

Outcome of the Senior-Level Policy Dialogue Addressing HIV and TB Challenges: from Donor Support and Emergency Response to Sustainable Health Systems

12-13 December 2017, Tallinn

The Senior-Level Policy Dialogue ‘Addressing HIV and TB Challenges: from Donor Support to Sustainable Health Systems’ took place from 12-13 December 2017 in Tallinn under the Estonian Presidency of the Council of the European Union and concluded with this outcome document.

The outcome document prioritizes two major challenges for HIV and TB:

- **Transition from donor-supported HIV and TB programs to sustainably financed services** that are integrated into national health systems;
- **Patient-centered HIV and TB services as an integrated part of health systems with an optimal costs of service.**

Beside these two challenges also the roles and responsibilities of different stakeholders were debated.

This outcome document outlines needs, challenges and opportunities along with a framework for multi-sectoral and multi-stakeholder action towards sustainable, resilient and people-centered systems for health that would lead towards the end of the HIV and TB epidemics and leave no one behind, as agreed in the UN Agenda for Sustainable Development [10]. The document is supported by multiple global and European commitments to tackle HIV and TB and develop stronger health systems.¹

¹ European countries and other UN member states committed to ending the AIDS epidemic and tuberculosis as a public health threat, providing universal health coverage and leaving no one behind by 2030. [10] The European Commission consolidated a joint European Community role inside Europe and globally in ‘European actions for sustainability’. [2] In the Tallinn Charter, European countries agreed to a values-driven agenda for strengthening their health systems including responding to key public health challenges like HIV and TB. [8] Their commitment and priority actions in HIV and TB are articulated in the Dublin, Malta, and Riga Declarations and in the Action Plans for HIV and TB for the WHO European region 2016-2020. [1, 4, 5, 6, 9] The European Parliament has called for political action including stronger political dialogue with the Commission and EU member States in neighbouring countries, and updating the Dublin HIV Declaration. [3] Cities across Europe also recognize their great role in fast-tracking for HIV.[7]



HIV and TB epidemics management at risk in Europe

The European Union and European Economic Area (EU/EEA) have steadily reduced rates of new TB infections, AIDS cases and AIDS-related deaths.^{2,3} However, the insufficient speed of that reduction, along with continuing stable levels of new HIV infections in the last decade, will prevent Europe from reaching the SDG goals on HIV and TB by 2030. Half of new HIV infections are diagnosed late, while successful TB treatment and levels of drug-resistant tuberculosis have not seen major improvements in the last 10 years. HIV and TB remain disproportionately concentrated in vulnerable and key affected populations like men who have sex with men, people of foreign origin, including migrants, prisoners and people who inject drugs, among others.^{2,3}

In some EU neighbouring countries in Southern Europe, HIV and TB rates are low. However, new HIV cases have more than doubled in the last decade. The EU neighbourhood in Eastern Europe, together with Central Asia, remains the only region globally with a growing HIV epidemic and has one of the lowest rates of HIV treatment coverage in the world. Progress in reducing TB-notified cases has not yet translated into reducing MDR-TB (multi-drug resistant tuberculosis) and HIV-TB co-infection. The Eastern Europe and Central Asia region accounts for nearly 20% of the global burden of MDR-TB. A deadly combination of TB and HIV co-infection is on the rise there, in contrast to EU/EEA, reaching a level of co-infection of 9%, yet only two thirds of HIV-TB co-infections are diagnosed.

Two EU member states (Bulgaria and Romania) and associated countries in Southeastern Europe (Albania, Bosnia-Herzegovina, former Yugoslav Republic of Macedonia, Montenegro, and Serbia) are currently transitioning from the international funding that helped develop their HIV and TB responses, notably the Global Fund to fight HIV, TB and Malaria. Several other Eastern European countries in the EU neighbourhood are projected to transition out from this support in the next 10 years.

HIV and TB efforts have been developed as an emergency public health response, but in some cases through vertical systems and in dependency on external financing for certain interventions. Reaching and sustaining ambitious global targets often requires increased domestic financing to the response of the disease. It also requires doing more with the current resources to achieve greater efficiency, integration of services and building resilient health systems.

Stigma, insufficient community support and lack of patient-centered support and services in health systems are often the main reasons why people are routinely diagnosed too late or do not receive early care after getting infected. Infections spread faster and further in vulnerable communities, key affected populations and in our societies at large.

² European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2017 – 2016 data. Stockholm: ECDC; 2017

³ ECDC /WHO Regional Office for Europe. Tuberculosis surveillance and monitoring in Europe 2017



By 2050, an additional 2.59 million lives could be lost through MDR-TB alone in the European Union; and the additional morbidity, mortality and other costs associated with the pandemic could reduce entire global GDP by 0.63 per cent. [11]

Challenges and opportunities in transition and integration

Programmatic and financial sustainability of HIV and TB responses is crucial to achieve for all countries regardless of having donor financing or not. Countries face difficulties in delivering greater and sustained domestic finances, and in merging parallel systems and policies created by donor-funded responses with domestically-owned ones, notably on procurement and governance. Insufficient domestic resources prioritize life-saving care such as healthcare services, sometimes sustaining existing sub-optimal care infrastructure but often leaving aside counselling and prevention services. There is also a tendency that countries are often not ready, willing or able to start investing in people-centered support and prevention among key affected populations who are outside health systems due to stigma and discrimination, and who are outside compulsory and subsidized health insurance coverage but can and have been reached by community-based and non-governmental organizations that mostly operate with donor funding. Monitoring of those groups, which should provide an important element of domestic monitoring and evaluation of the epidemic and response, is often discontinued as international financial support phase out. In parallel to donor transition, countries face reduced international technical partner support, loss of international discounts for pharmaceutical products and less engagement in global accountability mechanisms.

Greater integration of HIV and TB services into health systems can enable a holistic response to people needs and improve the outcomes of the treatment on the one hand, and, on the other, better pooling and optimized use of available financial, human and other resources for the epidemics, i.e. achieving greater sustainability and resilience in systems. Commitment to people-centered and integrated approaches could drive reforms in the TB sector to reduce unnecessary hospitalization, improve patient's well-being and their ability to follow treatment plans and treatment outcomes, thus reducing TB costs for health systems and patients. Integration could facilitate revisiting and reforming traditional roles in systems and implement task-shifting, for example, community-based and self-testing for HIV, better engagement with primary care and utilization of internet and mobile technologies. Like all changes, these might be met with system inertia and resistance to transformation.

Practical implementation of integration of services should, however, strike a balance between specialized and integrative approaches. As the epidemics continue to disproportionately affect key affected populations who face stigma and discrimination, specialized, population-tailored approaches separate from the mainstream public health services – and which are designed to be accessible and user friendly to key populations and delivered by community organizations – are better equipped to reach and link them with public systems. Those services should, however, re-



calibrate models to increase reach, uptake and outcomes, and better coordinate with other services. Adopting an integrative approach would develop a policy environment, with engagement of various sectors and topics involved – migration, drug policy, sexual orientation and gender identity, prison and criminal justice, access to justice, psychological support, social integration among others – that effectively addresses social, economic and other determinants of these diseases and prioritize health and human rights.

The transition and integration processes, if well planned, managed, supported and incentivized, with strong stewardship and multisectorial engagement, could present opportunities for domestic partners to revisit policies, approaches and resource-use for coherent, inclusive, efficient and domestically-owned effective solutions. In the phase of transition from external financing, increases in domestic financing may be needed to support specific interventions often financed by donors as well as to scale up service coverage.

Recommendations for implementation of transition management and service integration for sustainable responses

The following recommendations could support countries in their efforts towards sustainability in conjunction with their ongoing work. As solutions are country-specific, unique country circumstances may call for other factors, not listed in this document, to be considered and addressed.

Both processes – service integration into health systems and transition from donor-funded to sustainable domestic systems – have their particularities but share the following principles:

- The changes need to be planned in advance, with a clear definition of responsibilities, timelines and end results, and adequately funded.
- Policy dialogue, advocacy and technical support will be needed and should be supported during these processes.
- Communities of people most affected should be at the center of decision making.

Plans and actions should evaluate systematically and reform policies, systems and practices at national and local levels. The evaluation should be made at least for following aspects: health needs of different affected groups, services provided by the current system (incl access and integrity of the services) and by community and gaps in it, models of services, social and other determinants of health policies, legislation, financing, workforce and capacities, procurement and supply chain of medicines and access to medicines, governance of the systems, monitoring and evaluation systems and quality assurance at different levels.



The following seven components would need to be addressed to effectively manage the transition from donor financing and service integration for sustainable responses. Below are important aspects and elements to consider for each component:

| Component | Transition from donor to sustainable financing – important aspects and elements to consider | Integration of services into health systems – important aspects and elements to consider |
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| Evidence | <ul style="list-style-type: none"> • Analysis of gaps in services, including possible ways to integrate the services along with opportunities for integration • Analysis on effectiveness and cost-effectiveness of the approaches • Availability and reliability of funding • Possibilities to optimize funding streams • Prioritization of services to identify those with highest impact | |
| Motivation and political will | <ul style="list-style-type: none"> • Continuous dialogue between different stakeholders (incl politicians, policy makers, community representatives) • Communication about the impact of action and inaction • Response to HIV and TB in a broader political and global context | <ul style="list-style-type: none"> • Continuous inclusive dialogue and communication, particularly between systems and stakeholders that should create the change • Identify positive aspects for key stakeholders and for general public as well as for the vulnerable and most affected groups |
| Policy | <ul style="list-style-type: none"> • Well defined general plan for transition which, where possible, should be part of a legal document (i.e. national strategy) • Prioritization of most affected populations • Prioritization of most important services • Addressing social determinants and underlying vulnerability factors • Contract community-based and non-governmental organizations to provide services | <ul style="list-style-type: none"> • Continuous inclusive dialogue with stakeholders from health systems and communities • Adapting to the country programming approach: national HIV and TB programs could be separate documents with multi-stakeholder participation and/or integrated in comprehensive national health programs • Support innovation and revision of service delivery models including changes in roles and settings • Striking a balance between integration and specialized services, based on evidence and priorities • Integration not only of HIV and TB but also linked with other related areas, for example, sexual and reproductive health and rights, and drug control |



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| Planning and implementation | <ul style="list-style-type: none"> • Continuous diligent revision of the situation, existing services and actual costs after changes are implemented • Clear and consolidated implementation plan with clear responsibilities • Clarity on which sectors, governance structures, agencies and organizations are responsible and when • Placing patients, their empowerment and involvement in the centre when planning and delivering services • In case of donor transition, start planning from the very beginning of donor support | |
| Funding | <ul style="list-style-type: none"> • Pooling resources and setting priorities, with a good balance and flexibility, allowing shifts depending on priorities and changes in the situation • Diversification of funding sources for programs • Consider funding medical costs for HIV and TB (and prevention where relevant) from national insurance schemes, but also reckon with people affected who do not have health insurance to insure equal access • Consider providing state health insurance to most affected groups and people with HIV and TB • Seeking greater efficiencies in systems to free resources, including better pharmaceutical policies | |
| Services | <ul style="list-style-type: none"> • Allocating additional resources (including increasing domestic resources) • Improving transparency and patient centredness of the services and their integration into the health system • More attention to quality of services • Approaches to continuous capacity building of human resources and their management systems | <ul style="list-style-type: none"> • Creating relevant incentives for integration and cooperation • Mapping and sharing models of integration and cooperation at service and local settings • Rearranging accountability for better outcomes and integrity • Supportive technical and normative guidance for greater integration, innovation and task-shifting • Sensitization and development of workforce and its competences • Local leadership and management to enable service coordination |
| Partnership and leadership | <ul style="list-style-type: none"> • Strong governance focused on HIV and TB, clear reform plans and following implementation of reforms • Multisectorality and inclusiveness to create ownership in all actors and to tackle determinants of health • Government stewardship and accountability | |



Roles and responsibilities

| Components | Government (<i>ministry responsible for health and other relevant ministries and public institutions</i>) | Health sector (<i>including hospitals and other entities who provide health care services or counselling etc</i>) | Civil society (<i>including community organisations</i>) | European Commission | International donors and partners |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| Evidence | Leadership; Enhancing research; Data collection; Data analysis | Documenting service provision Providing data | “Watchdog” | Enhancing research; Providing platforms for exchange of experiences between Member States and other stakeholders | Predictable support and coordination among partners |
| Motivation and political will | Multisectoral inclusive governance; Sieveing out priorities; Communication of risks; Advocacy of possible benefits to stakeholders and general public | Expert opinion Readiness to improve current system | Advise and support | health in all policies | International accountability mechanisms |
| Policy | Developing policies and legislation | Expert advice, technical guidance | Sharing experiences and practical experiences, “Watchdog” | Enhancing research and providing platforms for exchange of experiences between Member States and other stakeholders | Evidence, guidance and support |



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| Planning and implementation | Addressing social determinants, clear and realistic plan and actions, coordination of implementation | Pooling resources and financial incentives | Needs and voices of underserved | Cross-border solutions and sharing best practices | Dialogue on bottlenecks and policy change |
| Funding | Recognition and funding of services in health systems but also supporting civil society services; Monitoring and evaluation of the changes/indicators | Responsible and effective use of resources | Citizen engagement for resources allocated by others | Structural support for inequalities and research | Sustainability bridge funding |
| Services | Developing the concept of integrated and patient-centered services in close cooperation with health sector Funding and monitoring of services (quality and quantity); Monitoring the main affected groups in the population; planning and educating sufficient | A proper team of healthcare professionals and other relevant professionals needed to provide patient centred services | Citizen engagement on quality of care and services | | |



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| | medical personell and other relevant professionals needed to provide services | | | | |
| Partnership and leadership | | Efficient use of resources | | | |

National governments, with the involvement of parliamentarians and local authorities, should sustain their leadership, multi-stakeholder governance, transparent and accountable strategies and planning for HIV and TB, including integration of those responses, coherence with other policies, funding and addressing social determinants. They should also be transparent and accountable.

Health insurance funds and health systems have to ensure better integration and optimization of responses to diseases including their funding and financial incentives, monitoring and quality assurance systems.

Health systems and health care providers should work towards better cooperation, support the gathering of evidence on situations, services and challenges for key affected populations, and strengthen human resources including task-shifting and awareness-raising among vulnerable populations and including them in state-supported universal health coverage.

Justice, prison, law enforcement, social and other sectors should engage in reviewing legislation, policies and practices to address social determinants, and should actively participate in governance for HIV, TB and health.

Ministries of Finance should support optimization of services, engage in dialogue for optimization of pricing and pharmaceutical policies.

Governments, with the engagement of various ministries, parliaments as needed, local authorities and civil societies should all work to recognize, plan and support effective community-based approaches through community-based and non-government organizations including social contracting mechanisms, sustainable funding and accountability mechanisms.

A greater role of local authorities and cities should be further recognized and activated for more sustainable, multi-sectoral, locally adapted and adequately funded solutions.

Community and civil society groups could enable the gathering of data on the HIV and TB related needs of local and vulnerable communities and provide them for decision making and improvement of service delivery.



Community and civil society groups should continue providing services for HIV and TB prevention, case finding, care support, addressing health, social, legal and other needs of the populations served, and better linkage and integration with health service providers.

Community and civil society groups should lead on collecting evidence on the role of community-based organisations (CBOs) and NGOs in systems for health.

Community and civil society groups should carry out dialogue, advocacy and watchdog functions to keep high political commitment, effective governance, policies, recognition of community systems in systems of health.

The EU institutions, including the European Commission, should support countries in their reforms on moving towards sustainable responses to HIV and TB, on pharmaceutical policies, addressing human rights in HIV and TB responses, bringing public health evidence and human rights imperatives in policies on drugs, migration, criminal justice and others, recognition of CBO and civil society sectors in health systems. Those solutions are needed within the European Union and in candidate, associated and Eastern partnership countries

The EU institutions, including the European Commission, should facilitate exchange of practices and voluntary collaboration among the countries in their integration and assist with Joint Actions, supporting cross-border solutions for mobile populations, support multisectoral political dialogue beyond health, and inform countries of the opportunities for structural funds and existing financial instruments for outside the EU, and support political dialogue in candidate countries.

EU and UN agencies including ECDC, WHO and UNAIDS will continue providing countries with evidence for policies and practices, technical guidance, support in governance, monitoring, costing and optimization solutions, as well as monitoring of country situations, responses and needs.

Donors will increase predictability of their support for HIV and TB and actively work with countries including technical partners and civil society towards sustainable support and reducing any negative affects of their transition.

Volunteer donors will work with countries losing major HIV and TB grants to provide a small amount of sustainable bridge funding to address the most challenging elements in transformation, focusing primarily on civil society and vulnerable populations.

UN and other intergovernment structures should develop greater accountability mechanisms for countries to measure the progress.



Next steps

The Senior-Level Dialogue participants will use this document to inform the upcoming relevant events and initiatives, among those:

- Tallinn Charter Anniversary High-Level Meeting “Health systems for prosperity and solidarity – leaving no one behind” in June 2018;
- International AIDS Conference in Amsterdam in July 2018;
- UN General Assembly High-Level Meeting on TB in 2018.

The wealth of knowledge and lessons learnt from integration and transition in building resilient systems should be shared among countries and across various sectors, including in other areas facing similar challenges.



References

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