and requested assistance from TB-REP to assess project effectiveness and identify how to implement projects in the most beneficial way. It is important, he said, that we do not dwell on projects that are not working, but rather scale-up projects that are working. Partnerships within TB-REP will be vital for implementing approaches in the future.

### *Questions and answers*

A question was asked about harm reduction in outpatients in Kyrgyzstan, specifically in relation to whether TB control measures linked to methadone programmes existed. The response

indicated that about six treatment centres working with TB patients, largely in big cities, provide methadone. Expansion of these projects will be discussed with the Global Fund and the United Nations Development Programme.

A participant commented from the floor that while recognition of the importance of outpatient care was important, it was also vital to be aware that inpatient services will not “go away” and that they should play a role in certain circumstances. It was also suggested that within the framework of this project, it should be ensured that TB doctors receive the same bonuses given to those who work in HIV. Other innovative ideas to attract professionals to work in TB services included allocation of housing for TB health care workers.

Dr Tamar Gabunia (Georgia) raised a topic that became a recurring theme: the readiness of PHC services to deal with treatment and follow-up of TB care. She stressed that PHC workers often have (or can learn) the competences required for TB control. TB care will be much more successful if the system allows them to practise and retain their skills, she said. The Global Fund and the United States Agency for International Development (USAID) have done a lot of work in primary care in Georgia. A performance assessment carried out to assess whether the projects led to tangible changes in practice found they were effective in areas such as PHC physicians’ referral practices. Systematic barriers in the health system, however, did not always allow PHC physicians to carry out work for which they are capable – these barriers should be addressed.

Dr Ronald Horstman (WHO temporary adviser) asked panellists to shed some light on how case detection is carried out in their countries. Ms Ibraeva (Kyrgyzstan) responded that screening was not nationwide in her country, with vulnerable groups and communities (such as migrants in remote areas) being targeted. PHC is doing quite well in performing active case-finding, but the subsequent quality of – and access to – care is a greater issue. Dr Ostashko (Ukraine) said that TB case-detection is a very important issue that has significant room for improvement in Ukraine.

Three key themes were identified by the chair of the session:

- people-centeredness – reducing stigma, improving earlier detection and addressing dropouts from treatment are vital; we have good strategies for each and know what needs to be done, but need to find the best country-specific ways of implementing them;
- service delivery – everyone is in agreement that primary care is the ideal setting in which to manage and possibly diagnose TB, but at the present time, access to TB care is sometimes only available at hospital level; and
- systemic barriers – tackling or removing those that are structural require a long-term political strategy involving improving HR and better training and education.

### ***Introduction to the importance of adequate HR management and development for TB prevention and care***

Dr Galina Perfilieva (WHO Programme Manager, Human Resources for Health) briefly introduced the importance of HR for health (see Annex 2), saying that HR is the main strategic resource and plays a key function in all health services. WHO therefore sees HR as a very important strategic component of health system delivery. It is well recognized that the health sector cannot address this problem alone – it requires cooperation with others, such as ministries of finance and education.

Ms Ieva Leimane (European Respiratory Society) noted that the European Region has the highest number of health care workers. Issues to address include, but are not limited to, the number and type of health care workers, their workload and remuneration. It is important to recognize, she noted, that the term HR incorporates a huge range of people – doctors and nurses certainly, but also radiologists, hospital staff and allied health professionals. Competences within HR do not necessarily translate into service delivery: other barriers will also impede this. Ms Leimane said that to tackle the HR issue, the number, location, workload and types of health care workers need to be determined: existing capacity-building activities should then be reviewed and their performance examined.

***Panel discussion: what measures should be taken to improve TB-related HR development?***

Dr Perfilieva asked panellists: what are the main challenges to HR in the context of TB control, and what strategies and plans for HR development do you have in your country?

Mr Aram Manukyan (Armenia) stated that a main challenge in his country is that TB care is not very attractive to health care workers. Salaries can be improved to a degree, he said, but ultimately, profits offered from TB are not great. The ageing workforce also poses a problem; it is difficult to train them to use new technologies. HR is not stable in Armenia, with many experts leaving the country for the Russian Federation or elsewhere. This so-called brain drain has proven very difficult to challenge and change. Refresher and on-the-job training is made available to staff within the framework of the national TB programme. Mr Manukyan alluded to the importance of engaging specialists from related fields, such as infectious disease specialists, to work in TB.

Dr Alena Skrahina (Belarus) reiterated some of the points made by her colleague from Armenia. The main question, she said, is how to make TB care attractive to young trainees. She suggested that the rotation of staff between inpatient and outpatient units might be a solution to stagnation. An online TB portal has been established in Belarus<sup>1</sup> to make the condition more attractive to trainees – the resource provides specialists with clinical information on each TB case in the country.

Dr Tamar Gabunia (Georgia) commented that under recent reforms, many different specialists (TB physicians, public health physicians, PHC physicians) have taken on responsibility for various aspects of TB service delivery. Initially, this posed a significant challenge, as these specialities were not ready to take on the care of TB patients. She reiterated the unattractiveness of the specialty and the ageing of the TB physician workforce. The government tried to integrate TB care into pulmonology in 2014, and two-month training programmes have been provided for TB physicians to enable them to work in pulmonology (and vice versa): no quality assessment of the training has yet been performed. In some cases, when TB physicians were seeing very few patients on a daily basis, there was a natural incentive to broaden their training. Salaries have also been increased in an attempt to attract physicians to the area.

Dr Kurbonkhon Zakirova (Tajikistan) stated that the main reason for low HR in the country is lack of motivation and fear of infection. TB work is very low-paid, despite the demanding workload. PHC is involved in the four main components of TB care in Tajikistan: detection, treatment, contact-tracing and prevention of contact contraction. The government established a

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<sup>1</sup> Belarus tuberculosis portal (<http://obsolete.tuberculosis.by/>, accessed 1 August 2016).



national coordinating committee in 2014, in part to help address these issues. The coordinating committee developed a set of measures to improve TB-related HR: medical universities are required to fill posts in TB care in regions that are greatly affected by TB; and TB physicians have been provided with plots of land for house-building as an incentive to stay in the same area. Salaries have also been increased for those in TB care.

In answer to a question from the chair on expectations of the HR component of TB-REP, Mr Manukyan (Armenia) said the hope was that it would incentivize young physicians to be involved in international activities and research. Dr Skrahina (Belarus) spoke of the need to initiate a working group with a specialist in HR development to produce a document to describe the capacities and functional responsibilities of physicians managing pulmonary conditions, including TB. It would also make sense, she suggested, to help widen the functions of TB nurses. Dr Gabunia (Georgia) said it would be useful to define who does what, in what circumstance, and with what means. It is hoped that TB-REP will help Georgia to develop a roadmap of the roles of various professionals in TB care. A colleague from Kyrgyzstan said the aspiration was to improve training for people working in TB, perhaps by working with international specialists and partners.

Dr Rafail Mehdiyev (Azerbaijan) drew attention to how bad HR conditions were in the penitentiary system. His country has been training interns (doctors, radiologists and laboratory workers) recently through the military system to work in the penitentiary system – this is directed, narrow field training in which trainees are assigned rank and trained with support from the national TB centre.

Mr Maskut Kulzhanov (Kazakhstan) said that PHC workers in his country are grossly overworked. Using oncology care as an example, some PHC workers are trained but not fully willing to take part in various aspects of care. Salaries and bonus payments for PHC specialists have been increased, but PHC has not been made more attractive. He felt that increasing salaries would not necessarily work, but broadening the remit of pulmonary physicians would perhaps be a worthwhile initiative. He also stressed the importance of a strong nursing workforce.

Ms Ainura Ibraimova (Project Director, USAID Defeat TB Project, Kyrgyzstan) expressed the opinion that TB doctors in some areas in her country may not work particularly hard, yet receive full salaries. She therefore felt that a move towards TB–pulmonology makes sense.

Mr Paul Sommerfeld discussed the use of so-called patronage nurses in Bulgaria, suggesting it was a good initiative but not sustainable without ongoing Global Fund money.

Mr Nicolas Cantau expressed the Global Fund view that regulatory frameworks in countries sometime do not facilitate effective reform of HR provision and financing.

In summary, the chair identified some themes that had been identified throughout the discussion:

- HR deficiencies
- poor motivation of health care workers
- ageing workforce
- low wages and poor working conditions.

The general feeling was that TB-REP can help countries develop specific TB training programmes, perhaps aided by specialists from the European Union (EU). The chair acknowledged the reality that moving TB care to outpatient/PHC delivery is made difficult by

the lack of incentives for physicians and nurses to work in primary care. In the framework of TB-REP, the role of nurses and allied health professionals in the delivery of TB care – as well as doctors – needs to be discussed. She welcomed the focus on training of HR.

## Session 7

Time	Topic	Speaker	Chairperson/facilitator
11:30–12:30	Panel discussion: how project partners will contribute to the project and support country-level TB prevention and care activities.	Mr Zlatko Nikoloski, London School of Economics and Political Science Ms Ieva Leimane, European Respiratory Society Dr Anna Odone, London School of Hygiene and Tropical Medicine Mr Sergii Filippovych, TB Europe Coalition Mr Gregory Paton, Stop TB Partnership	Chairperson: Dr Uldis Mitenbergs, Facilitator: Dr Stela Bivol (Director, Programs, PAS Center)

### *Panel discussion: how project partners will contribute to the project and support country-level TB prevention and care activities*

Dr Uldis Mitenbergs (Fund Portfolio Manager, Global Fund) introduced the panellists and likened the multidisciplinary approach of TB-REP to that of an orchestra, where each member must fulfil his or her role to create a harmonious outcome.

Mr Zlatko Nikoloski (London School of Economics and Political Science) overviewed activities that will be offered by his institution within the context of TB-REP. He recalled the burden of MDR-TB in the Region and warned that given the heavy dependence of some TB-REP countries on donor funding, withdrawal of the Global Fund poses a threat to TB services in these countries. He gave an example of an unnamed country in the EU that has the lowest level of total expenditure on health per capita and, perhaps as a result, the highest burden of TB/MDR-TB in the EU.

He showed that the London School of Economics and Political Science has two main functions in relation to TB-REP, which are to develop sustainable financing models for TB control in project countries and provide payment mechanisms for TB care. In addition, the project aims to capture what has been done in countries in the Region (either with donor support, domestic resources, or a mix of the two) in relation to provider allocation and sustainable financing models. All of these tasks will be conducted in close coordination with the London School of Hygiene and Tropical Medicine and the European Respiratory Society.

Mr Nikoloski suggested that target areas on which his institution may focus in relation to service improvement include:

- the current heavy emphasis on inpatient services, which may not be the most efficient way of using limited resources;
- current methods of payment that encourage hospitalization and potentially excessive hospital stays; and
- incentives for patients to adhere to their prescribed treatment.

Dr Anna Odone (London School of Hygiene and Tropical Medicine) discussed the role of her institution in TB-REP. It will assist in one of the key objectives of TB-REP – that of using evidence to inform the development of up-to-date and patient-centred TB models of care that can be replicated in a feasible, cost-effective and context-adapted manner. She said that the school will provide technical assistance through systematic pooling of available evidence and expert interviews. The specific question for the literature review will be defined in a meeting with WHO experts in May/June. For their work to be successful, input and direction from project countries is required to ensure that any recommendations can be effectively implemented, replicated and adapted in a country-specific setting. Work is needed to assess the underlying assumptions in any model of care identified or developed to ensure its applicability to each country.

Ms Ieva Leimane (European Respiratory Society) stated that the society will work primarily in the area of HR.

Mr Sergii Filippovych (TB Europe Coalition) expressed his organization's intention to support grassroots advocacy, with active participation of civil society. He outlined the Alliance for Public Health, which is part of a large TB/HIV/AIDS initiative that works in Ukraine and elsewhere in the Region. The alliance provides technical assistance related to activities in HIV/TB, particularly within vulnerable populations such as drug users and sex workers, and has been involved in drug procurement for MDR-TB patients in Ukraine. Its focus in relation to TB-REP is advocacy and the provision of technical support in project implementation, playing an important role in the development of an advocacy strategy for TB-REP. He noted the agencies in each of the TB-REP countries with which the alliance will link (10 in total). These links will facilitate information-sharing within partner networks; regular webinars will be held and three regional meetings will be devoted to the regional TB advocacy strategy (the first of which will be on 14–16 September 2016). The alliance will also provide oversight, monitoring and evaluation of CSO activities.

Mr Gregory Paton (Stop TB Partnership) suggested possible areas for advocacy activity, such as drug procurement via the Global Drug Facility. He also briefly detailed a small grants programme<sup>2</sup> that has received over 200 applications for funding (29 from eastern European countries); he encouraged delegates to apply for funding via this programme. He then referred to the Global TB Caucus, a meeting of parliamentarians from more than 100 countries that provides an opportunity to promote TB control activities. In relation to TB-REP, he hopes to work with project countries and WHO to instigate high-level meetings to improve TB control.

From the floor, Dr Shakhymurat Ismailov (Kazakhstan) urged countries to be flexible in their approach to adapting TB care. He noted education projects taking place in his country but said, “we cannot wait”, just as the TB patient who requires treatment cannot wait. PHC in Kazakhstan shoulders much of the burden of service delivery and it may be difficult to add TB to its workload. Dr Zhumagali Ismailov (Kazakhstan) showed a number of slides that detailed preliminarily approved measures, including incentives/funding to be used in PHC, to tackle TB in Kazakhstan. He noted that the government funds all TB activities, including drug procurement, and said that sufficient money is available for effective TB care, but the balance remains in favour of provision in inpatient settings. Of three strategic directions recently approved for TB control, the third prong is especially relevant for civil society and other partners

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<sup>2</sup> Challenge facility for civil society [website]. Geneva: Stop TB Partnership; 2016 (<http://www.stoptb.org/global/awards/cfcs/>, accessed 1 August 2016).

– social contracting and standardization of medical services. HR issues, such as the number of TB physicians (one TB polyclinic per 20 000 population and each TB physician dealing with approximately 12–13 patients), are also important.

Dr Masoud Dara highlighted the essential nature of transparency and suggested monthly teleconferences for partners to share progress – this was met with what seemed like broad agreement from the panellists.

Mr Uldis Mitenbergs concluded the session and emphasized how the multiple components of partners’ work will run in parallel and require close collaboration.

## Session 8

Time	Topic	Speaker	Chairperson/facilitator
13:30–13:45	Overview of lessons learnt from regional Eurasian Harm-reduction Network Global Fund project	Dr Olga Fomina, representative of the European Harm-reduction Network	Chairperson: Mr Alexandre Lourenço Facilitator: Mr Paul Sommerfeld
13:45–14:00	Introduction to development of country roadmaps	Dr Bert Schreuder, WHO Temporary Advisor	
14:00–14:15	Question and answers		
14:15–14:30	Introduction to matching country groups with external experts	Dr Martin van den Boom	Chairperson: Mr Gregory Paton Facilitator: Dr Ana Odone
14:30–15:15	Introduction to group work: checklists on minimum requirements for country roadmap development, specifically in the areas of models of care, TB-relevant health financing and TB-relevant human resources development	Facilitators	
15:15–15:30	Discussion		

### *Overview of lessons learnt from regional Eurasian Harm-reduction Network Global Fund project*

Dr Olga Fomina (European Harm-reduction Network) shared the experience of her network, the goal of which is to work at individual, community and society levels to reduce harm, often related to drug use. The network’s regional programme was launched in 2013 with the main goals of ensuring a landscape that facilitates strategic and sustainable investments in harm reduction and increasing communities’ advocacy capacity.

The project has had three key stages since its inception.

- Stage 1, in which data relating to investments in harm reduction were collected (to find out which were efficient and which were not). National experts analysed cost-effectiveness.

- Stage 2 focused on assessment of projects/platforms at national and regional levels to ensure good data collection to show the benefit of work in harm reduction. The project was presented at a regional conference on harm reduction in 2014 and was useful in guiding civil society on where to target activities.
- Stage 3, in which the plan is to continue advocacy at country level, monitor country-level budgets on harm reduction and engage NGOs who are willing to work in the field of harm reduction.

The project has achieved much, including:

- improved systematic data on harm reduction;
- improved resources, evidence-based and targeted advocacy for harm reduction and its financing and sustainability across six countries; and
- broadened partnerships and coordination.

Achievements at national level include:

- the generation of an evidence base on harm reduction, data-gathering and identification of data and service gaps;
- the building of a collaborative environment; and
- promotion of advocacy capacity-building.

Dr Fomina highlighted some lessons of running a large regional project, such as:

- the importance of acting like partners when looking for funds (rather than feeling like beggars);
- acknowledging that you cannot win all arguments; and
- acknowledging that although we all wish to engage communities, it takes a long time – we need to concentrate efforts on capacity-building within our communities.

She also highlighted a large number of challenges, predominantly external factors such as political challenges, economic crises and the lack of a long-term strategy.

### *Introduction to development of country roadmaps*

Dr Bert Schreuder (WHO temporary adviser) set out his stall to focus on country-level specificities from this point onwards. He initially dealt with country profiles before discussing the health system building blocks model and the role and composition of the National High-Level Working Group mechanism.

He detailed the way in which country profiles were created, taking into account factors such as the organization of TB services, overall health financing, TB-specific financing and health system reform. The analysis made apparent the enormous differences between countries in terms of wider (GDP) and TB-specific measures (TB financing). There is also great heterogeneity of ongoing health system reforms. He drew attention to the WHO health system strengthening quick scan tool,<sup>3</sup> which may help in the creation of country profiles.

Regarding health system building blocks, he emphasized the importance of people-centred health service delivery and urged countries to find the right composition of the national group mechanism. He suggested a means of doing this that requires three steps:

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<sup>3</sup> Health system strengthening quick scan. Copenhagen: WHO Regional Office for Europe; 2015 (<http://apps.who.int/iris/handle/10665/152670>, accessed 1 August 2016).

- create a provisional list of parties/persons to be involved
- formulate what each party contributes
- define what each party receives in return.

He closed by defining eight ways in which care services could become more patient-centred:

- assess how patient-centred the current TB care system is;
- conduct a SWOT (strengths, weaknesses, opportunities, threats) analysis of the current system;
- agree on how the ideal future service delivery system should look;
- define the major challenge to arriving at this future patient-centred service delivery system;
- identify the major health system obstacles to be addressed;
- identify the root causes of these obstacles;
- define a list of priority actions; and
- convert these into a roadmap/plan of action.

### ***Question and answers***

Dr Martin van den Boom and colleagues from the Regional Office provided clarification on the differentiation between roadmaps and work plans. It is essential to understand the root causes of obstacles to health system reform prior to defining the roadmap/work plan.

### ***Introduction to matching country groups with external experts***

Dr van den Boom introduced the purpose and scope of the country groups, including how experts were chosen and matched. He stressed the importance of dialogue among project partners, TB-REP countries, the National High-Level Working Groups mechanism and technical advisers, and noted that 100 applicants had applied to work on the project, 20 of whom were deemed suitable in terms of experience and expertise.

### ***Key objectives of TB-REP partners' participation***

Dr van den Boom briefly described the two key objectives of partners' participation:

- 1) to increase political commitment to end TB through regional cooperation and evidence-sharing for effective and sustainable transformation of health systems; and
- 2) to support countries to implement effective and efficient TB service delivery systems with sustainable financing.

### ***Discussion/country feedback***

Countries were invited to write down a couple of their queries, criticisms and comments, which were then addressed, with Dr Hans Kluge and Dr Masoud Dara moderating the session.

Questions were varied and included the following.

- Clarification was sought on National High-Level Working Groups, in that some countries were concerned that the introduction of a further working group where a similar mechanism already exists may not be appropriate. Responses from Dr Stela Bivol and Dr Masoud Dara were that:
  - we do not necessarily want to introduce new artificial structures if they already exist, such as CCMs;
  - each decision should be made on a country-by-country basis; and

- Dr Masoud Dara emphasized that TB-REP funds are minimal – resources are unfortunately insufficient to support the posting of permanent consultants to countries; the goal is therefore to support and make best use of existing country mechanisms and expertise, where possible.
- How will the London School of Hygiene and Tropical Medicine and other partners cooperate? They will:
  - work together to define the research question in a defined timeline; and
  - their role (according to Dr Hans Kluge) will be to review existing evidence then come up with instruments/tools for project implementation, before policy formulation is accomplished by countries in conjunction with WHO; WHO representatives will travel to London at the end of May for a meeting to help in the definition of specific research questions for the school and the London School of Economics and Political Science.

Other suggestions included studying international best practice in developing models of care by reviewing practices in TB nursing care, early detection and the impact of monetary and non-monetary incentives in the treatment of TB patients.

In response to a query on training, especially of nurses and PHC physicians, Dr Hans Kluge drew attention to two specific flagship courses in health systems strengthening that will be launched soon: one on health financing, the other on prevention and control of noncommunicable diseases.

***Introduction to group work: checklists on minimum requirements for country roadmap development, specifically in the areas of models of care, TB-relevant health financing and TB-relevant HR development***

Dr van den Boom provided an overview of the afternoon and morning’s planned group activities.

**Session 9**

Time	Topic	Speaker	Chairperson/facilitator
16:00–17:00	Group work I	Facilitators and representatives of all (partner) organizations rotate from group to group, roster of HSS/TB experts rotate between their assigned countries	Group work

**Day 3. Workshop on developing country roadmaps**

**Session 9 (contd)**

Time	Topic	Speaker	Chairperson/facilitator
09:00–10:30	Group work II	Facilitators and representatives of all partner organizations rotate from group to group, roster of HSS/TB experts rotate between their assigned countries	
11:00–12:30	Group work III	Facilitators and representatives of all partner organizations rotate from group to group, roster of HSS/TB experts	

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		rotate between their assigned countries
13:30– 14:15	Group work IV	Facilitators and representatives of all partner organizations rotate from group to group, roster of HSS/TB experts rotate between their assigned countries

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The group sessions had two main aims. Delegates would:

- 1) perform brief SWOT analyses of the TB control activities in their respective countries; and
- 2) begin discussions on developing country-specific roadmaps for the reform of TB-related health service delivery in their countries.

Delegates developed a short presentation on their SWOT analysis, goals they wish to achieve within the context of TB-REP and whom they hope will play a key role in achieving the goals. It was suggested that their presentations reflect four aspects of TB care delivery:

- overall governance
- TB health financing
- models of care/TB service delivery
- TB-relevant HR development.

## Session 10

Time	Topic	Speaker	Chairperson/facilitator
14:15– 15:30	Country presentations on group work and roadmap outlines: part I, including discussion	Representatives of five countries present	Chairperson: Dr Hans Kluge Facilitator: Dr Uldis Mitenbergs
16:00– 16:45	Country presentations on group work and roadmap outlines: part II, including discussion	Representatives of five countries present	Chairperson: Dr Stela Bivol Facilitator: Dr Martin van den Boom

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Dr Hans Kluge drew attention to the WHO publication *Good practices in strengthening health systems for the prevention and care of tuberculosis and drug-resistant tuberculosis*,<sup>4</sup> which is now also available in Russian.<sup>5</sup>

The SWOT analyses of each country, as presented by their respective delegates, are presented below.

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<sup>4</sup> Good practices in strengthening health systems for the prevention and care of tuberculosis and drug-resistant tuberculosis. Copenhagen: WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/publications/abstracts/good-practices-in-strengthening-health-systems-for-the-prevention-and-care-of-tuberculosis-and-drug-resistant-tuberculosis-2015>, accessed 1 August 2016).

<sup>5</sup> Примеры надлежащей Практики в области укрепления систем здравоохранения с целью Профилактики и лечения туберкулеза и лекарственно-устойчивого туберкулеза. Copenhagen: WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/publications/abstracts/good-practices-in-strengthening-health-systems-for-the-prevention-and-care-of-tuberculosis-and-drug-resistant-tuberculosis-2015>, accessed 1 August 2016) (in English and Russian).



## *Azerbaijan*

<b>Strengths</b>	Political will; good experience of ambulatory treatment from day 1; political buy-in from ministries of health and justice; good use of NGOs; availability of efficient CCM.
<b>Weaknesses</b>	Legislative framework does not provide for total completion of outpatient care delivery; CSOs not fully involved in delivery of treatment (different from HIV services in the country); lack of cooperation between ministers from different departments, such as health and social services.
<b>Opportunities</b>	Revision of legislative framework to improve outpatient service delivery – need technical assistance and high-level political buy-in to do this, as well as collective action from ministries of health and justice.
<b>Threats</b>	The healthcare financing system – the country is trying to introduce mandatory health insurance and, if possible, TB-REP should help the country to adapt the group that is dealing with mandatory health insurance models; stigmatization of patients and staff; workforce issues – lack of TB staff motivation, suboptimal knowledge/training.

In particular, it was requested that TB-REP help with the analysis and adaptation of the current legislative framework affecting TB service funding to ensure smooth transition from Global Fund to domestic funding. Five essential next steps in this regard, which the country hopes will be taken in coming years, were suggested: 1) analyse existing legislative frameworks, with participation from stakeholders; 2) propose revision of legislative and financial assistance, with WHO support; 3) develop draft regulatory documents, with experts from various fields; 4) approve these documents; and 5) implement legislative reforms.

## *Kazakhstan*

<b>Strengths</b>	Availability of an approved strategy for integrated TB control (government approved); government is considering measures to improve outpatient care.
<b>Weaknesses</b>	Lack of sufficient political will to ensure cooperation of TB PHC services, HIV services and other partners; political will is, however, present to control TB at the highest level (an opportunity to be capitalized upon); the impact of TB on businesses is to be discussed in the near future.
<b>Opportunities</b>	Need total engagement of PHC in the diagnosis, treatment and care of TB – legislative change is vital to allow this; flows of finance need to be changed from inpatient to outpatient care services; new payment mechanisms for ambulatory care are required, such as payment for successful treatment only.
<b>Threats</b>	Despite striving for reforms at local, district and national levels, some people are reluctant to change their practices.

Regarding models of care, upcoming plans for TB care in the country give PHC physicians responsibility for TB treatment. TB specialists will deal with epidemiological control and surveillance, and PHC services will be responsible for case management. At the current time, the lines of responsibility are blurred.

In relation to HR, the country needs to develop a clear plan for the responsibilities of PHC staff. Ideally, the plan would decrease the workload and increase the quality of care delivered by staff in this sector.

On financing of care, there is a need to develop social contracting, partly to help with the delivery of services to vulnerable populations. In response to a question from Dr Kluge, it was confirmed that the government ultimately makes decisions regarding provision of finance.

### *Kyrgyzstan*

<b>Strengths</b>	Acknowledgement of TB as a national priority within the context of health systems strengthening; political will, including from Ministry of Finance; at national level, the country has a coordination council that functions under the auspices of the government.
<b>Weaknesses</b>	Lack of national–regional links, and deficiencies in links between secondary/tertiary health care and PHC; insufficient incentives, knowledge and skill levels of PHC staff; ageing workforce; stigmatization of patients – most of the population believes that patients should stay as inpatients.
<b>Opportunities</b>	Possibility of engaging religious leaders, who may have a role in TB control.
<b>Threats</b>	Restructuring of TB services may be incomplete; the country roadmap talks about restructuring TB clinics, but there has been significant resistance from doctors and high-level authorities; low levels of support from TB specialists for reforms.

The representative from Kyrgyzstan also highlighted the need for reform of legislation to deliver the most effective health care reform, the need for smooth functioning of services during the transition from Global Fund funding and the importance of improving conditions and motivation for health care workers in TB services. Health system reforms [Den Sooluk] are taking the country roadmap into consideration.

Dr Galina Perfilieva asked about paying for training/education in TB care and monetary incentives to cover postgraduate studies to attract doctors to the TB field. The reply indicated that the Ministry of Health had raised this question in the past. The republican budget covers initial training expenditures; the next issue is to cover the costs of specialty training, with steps being taken in September 2016 to provide governmental support for postgraduate training for doctors. Options for free training exist for a defined number of students, but few are willing to be trained in the field of TB.

### *Tajikistan*

<b>Strengths</b>	Availability of national strategic plan 2015–2020; access to TB diagnosis (Gene Xpert in a number of regions) – 35 new Xpert machines are to be procured in the next year or two; availability of primary indicators in PHC for implementation of TB programme.
<b>Weaknesses</b>	Deficits of TB specialists in 16 districts of the country – there are no TB specialists at all in eight, covering a population of approximately 200 000 people); lack of motivation of PHC workers and TB specialists.
<b>Opportunities</b>	The WHO mandate should help TB services to interact with the highest political levels; hope to develop and introduce new mechanisms of financing, such as payment on a per-case-treated basis; aim to improve intersectoral cooperation and create new partnerships; government has created national coordination council.
<b>Threats</b>	Insufficient government financing; stigma in the field of TB; not possible to have social financing as government cannot finance NGOs.

The representative from Tajikistan stressed the need to develop alternative mechanisms of financing, especially to pay and incentivize PHC physicians and TB specialists to work in the area. She highlighted the importance of firm implementation of the national strategic plan and of moving towards outpatient care, with the goal of providing hospital care for smear-positive and complicated patients only.

Regarding HR, the desire was expressed to assess current levels of knowledge and the requirement for retraining. Given Tajikistan's mountainous landscape, innovative ways of servicing remote populations with suitable HR for TB control should be developed.

Dr Uldis Mitenbergs asked if patient-centredness needed to be incorporated into the national strategy, or whether the existing strategy needed to be implemented? The response was of the need to implement the strategy, of which patient-centredness is already a part.

### *Ukraine*

<b>Strengths</b>	Strength of health care management; eight regional pilot projects; approved protocol for outpatient treatment of smear-negative TB patients; recently improved engagement and awareness of TB care models; actively engaged NGOs in various aspects of TB control; existence of a national TB coordinating mechanism.
<b>Weaknesses</b>	Dependence on donor funding; lack of incentives for HR to implement effective TB care; limited opportunities for an integrated care approach for those with concomitant disease (such as HIV).
<b>Opportunities</b>	Some reforms are beginning to take place with regards to health systems strengthening; recent improvements have been seen in partner organization engagement; resources have been used for education programmes.
<b>Threats</b>	Lack of adequate regulatory and legislative framework; poorly motivated staff and health care worker resistance to reforms; war; lack of funds for drugs, staff and HR motivation.

It was stated that two of the main objectives of the Ukrainian country roadmap are to transition to an outpatient model of care and reform funding mechanisms. There was recognition of the need to adapt the legislative framework in Ukraine to facilitate these goals.

### *Georgia*

The representative from Georgia focused on challenges to TB control in the country and potential solutions.

Georgia is about to enter a new phase of TB care, with a new strategy that is in line with the regional End-TB strategy being endorsed last year.

A few areas in which TB-REP may be able to improve TB care in the country were highlighted, including the provision of:

- operational support to the TB CCM
- support to ensure a smooth transition from donor to domestic funding
- technical advice to facilitate the move from inpatient- to outpatient-focused TB services
- assistance on how to improve HR planning in the medium-to-long term
- suggestions on how to maintain investment in TB.

The Georgian representative touched on the positive relationship between CSOs and the private and public sector services involved in delivering TB care.

### *Armenia*

The representative from Armenia spoke largely about his country's CCM. The CCM coordinates care reform and is the mechanism that ensures stakeholder engagement. He detailed the structure of health/TB services in the country and suggested that TB-REP could assist in the creation of an additional working group to work under the CCM.

Armenia also has a national plan for TB control 2016–2020, which was approved in March. A new V-DOT for delamanid initiative has recently been launched.

Regarding HR, Georgia plans for pulmonologists to treat TB patients and wants to introduce per-treated-case bonuses and early diagnosis payments.

Expected outcomes in the course of TB-REP are to:

- develop a transition plan for the move from international to national funding
- develop new payment methods
- optimize the laboratory network.

Dr Hans Kluge congratulated Armenia on the progress made.

### *Republic of Moldova*

<b>Strengths</b>	The presence of a national TB programme and a national coordination council; recent improvements in outpatient TB treatment (10% of MDR-TB and 40% of sensitive-TB patients are currently managed in the outpatient setting); 10 pilot community centres where there is a significant multidisciplinary team approach to TB have been set up; performance-indicator bonuses have been introduced to PHC.
<b>Weaknesses</b>	Financing based on bed-days leads to excessive hospitalization; lack of a legal framework allowing full transition to outpatient treatment; insufficient utilization of directly observed therapy in rural areas; payments for early and advanced TB detection are the same; lack of follow-up and control of welfare coupons given for treatment (such as food vouchers).
<b>Opportunities</b>	Improving political commitment; gradually reducing the number of beds; optimizing financing mechanisms; possibility of adjusting payment for service providers to link to clinical results; plans to improve cooperation between medical and welfare services by, for instance, making better use of community centres; plans to improve monitoring of directly observed therapy in rural areas – possibly giving money and food vouchers to medical staff in charge of distributing the funds/treatment.
<b>Threats</b>	Medical resistance to transition to outpatient care; TB service financing after Global Fund withdrawal.

To greatly improve TB care, there is a need to:

- tackle the legal framework surrounding the reform of TB care
- introduce per-case-based financing and performance-based payments
- reorganize the outpatient care delivery system.

In response to a request for elaboration on medical resistance to outpatient care and the country's plans to combat this, the represented responded as follows:

- currently, funding of hospital units is based on utility, which is judged by the number of hospital beds used;
- plans are in place to combine the work of pulmonologists and TB physicians – there are currently two university chairs and two university departments, so this change will take time; and
- as bed numbers reduce, doctors may have to be convinced to take on a different caseload.

### *Belarus*

The representative from Belarus briefly touched upon her country's CCM, which incorporates all stakeholders to optimize care for TB patients. She discussed a number of key areas of TB care that she hopes will be addressed in the near future, some of which may be facilitated by TB-REP, including:

- holding a high-level policy dialogue to increase awareness of TB;
- developing a health finance mechanism for improved resource allocation from inpatient to outpatient care (and using the money saved on outpatient care);
- creating a working group on TB funding reform;
- incorporating the TB specialism under the umbrella of pulmonology;
- scaling-up the Mogilev project (a pilot project that illustrated the utility of financial incentives in TB care); and
- implementing recommendations from the national TB programme review.

Ms Ainura Ibraimova (Project Director, USAID Defeat TB Project, Kyrgyzstan) noted that 20 years ago, many of the countries started from a similar level, but countries are now quite heterogeneous. She highlighted TB reforms as an entry point for general health system reform. WHO, she said, should play an important role in the definition of the medical specialty, suggesting, as others had done previously in the meeting, expansion of the scope of the TB speciality. She even suggested use of the term phthisopulmonologist.

### **Session 11**

Time	Topic	Speaker	Chairperson/facilitator
16:45– 17:00	Communication and information-sharing on TB-REP	Dr Stela Bivol	
17:00– 17:15	Next steps	Dr Hans Kluge, Dr Stela Bivol	<b>1.</b>
17:15– 17:30	Closure	Dr Hans Kluge	

### *Communication and information-sharing on TB-REP*

Dr Stela Bivol acknowledged that coordination and communication are potential obstacles that will be faced during the TB-REP project. She highlighted three main means of communication (telephone, videoconference and country visits) and three different strands to ensure adequate coordination (between partners, coordination with other regional projects, and coordination with national grants and country programmes). She also drew attention to the upcoming TB-REP meetings taking place in Bratislava, Slovakia, in June.

Work is currently underway to finalize the TB-REP website, which should be available by June 2016; the project also has a Facebook page.

Dr Bivol summarized some key TB-REP technical interventions (the main responsible partner is identified in brackets):

- sustainable high-level advocacy for effective TB control:
  - national/regional-level policy dialogue (WHO)
  - joint high-level advocacy missions (WHO)
  - ad hoc TB advocacy assistance (Stop TB Partnership)
  - bottom-up country efforts (TB Europe Coalition-Alliance)
  - exchange of advocacy best practices (TB Europe Coalition-Alliance);
- regional dialogue and capacity-building for sustainable health systems transformation:
  - upcoming flagship WHO course on health systems strengthening for TB control (Barcelona, Spain, 17–21 October 2016);
- development of efficient patient-centred TB care models;
  - HR planning methodology (European Respiratory Society);
  - patient-centred TB care models (London School of Hygiene and Tropical Medicine);
  - sustainable financing models (London School of Economics and Political Science);
  - allocation and payment mechanisms for TB care (London School of Economics and Political Science).

Work to assess the project's achievements will be carried out in 2018. Specific targets are to decrease the percentage of:

- new TB cases hospitalized (from 67% to 30%)
- drug-resistant TB patients hospitalized (from 86% in 2013 to 50% in 2018).

Key Year 1 outputs are:

- at regional level, to have completed final versions of country profiles;
- at government level, to establish focal points and coordination groups, ensure political commitment, raise awareness of goals and ambitions, and initiate country roadmap development and regulatory impact analysis; and
- at CSO level, to conduct a situational analysis, assist in the development of national and regional advocacy strategies, and inform patients about outpatient models.

Dr Bivol finally offered some next steps for countries and partners. Countries, she suggested, should:

- identify a focal point for optimal development and/or function of a National High-Level Working Group (or supporting structure if one is already in place);
- finalize country profiles and identify 3–4 key issues to address;
- develop a list of people to meet in high-level advocacy meetings (ideally, those who will be sympathetic to our cause!) and identify possible dates; and
- identify the best methods of coordination and communication with national Global Fund grants and other projects (to avoid overlaps and generate a synergistic effect).

Partners should:

- help to fine-tune and assist countries to follow their national work plans
- enlarge the communication circle and coordination among all partners

- finalize communication means
- establish and maintain a calendar of upcoming events.

## **Closing remarks**

Dr Hans Kluge discussed the difficult issues of managing change and innovation. He stressed the need to continue to learn from one another and scale-up pilot projects when appropriate. Political commitment, he reiterated, is key. Civil society is vital in ensuring this, as it will hold governments to account.

He urged participants not to forget that we have a moral obligation to remember the human face of TB and continue to be grounded in the belief that health is a human right. He called for zero tolerance of stigma and discrimination.

The agenda is enormous, Dr Kluge said. He warned that we will get frustrated at times during the project. At these times, he encouraged participants to act on things that are achievable and to “think big, start small and act fast”.

## *Annex 1*

### PARTICIPANTS

#### **Armenia**

Mr David Hambardzumyan  
Head of the Department of State Budget  
Expenditure Planning, Ministry of Finance

Dr Aram Manukyan  
Deputy Director of the National Tuberculosis  
Control Centre, Ministry of Health

Mr Artur Tadevosyan  
TB Coordinator for the GF PIU, Ministry of Health

Mr Saro Tsaturyan  
Head of the State Health Agency, Ministry of  
Health

#### **Azerbaijan**

Irada Akhundova  
Deputy Director of Smoking-related Interstitial  
Lung Diseases (SRILD) Department

Natavan Alikhanova  
Head of the M&E department, SRILD, and Deputy  
Manager, National TB Programme (NTP)

Mr Rafail Mehdiyev  
Head of the Main Medical Department, Ministry of  
Justice

#### **Belarus**

Mrs Liubou Kazmina  
Head of the Department of Financing, Health  
Care and Sport, Ministry of Finance

Dr Marina Sachek  
Director, Republican Scientific Medical Centre  
of Medical Technologies, Information,  
Management and Economy

Dr Alena Skrahina  
Deputy Director, Republican Scientific and  
Practical Centre for Pulmonology and TB

#### **Georgia**

Dr Tamar Gabunia  
Vice-chair of Country Coordinating Mechanism

Dr George Kuchukhidze  
Monitoring and Evaluation Officer, Global Fund TB  
Programme of NCDC

#### **Kazakhstan**

Dr Zhumagali Ismailov  
Director, National Centre for TB Problems

Dr Shakhymurat Ismailov  
Project Manager, GFATM TB Grant, PIU  
National Centre for TB Problems

#### **Kyrgyzstan**

Ms Aida Abarbekova  
Head of Financial Management, Ministry of  
Finance

Dr Oleg Gorin  
Deputy Minister of Health

Ms Aelita Ibraeva  
Chief Specialist on Tuberculosis, Ministry of Health



**Republic of Moldova**

Mrs Ana Ciobanu  
Deputy Director on Management and Strategies,  
Chiril Draganiuc Phtisopneumology Institute

Mr Dumitru Parfentiev  
Director, National Health Insurance Company

Mrs Maria Semeniuc  
Head, Department of Finances in Health Care and  
Social Protection, Ministry of Finance

Mrs Aliona Serbulenco  
Deputy Minister of Health

Mrs Valentina Stratan  
Vice-President, Committee on Social Protection,  
Health and Family

**Tajikistan**

Dr Sadridin Boronov  
Deputy Head, Agency for Control over Medical  
Activities

Mr Safarov Sayvali  
Head of the Main Department of the State Budget,  
Ministry of Finance

Dr Kurbonkhon Zakirova  
Child TB specialist, Ministry of Health

**Turkmenistan**

Mrs Guljan Atajanova  
Head, dispensary department of the Mary regional  
TB hospital

Mrs Aysoltan Charyyeva  
Central Administrative Department of Infectious  
Diseases Control, and Deputy Director, TB  
Prevention Centre

Mr Marat Gulmyradov  
Head of Health, Social, Culture and Science  
Finance Department, Ministry of Finance

**Ukraine**

Dr Svitlana Ostashko  
Director, Department of Public Health, Ministry of  
Health

Dr Ihor Perehinets  
Deputy Minister of Health

Ms Olesia Tsykaliuk  
Deputy Head, International Relations Department,  
and Head, Division on International Relations and  
International Technical Programme Support,  
Ministry of Health

**Uzbekistan**

Dr Shukhrat Nishanov  
Head of Main Department for Organization  
of Treatment and Prophylaxis Services, Ministry of  
Health

Mr Botir Pardayev  
Head of Department for Health Care Financing,  
Ministry of Finance

## **Representatives of other organizations**

### **Centre for Health Policies and Studies (PAS Centre)**

Dr Stela Bivol  
Director, Programmes

Ms Cristina Celan  
Project Coordinator/TB Programme Officer

### **Eurasian Harm Reduction Network**

Ms Olga Fomina

### **European Respiratory Society**

Ms Ieva Leimane

### **Global Fund to Fight AIDS, Tuberculosis & Malaria**

Mr Nicolas Cantau  
Regional Manager, Eastern Europe & Central  
Asia, Grant Management Division

Mr Uldis Mitenbergs  
Fund Portfolio Manager

### **London School of Economics and Political Science**

Dr Zlatko Nikoloski

### **London School of Hygiene and Tropical Medicine**

Professor Martin McKee  
Professor of European Public Health

Dr Anna Odone

### **TB Europe Coalition**

Mr Paul Sommerfeld

### **Alliance for Public Health**

Mr Sergii Filippovych  
Director, Treatment Procurement and Supply  
Management Department

Ms Yuliya Chorna  
Project Manager: TB Advocacy

### **Stop TB Partnership**

Mr Gregory Paton  
Project Coordinator

## **Temporary advisers**

Dr Agostino Borra  
Denmark

Dr Ronald Horstman  
Netherlands

Ms Ainura Ibraimova  
Kyrgyzstan

Dr Maksut Kulzhanov  
Kazakhstan

Mr Alexandre Lourenço Carvalho  
Portugal

Dr Andrei Mecineanu  
Republic of Moldova

Dr Bert Schreuder  
Netherlands

Dr Oleg Sheyanenko  
Kyrgyzstan

Dr Natalia Vezhnina  
Russian Federation

## World Health Organization

### Regional Office for Europe

Dr Andrei Dadu  
Technical Officer, Tuberculosis & M/XDR-TB

Dr Masoud Dara  
Programme Manager, Tuberculosis & M/XDR-TB

Dr Pierpaolo de Colombani  
Medical Officer, Tuberculosis & M/XDR-TB

Dr Nedret Emiroglu  
Director, EU/DCH Communicable Diseases and  
Health Security

Ms Anne-Birgitte Gradman  
Secretary, Tuberculosis & M/XDR-TB

Dr Hans Kluge  
Director, Division of Health System and Public  
Health

Ms Monika Kosinska  
Programme Manager, Governance for Health

Ms Elizabeth Neville  
Programme Assistant, Tuberculosis & M/XDR-TB

Dr Galina Perfilieva  
Programme Manager, Human Resources for  
Health

Dr Juan Tello  
Programme Manager, Health Service Delivery

Dr Martin van den Boom  
Technical Officer, Tuberculosis & M/XDR-TB

Ms Regina Winter  
Consultant, Division of Health Systems and Public  
Health

### WHO country offices

Dr Gayane Ghukasyan  
Country Programme Officer, WHO country office,  
Armenia

Dr Javahir Suleymanova  
National Professional Officer, WHO country  
office, Azerbaijan

Mr Szabolcs Szigeti  
National Professional Officer, WHO country  
office, Hungary

Ms Tatiana Polunina  
Russian Federation

### Interpreters

Ms Lyudmila Yurastova  
Russian Federation

### Rapporteur

Dr Richard Tran  
United Kingdom

## Annex 2

### KEY TERMS

Term	Definition
<b>Capacity-building</b>	Continuing process of strengthening existing capacities and introducing more efficient technologies and systems in order to address a problem in a more effective manner. The United Nations Development Programme <sup>6</sup> defines capacity building as the process by which individuals, groups, organizations, institutions, and societies increase their ability to (i) perform core functions, solve problems, define and achieve objectives, and (ii) understand and deal with their development needs in a broad context and in a sustainable manner. <sup>7</sup>
<b>Country roadmap</b>	The country-specific plan developed to successfully achieve TB-REP project goals.
<b>Governance</b>	Governance in the health sector refers to a wide range of steering and rule-making related functions carried out by governments/decisions makers as they seek to achieve national health policy objectives that are conducive to universal health coverage. <sup>8</sup>
<b>Human resources development</b>	Functions involved in planning, managing, and supporting the professional development of the health workforce within a health system, both at the strategic and policy levels. <sup>8</sup>
<b>Human resources for health</b>	All people engaged in actions whose primary intent is to enhance health. <sup>9</sup>
<b>Inpatient care</b>	Medical or nursing care that is provided in hospitals.
<b>Intersectoral action</b>	Intersectoral action refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector. <sup>10</sup>
<b>Models of care</b>	The way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place. <sup>11</sup>

<sup>6</sup> Capacity development. New York (NY): UNDP Management Development and Governance Division; 1997 (Technical Advisory Paper II; <http://www.eldis.org/vfile/upload/1/document/0803/ID2251.pdf>, accessed 1 August 2016).

<sup>7</sup> WHO, United States Centers for Disease Control and Prevention. Planning the development of human resources for health for implementation of the Stop TB Strategy. A handbook. Geneva: World Health Organization; 2009 ([http://www.challengetb.org/publications/tools/hss/WHO\\_HRD\\_Stop\\_TB\\_Strategy.pdf](http://www.challengetb.org/publications/tools/hss/WHO_HRD_Stop_TB_Strategy.pdf), accessed 1 August 2016).

<sup>8</sup> Governance. In: Health systems [website]. Geneva: World Health Organization; 2016 (<http://www.who.int/healthsystems/topics/stewardship/en/>, accessed 1 August 2016).

<sup>9</sup> The world health report 2006 – working together for health. Geneva: World Health Organization; 2006 (<http://www.who.int/whr/2006/en/>, accessed 1 August 2016).

<sup>10</sup> Intersectoral action. In: Social determinants of health [website]. Geneva: World Health Organization; 2016 ([http://www.who.int/social\\_determinants/thecommission/countrywork/within/isa/en/](http://www.who.int/social_determinants/thecommission/countrywork/within/isa/en/), accessed 1 August 2016).

<sup>11</sup> Understanding the process to develop a model of care: an ACI framework. Chatswood (NSW); 2013 ([http://www.aci.health.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0009/181935/HS13-034\\_Framework-DevelopMoC\\_D7.pdf](http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf), accessed 1 August 2016).

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<b>National High-level Working Group</b>	A group existing or to be established under TB-REP, which will adapt and implement the appropriate TB model of care, taking into account the country-specific context
<b>Outpatient care</b>	Medical or nursing care that is provided outside of hospitals.
<b>People-centred care</b>	An approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases. The aim is to deliver care that sees the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health. <sup>12</sup>
<b>Working group</b>	Group of relevant stakeholders (such as politicians, national TB programme members, civil society, etc.) created to perform a particular function in the context of TB control.

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<sup>12</sup> Improving quality primary health care. From measurement to improvement: a roadmap. Geneva: World Health Organization; 2016 ([http://www.who.int/servicedeliverysafety/events/PHC\\_From\\_measurement\\_to\\_improvement.pdf](http://www.who.int/servicedeliverysafety/events/PHC_From_measurement_to_improvement.pdf), accessed 1 August 2016).