

FIRST WHO GLOBAL MINISTERIAL CONFERENCE
**ENDING TUBERCULOSIS
IN THE SUSTAINABLE
DEVELOPMENT ERA:
A MULTISECTORAL RESPONSE**

16-17 NOVEMBER 2017, MOSCOW, RUSSIAN FEDERATION

CONFERENCE VISION

The Global Ministerial Conference “Ending TB in the Sustainable Development Era: A Multisectoral Response” aims to accelerate country implementation of the WHO End TB Strategy in order to reach the End TB targets set by the World Health Assembly and the United Nations (UN) Sustainable Development Goals (SDGs).
The Ministerial Conference will inform the UN General Assembly High-Level Meeting on TB in 2018.

DRAFT POLICY BRIEFS

Working towards the Vision for the Conference, draft policy briefs have been developed on 8 *Expected Outcome Areas*. These areas are seen as critical to accelerating action in order to achieve universal coverage of TB prevention and care and act in all sectors to meet the milestones and eventually the targets set as part of the End TB Strategy. These actions can also lay the foundation for the transformational change needed to end the TB epidemic. Each draft policy brief aims to introduce the issue being addressed; describe major challenges and opportunities; and propose possible specific actions that Ministerial delegations to the Conference may wish to commit to for national action, and calls for action at global level.

Note: *These are first drafts for comments by the high-level Steering Committee for the Ministerial Conference and the Partners Group Consultation, and will be iterated with the help of engaged partners. Partners consulted to date or to be engaged are noted together with a roadmap of related events in the coming months. Additional partners are expected to contribute as well, including at the WHO STAG-TB meeting and End TB Strategy Summit in June 2017. The policy briefs will be finalized for translation for the Conference by September. They will also help guide discussions in plenary and parallel sessions at the Conference.*



KEY OUTCOME AREAS AND PROPOSED DELIVERABLES

Leading up to the United Nations General Assembly High-Level Meeting on TB in 2018, Ministerial commitment to:

SUPPORTED BY MULTISECTORAL ACCOUNTABILITY FRAMEWORK



1. UNIVERSAL COVERAGE OF TB CARE AND PREVENTION

Systems reforms, and full uptake of innovative tools, to optimize quality of integrated people-centred care and prevention, and ensure access so that no one is left behind.

DELIVERABLE: National End TB inter-ministerial coordination mechanism, convened by Ministry of Health, with Head of State as patron.



2. SUSTAINABLE FINANCING FOR TB, UHC AND SOCIAL PROTECTION

Sustainable financing, especially from domestic sources, to enable access to care and prevention embedded in comprehensive health and social systems that alleviate the risk factors and consequences of disease.

DELIVERABLE: Increased domestic financing, aligned broadly with 30-60-90 benchmarks, and additional bilateral, multilateral and blended financing streams, to complement Global Fund commitments.



3. RESPECT FOR EQUITY, ETHICS AND HUMAN RIGHTS

An equitable and human right-based response that prioritizes people affected by poverty, disease, stigma and marginalization, including global action on the plight of migrants, and on the special risks faced by other vulnerable groups such as prisoners.

DELIVERABLES: Charter on Equity, Ethics and Human Rights to End TB.
Global portal to facilitate access and continuity of TB care for migrants and refugees.



4. SCIENTIFIC RESEARCH AND INNOVATION

Increased and targeted financing and intensified capacity-building to foster rapid achievements in scientific research and innovation.

DELIVERABLE: Global Coalition for TB Research – Financing for top priorities.



5. MONITORING AND EVALUATION OF PROGRESS

Tracking progress towards SDG Target 3.3 and other SDG targets that impact the TB epidemic, and establishment or strengthening of digital systems to collect, store and analyse large volumes of disaggregated data.

DELIVERABLE: National TB-SDG monitoring frameworks.



6. ACTION ON AMR, HEALTH SECURITY AND MDR-TB

Addressing MDR-TB as an emergency and threat to health security, including within the global antimicrobial resistance (AMR) agenda.

DELIVERABLE: MDR-TB crisis addressed as a public health and health security priority, with national emergency response plans and increased global support..



7. STEPPED-UP TB/HIV RESPONSE

Integrated care for all people affected by TB and HIV, with a special focus on eliminating TB deaths among people living with HIV.

DELIVERABLE: Excess TB deaths eliminated by 2020 among people living with HIV – achieved through national plans for scale-up of the Three E's and integrated TB and HIV care.



8. SYNERGIES ACROSS THE RESPONSES TO TB AND NONCOMMUNICABLE DISEASES

Synergistic and joint actions against TB and noncommunicable diseases and their risk factors.

DELIVERABLE: High-level national mechanism to guide efforts on integrated TB and NCD care.
Strengthened multi-stakeholder coalitions to deliver and transfer knowledge and expertise.



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KEY OUTCOME AREA 1

UNIVERSAL COVERAGE OF TB CARE AND PREVENTION

Systems reforms, and full uptake of innovative tools, to optimize quality of integrated people-centred care and prevention, and ensure access so that no one is left behind.

The Issue

- **The health-related 2030 Sustainable Development Goal 3 (SDG 3)** incorporates two distinct yet closely related targets: ending the global tuberculosis (TB) epidemic (Target 3.3) and achieving Universal Health Coverage (UHC)(target 3.8). Ending the TB epidemic through universal coverage of TB care and prevention requires speedy implementation of the WHO End TB Strategy which demands significantly enhanced resources – human and financial – for an effective response through strengthened health and community systems.
- **An effective TB response must embrace innovation** through rapid uptake of new diagnostics and drugs and adoption of digital platforms and tools to modernize care provision. Working with communities and civil society, governments need to assume full responsibility of ensuring access to people-centred, modern, high-quality TB services regardless of whether care is sought from public, voluntary, private or corporate care providers.
Particularly in countries with a large private health sector, structural changes, enforcement of regulations, and policies that equip and incentivise private providers are essential.
- **An effective TB response must also be tailored to national, sub-national and local situations and needs.** Underserved and unreached populations merit priority attention. Urban and rural poor and near-poor populations, migrants, refugees and prisoners are at a greater risk. These are also the people that often face greater barriers to physical, financial, social and cultural barriers in accessing high-quality TB care. Men, women and children have distinct needs to seek and receive TB care and prevention services.
- **Multisectoral collaboration provides the essential framework for ending the TB epidemic.** Adequately resourced upstream actions on SDGs such as ending poverty (SDG 1), ending hunger(SDG 2) ensuring quality education (SDG 4), employment and decent work for all (SDG 8), reducing inequality (SDG 10), and making cities safe and sustainable (SDG 11) can contribute significantly to ending the TB epidemic and especially to TB prevention.
Securing comprehensive care along with essential support for each person with TB also calls for collaborations within and beyond the health sector. For this purpose, government ministries and departments including finance, social welfare, labour, law, women and child welfare, food and agriculture, urban development, education need to contribute to efforts coordinated by the ministry of health.



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- **Accelerating and facilitating sustained, coordinated multisectoral efforts to end the TB epidemic** requires elevated stewardship and informed leadership from the highest levels of governments to enable ministries of health and national TB programmes to guide a comprehensive and intensified response to the TB epidemic.

Challenges and opportunities

STRENGTHENING BASIC TB RESPONSE THROUGH MODERNIZATION AND INNOVATION:

Challenges

- **Despite major progress in fighting TB over the recent decades, around 5000 people still die of TB every day** and millions suffer from it. More than 40% of the estimated TB cases globally go undetected or unreported and do not receive high-quality TB care and prevention. Four out of every five persons with MDR-TB do not receive appropriate treatment. Almost half of all people with TB are managed without an HIV test result. Management of TB comorbidities such as diabetes, harmful use of tobacco and alcohol or undernutrition is rarely integrated into TB care. Deficiencies in patient-centred care provision and the multiple barriers faced by people with TB hinder their access to high-quality TB care and prevention services. Implementation and scale-up of proven models of care is woefully inadequate.

Opportunities

- **Based on WHO guidance and initiatives of partners and country programmes**, various innovative approaches have been implemented in diverse country-settings. These replicable and scalable approaches demonstrate ways to address persisting gaps in detecting and treating all people with TB by, for instance, undertaking systematic screening for active TB; involving all public and private care providers to ensure optimal management and reporting of all cases; addressing the MDR-TB crisis comprehensively; integrating care for comorbidities; using digital tools to enhance efficiency; and engaging communities and civil society organizations to address stigma and discrimination and make the fight to end TB a people's movement.

STRENGTHENING HEALTH SYSTEMS THROUGH UNIVERSAL HEALTH COVERAGE:

Challenges

- National TB programmes can only be as good as general health systems and services. Weak health systems – public and private – pose significant challenges to providing high-quality TB care and prevention services to all who need it especially the vulnerable and hard-to-reach populations. Deficient infrastructure, inadequate human and financial resources, weak coordination across the sector, slow adoption and uptake of new tools and innovations, uneven



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quality of care, weak enforcement of regulations, inadequate engagement of communities and civil society and overall limited capacity to mount a comprehensive response to the TB epidemic significantly impede the necessary massive and sustained effort essential to end the TB epidemic.

Opportunities

- **Commitments by governments of making resources available to achieve UHC** should enable addressing many of the systemic weaknesses. Opportunities presented by SDGs and ongoing health system reforms need to be seized upon to address above challenges and progress towards universal coverage of TB care and prevention to meet the milestones and targets set under the End TB Strategy.

Actions

National level:

SET UP BY THE FIRST UNGA HIGH LEVEL MEETING ON TB IN 2018, NATIONAL END TB INTERMINISTERIAL COORDINATION MECHANISM TO BE CONVENED BY MINISTERS OF HEALTH WITH THE HEAD OF STATE AS PATRON TO GUIDE AND MONITOR PROGRESS TOWARDS ENDING THE TB EPIDEMIC.

- To this effect, develop a legislative framework backed by adequate budget that empowers the ministry of health to carry out its enhanced responsibilities to end the TB epidemic through multisectoral effort guided and monitored by an inter-ministerial coordination group led by the highest political authority.

MINIMIZE BY 2020 AND THEN ELIMINATE, PERSISTENT GAPS IN TB CASE NOTIFICATION AND HIGH-QUALITY TREATMENT AND SUPPORT.

- To achieve this: a) make modern rapid diagnostic methods, treatment and preventive services available in both public and private health care facilities guaranteeing access to high-quality care and support to every person with TB; b) develop and implement digital platforms and tools to facilitate mandatory case notification and adherence support, and c) implement active case finding among high-risk populations.

Global level:

CREATE AND SHARE ONLINE, A GLOBAL REPOSITORY OF INNOVATIVE APPROACHES TO ADDRESS TB CASE DETECTION AND QUALITY TREATMENT GAPS.

- WHO and partners to develop and maintain the repository, and mobilize resources to assist countries to take innovations to scale

SET UP A GLOBAL PLATFORM TO DEVELOP SUSTAINABLE MODELS OF PRIVATE PROVIDER ENGAGEMENT IN TB RESPONSE.

- WHO and partners to facilitate sharing of experiences of regions and countries to develop and scale up sustainable models to engage private providers that manage nearly a quarter of the global TB burden especially in Asia.



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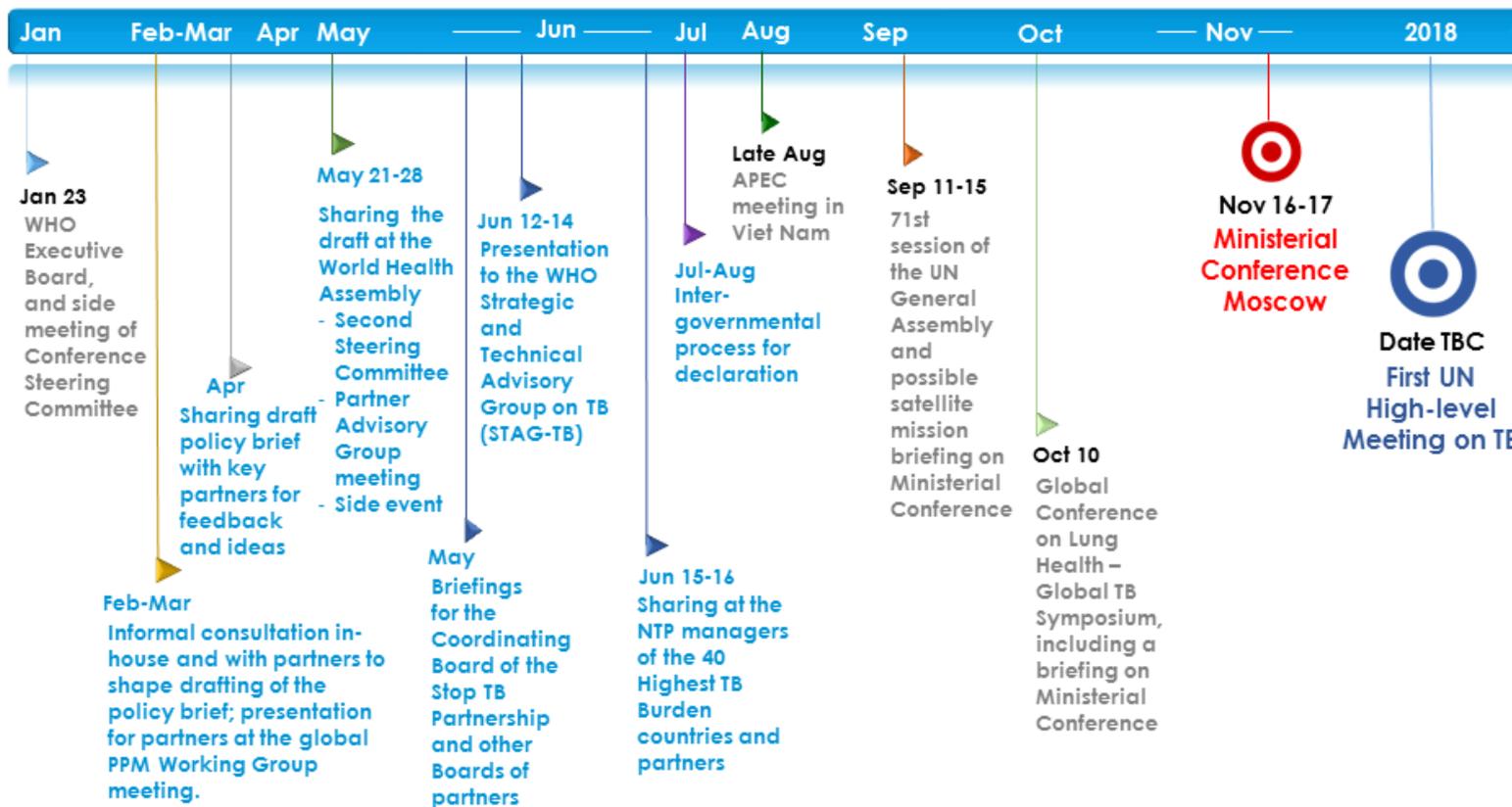
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KEY OUTCOME AREA 2

SUSTAINABLE FINANCING FOR TB, UHC, AND SOCIAL PROTECTION

Sustainable financing, especially from domestic sources, to enable access to TB care and prevention embedded in comprehensive health and social systems that alleviate the risk factors and consequences of disease.

The Issue

- Without major advances in **financing for Universal Health Coverage**, ending the TB epidemic will not be feasible, nor will elimination of catastrophic costs for TB-affected households. Sustainable financing will be impossible if accelerated and diversified financing is not provided now. For TB-specific response, there is a current annual financing gap of at least **US\$ 2 billion** of the \$8 billion needed in non-OECD countries¹. By 2020, the **total needs will be over US\$ 12 billion**, according to the Stop TB Partnership Global Plan to End TB, 2016-2020.
- The **MDR-TB public health crisis** will persist without the immediate infusion of local and global financing for diagnostics, drugs and care, with severe health security consequences as shown in recent analyses².
- Eliminating **out-of-pocket payments** is an acute concern that persists in far too many countries for diagnostic visits, first-line and/or second-line drugs and other onerous costs, especially facing MDR-TB patients. This needs to be accompanied by growth of social protection investments that can be linked up to serve TB-affected households.
- Therefore, ministers of health, finance, planning, and social development and partners need to grow the health and TB financing pie, achieve efficiencies, and advocate the case for investment.

Challenges and opportunities

Challenges

- **Many governments are investing insufficiently in health**, generating too little revenue and have weak public expenditure management. Few low- and middle-income countries are coming near the rough health spending target of at least US\$ 86 per capita. Specifically for TB-specific functions, 24% of available financing comes from international sources, but that figure is 87% in low-income countries.
- The **Global Fund** country TB financing envelopes are tight and absorption capacity is also a challenge. In addition, some countries, especially in Eastern Europe and the Americas, need to

¹ See *Policy Brief 4* for the urgent needs in financing for research and innovation.

² See *Policy Brief 6* on responding to MDR-TB as a health security threat, including through financing



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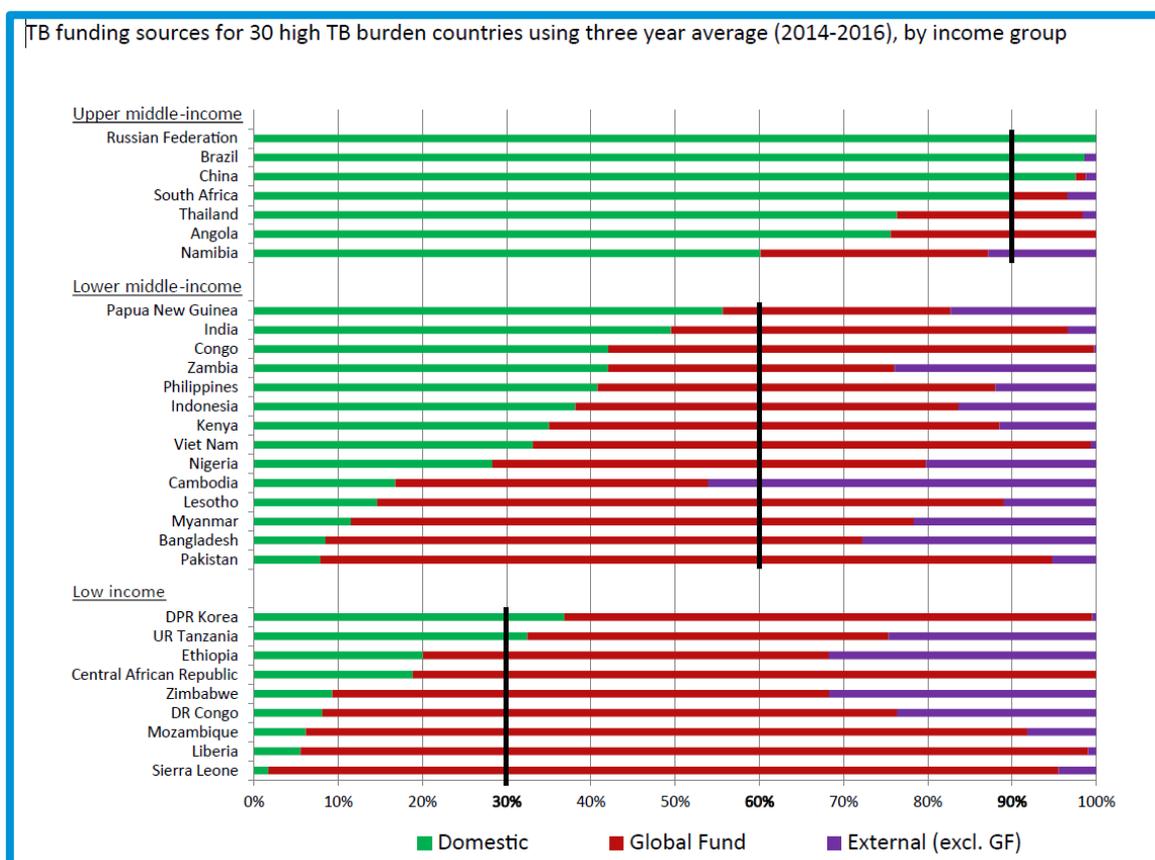
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plan for upcoming transition from financing, including for procurement of quality commodities and ongoing contracting of implementing partners.

- Very few **bilateral donors** provide bilateral financing for TB efforts, such aid can leverage domestic financing and technically support big streams of finance from The Global Fund, which is by far the largest source of international financing for TB control.
- TB prevention and care needs to be accompanied by strong national social protection efforts. yet the ILO reports that, globally, **only 27% of people have access to adequate social protection coverage**, and GDP share investments for social protection varies from only 0.5% in Africa to 6% in Western Europe.

Opportunities

- **Lessons from strong performers in domestic financing:** Several low and middle-income countries are enacting and implementing bold UHC policies, raising more revenue, and investing more in health. Further examining the effects for TB in these settings will be useful.
- For **TB-specific financing**, as shown in the chart below, a **minimum benchmark of 30%** domestic financing in low-income countries, **60%** for lower-middle income countries, and **90%** for upper-middle income countries should be feasible.
- **Efficiency gains** can improve capacity to extend access, through new diagnostics and drugs that cut diagnostic delays and reduce treatment time, through digital health, supply management and innovations such as strategic purchasing (public, private and community provider payment schemes) and improvements in patient benefits packages where insurance is in use.
- **Global health financing** will continue to increase over the coming years, though at a slower pace than during the MDG era, estimates the International Health Metrics Institute (IHME). Global Fund and other financing streams should have potential to still grow in the next years. High-income countries can continue to build awareness of the benefits of investing globally in TB to reduce the public health risks at home.
- **Additional bilateral funding for TB**, such as from all of the top Global Fund contributors, can help substantially to strengthen support and capacity. This includes for technical assistance, new policy adaptation, launch of innovations, monitoring and evaluation, and operational research. Support to date has leveraged the success of Global Fund financing. Complementary bilateral support on other global health priorities also has shown substantial benefits.
- **Blended health financing** is a promising area, and in TB there was a pathfinding example in the early 2000s with a “buy-down” of World Bank IBRD-level financing to concessional levels for China through UK co-financing. Bilateral, Global Fund and World Bank collaborations in health financing are increasing. There are also examples of **public-private financing** for access to new diagnostics and drugs, such as with UNITAID, US Government and Bill & Melinda Gates Foundation support.
- There are promising **cash transfer and other social protection schemes** in a majority of the highest TB burden countries. While coverage is still limited, there are examples of linkages across sectors to enable access to benefits for poor and vulnerable TB-affected households.



Actions

National level:

Countries commit to:

- **Increase domestic financing and efficiency** towards universal health coverage, with health financing schemes that: (a) reach poor and vulnerable groups; (b) enable effective communicable disease actions by public, private and civil society providers; and (c) provide financing for national TB efforts in line broadly with suggested 30-60-90 minimum benchmarks for low, lower-middle and upper middle-income countries respectively, and full financing towards TB elimination in upper income countries.
- **Speed up action to eliminate catastrophic costs** borne by TB-affected households, through: (a) health financing efforts; (b) action based on results of TB patient cost surveys; (c) measures to enable access to all effective new tools and people/ patient-centred care and prevention; (d) strengthened financing of social protection, including other needed social services, social assistance, food and employment security.



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Global level:

Countries call on:

- **Global health financing partners to expand the health financing pool:** including
 - The **Global Fund to Fight AIDS, TB and Malaria** to continue its vigorous resource mobilization efforts and, with partners, to help countries and associated implementers to continue to increase absorption capacity.
 - The Global Fund, bilateral development agencies, the World Bank, and regional development banks to pursue **additional financing** with TB impact, whether via disease-specific, TB/HIV, MDR and AMR response, health systems financing, blended financing, and financing for policy transfer, implementation, technical assistance, monitoring & evaluation, and operational research.
- **WHO, The Stop TB Partnership, academic, technical, civil society and other partners** to continue efforts to help countries develop and advocate for investment cases, with strong national strategic plans, costing, budgeting and impact projections, and work with other partners in related fields such as poverty reduction and social protection.



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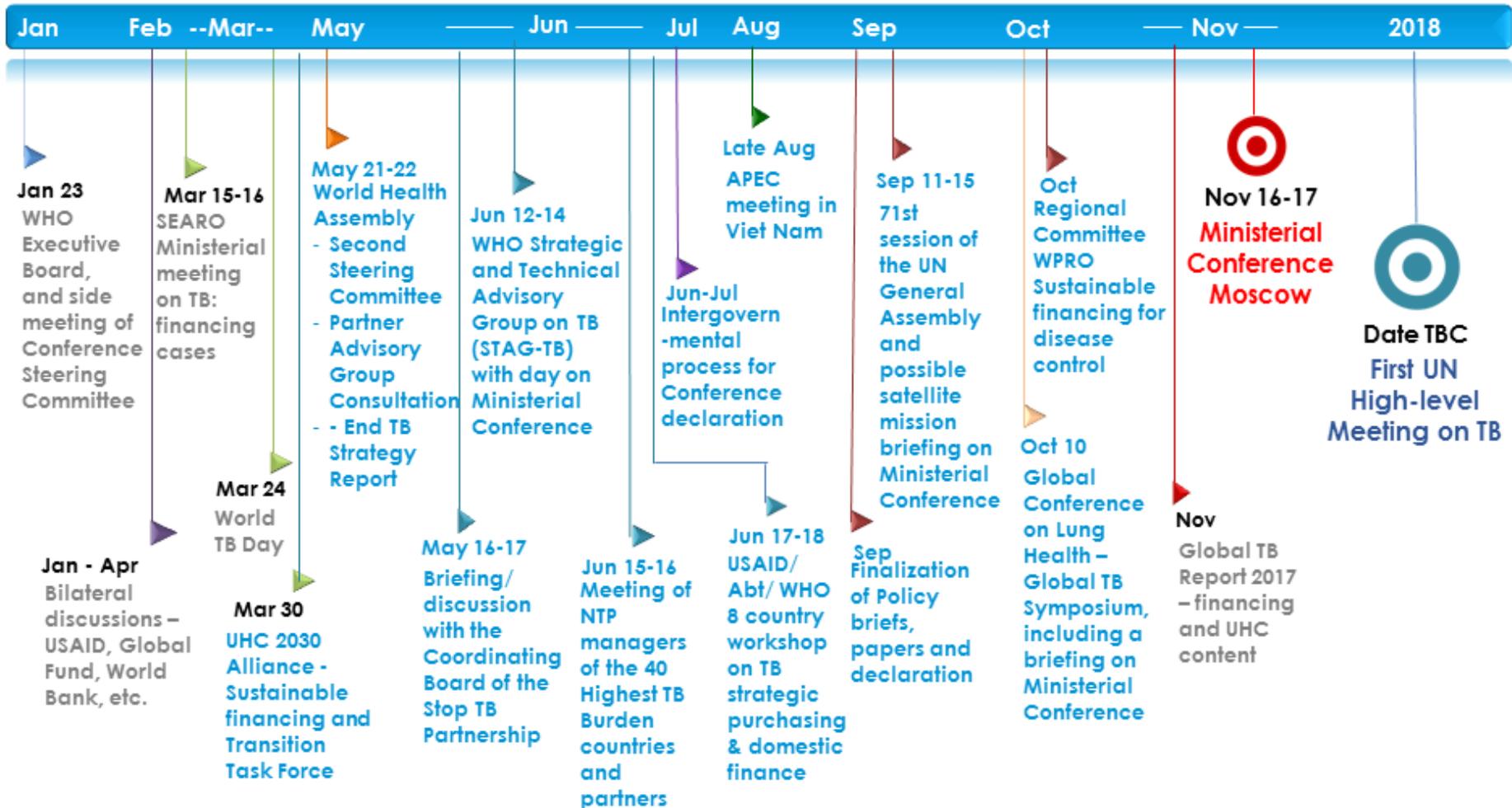


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- WHO Regional communicable diseases and health systems departments
- UHC 2030 Alliance Secretariat/WHO



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KEY OUTCOME AREA 3

RESPECT FOR EQUITY, ETHICS AND HUMAN RIGHTS

An equitable, ethically sound, and human rights-based response that prioritizes people affected by poverty, disease, stigma and marginalization, including global action on the plight of migrants, and on the special risks faced by other vulnerable groups such as prisoners.

The Issue

- The WHO End TB Strategy is built on a human rights-based approach including principles of non-discrimination, equity, participation, ethical values, access to justice and accountability. 2030 targets will go unachieved without explicitly pursuing these principles for all persons - 'leaving no one behind'.
- Yet, action is too slow in addressing the social determinants of TB, increasing access to quality and ethically-sound prevention and care services, and facing head-on violations of human rights. Without urgent action, vulnerable and marginalized populations such as the very poor, migrants, refugees, and prisoners will continue to be left behind with disproportionately high burden of TB. Ministers of Health have the opportunity to work cross-sectorally, including with other Ministries such as Justice, Social Welfare, Labour, Interior and Finance, as well as civil society and communities, to address this issue.
- Millions of migrants are denied access to health service and remain invisible in several key international health dialogues, both in context of large acute crisis driven migration or within the economic and disparity-driven migration. Given the urgent global health needs related to migrants and refugees, actions below include special attention on these populations.

Challenges

- **Vulnerable and marginalized populations** carry inequitable burdens of TB. These populations include: poor and food-insecure communities, prisoners, migrants, refugees, ethnic minorities, miners and others working and living in risk-prone settings, the elderly, marginalized women and children, drug users and those who excessively use alcohol. These groups face major barriers to accessing quality health and other services, due to socio-political, cultural, gender-related and legal barriers as well as direct violations of their human rights. These barriers include discrimination, stigma, marginalization and catastrophic economic costs. It is important that universal coverage and financial protection mechanisms, as outlined in *the policy briefs for outcome areas 1 and 2* address the needs of vulnerable and marginalized populations.
- **Lack of voice and meaningful participation:** Affected persons as well as, vulnerable and marginalized populations are still far too rarely provided the systematized means to participate



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actively in design, implementation and evaluation of development, health and TB-specific efforts at national and global levels.

- **Lack of ethical practices and/or human rights violations** are not infrequent: systemic or specific instances of involuntary detentions of people with TB; migrants being denied access to health services and/or deported while ill and/or in treatment; health care workers operating in unsafe environments; double standards on health care applied to prisoners; people stigmatized and discriminated against for having TB, often aggravated by factors pertaining to gender, race religion, ethnicity etc.; patients receiving poor-quality care, or being punished for not adhering to treatment, when care and support are needed instead; TB prevention and care may also involve inadequate protections from inadvertent harm, such as during disease surveillance, data sharing, population screening and clinical research.
- **Governments may face challenges in pursuing policy or enabling/enforcing practice** to protect and promote human rights and equity, especially for these populations. To protect all from disease transmission risks, many stakeholders have shared responsibilities and entitlements, including those affected by infectious diseases but more significant are those of governments, as duty-bearers. They must protect human rights and promote the rights and quality of life of those affected by TB and the communities they come from. They must also work across sectors, and actors, in health, labour, interior, justice, social welfare, housing, among others..
- **The large-scale movements of migrants and refugees create special and urgent challenges** for ensuring access to health services and continuity of care for affected people crossing borders, as well as stigma and discrimination due to their nationality, gender, religion, health status and due to the unsubstantiated perception of increased risk for host populations.
- **Socio-political, cultural, gender-related and legal barriers** are deeply entrenched, but the Sustainable Development Agenda provides hope to remove those barriers through concerted efforts ,including from civil society and lawmakers, and proper accountability frameworks.

Opportunities

- **The SDGs:** The Sustainable Development agenda promotes the interplay of poverty elimination, equity, justice and human rights more explicitly than previous development targets.
- **Engagement and empowerment:** Further engagement and empowerment of TB patients, families, civil society including those representing marginalized populations and health workers with policy makers, parliamentarians and the judiciary is crucial. The WHO Engage TB approach and related civil society End TB declaration and the Global Fund's Gender, Rights and Community financing are among the efforts reinforcing more engagement. Furthermore, many partners, including WHO and the Stop TB Partnership, are enabling the voice of those affected to be documented and amplified.
- **New guidance, tools and data:** A range of new WHO guidance and tools from partners have been made available in the last two years to support assessment, measurement, action and collaboration on equity, ethics and human rights in the TB response and need to be rigorously applied¹.

¹ WHO has released new *Ethics Guidance for the implementation of the End TB Strategy*. Overall guidance on implementing equity, ethics and human rights interventions are included in WHO's *Implementing the End TB Strategy: The Essentials*. The Stop TB Partnership and UNDP have produced assessment tools that are being rolled-out: (a) gender in the TB response and (b) legal environment assessments. The Global Fund requires assessment of related issues in country concept notes, has redress system for any human rights violations suspected to occur within financed projects, and is seeking to reinforce programming by countries supported CRG efforts. WHO, The Global Fund, Stop TB Partnership UNDP, USAID and others are working to improve available data



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- **Accountability frameworks** for the global HIV/AIDS and UN Child Health responses define government roles as duty-bearers and as stewards of actions by all stakeholders on rights. TB efforts could gain from adopting a similar strong accountability framework or charter.
- **On migration and TB**, a number of new guidance documents and resources are available^{2, 3}.
- **Action within the wider global agendas on migration, refugees and health:** There are upcoming opportunities with World Health Assembly discussions on a framework and global plan on migration and health, and planned adoption in 2018 of the *UN Global Compact for Refugees* and the *UN Global Compact for Safe, Orderly and Regular Migration*. These first-time high-level efforts, alongside 2017 and 2018 high-level TB events, could enable positive change for the health of nearly one billion migrants worldwide.

Actions

National level

In line with the UN Sustainable Development Agenda, the UN New York declaration for refugees and migrants (2016), WHO's End TB Strategy, and WHO's approach to health within the SDGs, health and human rights, ethics standards, and equity, Governments commit to:

PURSUE RIGOROUSLY EFFORTS THAT FULLY RESPECT AND ENHANCE EQUITY, ETHICS AND HUMAN RIGHTS TO END TB WITH PRIORITY FOCUS ON THE VULNERABLE AND MARGINALIZED

- **Fully respect equity, ethics and human rights** including to: Eliminate the social determinants of TB through multisectoral policies and practices; build stronger systems to engage and empower affected people and communities in the TB response; expand to universal free access to TB diagnosis, treatment and care, including for MDR-TB; ensure that health care workers operate, patients are served, and prisoners live in a TB safe environment; empower, and support patients to prevent TB transmission and pursue care; enable all health and social service providers to prioritize services for vulnerable and marginalized populations.

ADDRESS WITH URGENCY THE IMPACT OF TB ON MIGRANTS AND REFUGEES, AND PROTECT THEIR HUMAN RIGHT TO FULL CONTINUITY OF CARE

- **Enable access to and continuity of quality TB care for refugees and migrants** within and across borders, including via policy change, legislation and service expansion involving all public, private

on those affected by TB by geography, age, sex/gender, and risk group (see **area 5**), and to enhance action for specific groups, such as TB in children, and miners.

² WHO and the International Organization of Migration have adapted the End TB Strategy elements to the needs of migrants and TB, and WHO and UNHCR have highlighted actions for refugees. WHO's *Framework towards TB Elimination* puts special focus on top risk groups including migrants. Some WHO regional offices have frameworks for cross-border collaboration on TB and migration, or work in emergency and conflict settings. The Global Fund *Challenging Operating Environments* policy and sub-regional projects related to TB among migrants are bringing focused resources as is Stop TB's TB REACH; and the IOM has launched a TB and migration information portal.

³ The European Respiratory Society/WHO *Consilium* and US *TB Net* are examples of tools being used across countries among health providers and/or public health officials to enable better patient-centred care and continuity of care when there is cross-border movement by the individuals. Public health and immigration health officials from five low TB incidence countries (Australia, Canada, New Zealand, UK, USA) along with the IOM, WHO and ECDC are collaborating to help unify/synchronize their TB policies for migrants/immigrants and increase their collaboration with countries with high burdens of TB; there are also some experiences in cross-border collaboration on TB patient care and referral, including high burden countries, in all WHO regions. For example, Southern African countries have collaborated on documenting/aligning TB guidance and tools given large numbers of labour migrants, including particularly in the mining sector.



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and nongovernmental providers, and multisectoral and cross-national collaboration; remove policy and practices that deny access to care for migrants, including for TB screening, diagnosis, TB treatment and care; Eliminate any regulations that allow or require the deportation of persons ill with active TB before or during treatment; and

- **Advocate for and ensure government leadership in agreeing that both the *UN Global Compact on safe, orderly and regular migration*, and the *UN Global Compact on refugees* adequately and specifically address migrant health issues, and that achieving end TB targets are addressed among the priority health challenges therein.**

Global level

Governments call for the:

DEVELOPMENT OF A GLOBAL END TB CHARTER ON EQUITY, ETHICS AND HUMAN RIGHTS

- WHO, working with Member States, OHCHR and other UN partners, non-governmental actors and civil society, to develop this Charter, linked to wider human rights instruments, to be put forward for launch at the UN General Assembly High-level Meeting on TB in 2018⁴.
- Partners to financially support the development of the Charter and its implementation.

PROVISION OF A GLOBAL PLATFORM TO FACILITATE ACCESS AND CONTINUITY OF TB CARE FOR MIGRANTS AND REFUGEES

WHO with partners to provide a linked-up platform to enhance knowledge management and promote information exchange, and use of products and mechanisms from four streams of work:

- (i) **Operational standards of practice** for TB screening, diagnosis and continuity of care among migrants: WHO to work with the IOM, ECDC, IFRC researchers, experts from Ministries of Health, Interior and Labour, civil society, and other partners, to develop operational standards of practice for care for migrants and refugees to enable continuity of TB care across borders⁵.
- (ii) **Facilitation of rapid communication** of public health authorities regarding persons in need of referral for care, via WHO Regional Offices, regional entities such as ECDC, and other national, binational or international networks, such as the ERS/WHO consilium or US TB-Net, or others beyond TB.
- (iii) Expansion and maintenance of migration health and TB resources, including the best available data and good practices shared via the **IOM TB and migration information portal**, in collaboration with WHO and other partners.
- (iv) **Information and experiences-sharing among refugees and migrants**, via social and technological innovations including data applications, in partnership with UN agencies, NGOs, and other services.

⁴ It will address enabling meaningful participation of affected communities and key populations, strengthening governmental/non-government links for action on the social determinants of TB for specific populations; access to quality prevention and care services including equitable rapid access to new diagnostics, drugs and more effective future vaccines; creating enabling legal and policy environments; developing related accountability mechanisms including international and regional instruments needed to address the rights of refugees and migrants.

⁵ Including noting where there needs to be more evidence to arrive at standards, or where options are needed given widely varying operational environments affecting effectiveness, feasibility, cost-effectiveness, and acceptability, including across and within settings with high TB incidence and low TB incidence.



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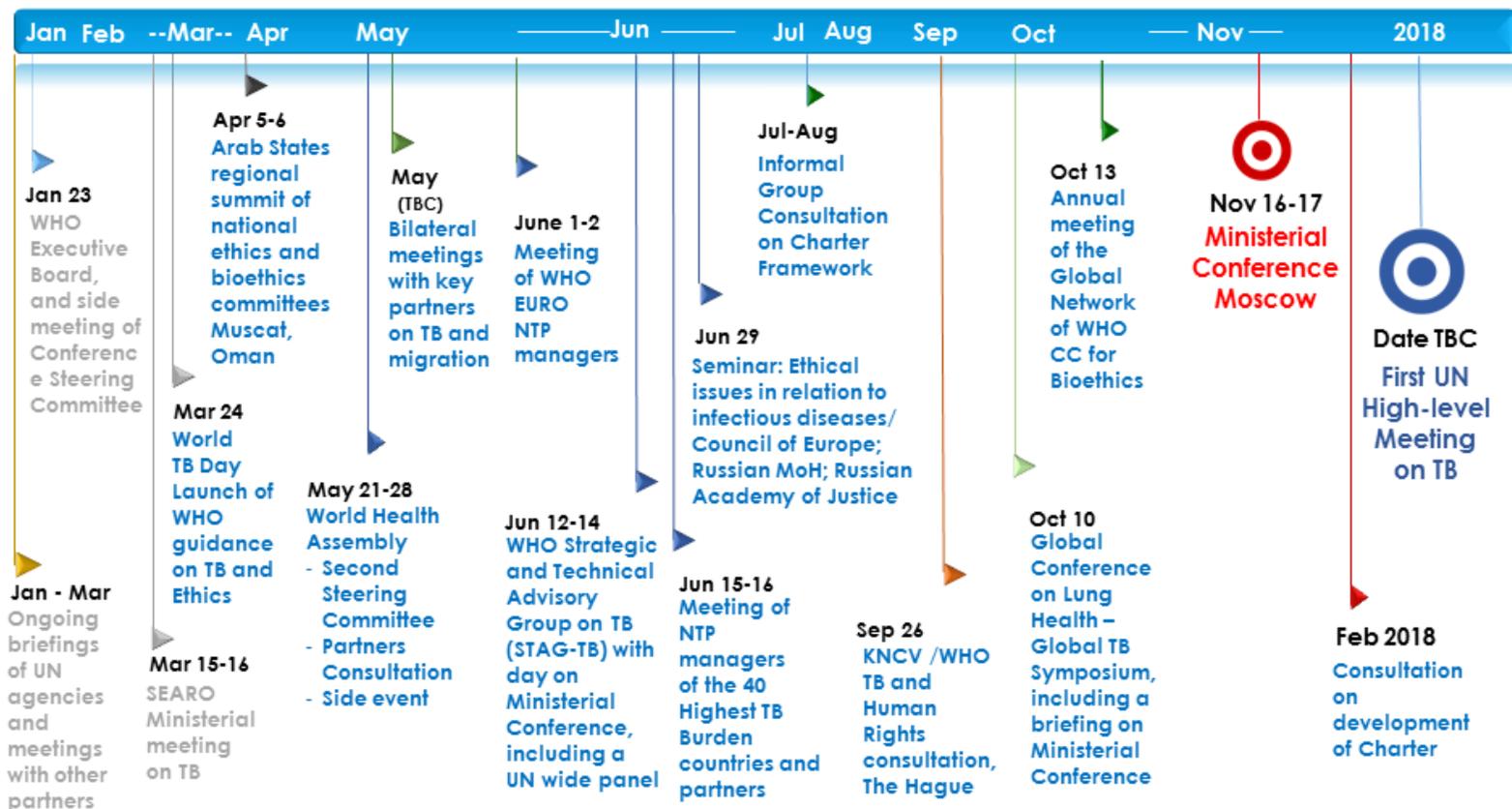
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PROVISIONAL ROADMAP

2017

2018





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KEY PARTNERS

MoH Russia

MoH Italy

Médecins Sans Frontières

Columbia University

TB ACTION Group

KNCV

TAG

US CDC

IFRC

OHCHR

University of Chicago Law School

Rutgers New Jersey Medical School Global TB Institute

LSHTM

IOM

UNHCR

UNICEF

MSF

Global Fund

Stop TB Partnership

World Medical Association

The Union

KELIN

ICN

Institute on Disability and Public Policy

WHO/EURO and WHO/WPRO

Georgetown University

TFCS

WHO Civil Society Taskforce



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KEY OUTCOME AREA 4

NEW FUNDING MECHANISM FOR GLOBAL TB RESEARCH AND INNOVATION

Increased and targeted financing and intensified capacity-building to foster rapid achievements in scientific research and innovation.

The Issue

- **Context:** The field of tuberculosis (TB) research has suffered enormous neglect over the past several decades and the consequences have been striking, with TB becoming the leading infectious disease killer in the world: in 2015, 1.8 million people died from TB, including 400,000 with HIV infection, and there is an increasing threat from drug resistant forms of the disease. This proves the need to develop more effective and affordable diagnostics, drugs and vaccines. It is critical to question the usual assumptions that have driven the field of TB research, and think in new and innovative ways, employing all the modern tools of biomedical research, to develop the transforming innovations that are needed to end the global TB pandemic. The third pillar of WHO's End TB Strategy, adopted by all WHO Member States at the World Health Assembly in May 2014, calls for salient invigorated efforts in research, along its full continuum to develop new tools and strategies for improved care and control, adapted to specific country needs.
- **Issue:** Despite some progress in the pipeline of new diagnostics, drugs and vaccines, TB research and development (R&D) remains severely underfunded. According to estimates in the Global Plan to Stop TB, at least US\$ 2 billion per year is needed for TB R&D, but only 1/3 of projected needs is currently available. Furthermore, the prospect for future R&D funding is not promising, with 2015 experiencing a lower investment globally than at the height of the recent global recession. Considering that governments are making greater demands to justify the expenditure of public funding on research, there is an increasing pressure for assessments of the wider public health impact of research.
- **Aim:** The risk of losing the gains made in the past decade is real and we must take immediate action. WHO is calling upon all Member States to pursue bold actions to effectively tackle TB. The 2030 global targets will not be achievable unless all existing interventions are implemented in an optimal way and new transformational tools are developed and used everywhere. This requires strong decision and commitment, especially from high- and medium-TB burden countries to stepping up their TB response efforts, including investments in health R&D, with well-developed and clearly visible asks for TB research, thus allowing the End TB Strategy pledged to support at the World Health Assembly in 2014 to be successful.



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Challenges

- **TB is responsible for 1.78% of disability-adjusted life-years (DALYs)** and 2.24% of deaths globally, but only receives 0.25% of the estimated \$265 billion spent on medical research annually.
- **With a global figure of \$620,600,596 in 2015**, funding for TB R&D has not grown appreciably since 2009. It has decreased by 50 million USD since the preceding year, and has even lost ground in the face of inflation. Consequently, TB R&D pipeline has lagged behind those for HIV and malaria, suggesting that limited funding has slowed the pace of research.
- **There is a concentration of funding among a few donors from a few countries:** the United States government and the Bill & Melinda Gates Foundation together accounted for almost 60 percent of TB R&D funding over the last 10 years, witnessing an insufficient solidarity underpinning the TB research cause.

Opportunities

- **The MDR-TB crisis cannot be confronted with a business-as-usual approach.** It needs to be addressed with a sense of urgency driven by innovative funding mechanisms, multisectoral approaches and catalytic interventions. At the global level, at least two high-level initiatives present ample opportunity to address MDR-TB within broader health agendas:
- **The Global Action Framework for TB Research published by the WHO** in support of the 3rd Pillar of the End TB Strategy serves as a blueprint for the promotion of research both at the national and global levels, relying on the development of national and regional TB research agendas and networks, as well as on regular information sharing fora, such as the Global TB Research Funders' Forum;
- **The TB R&D pipeline has significantly expanded** in the past decade, with potential promising compounds emerging. With more focused research investments that can help identify and implement the most suitable tools and interventions that will transform current approaches, there is a chance to progress more rapidly;
- **With the establishment of a new institute by the Bill & Melinda Gates Foundation** that also prominently includes in its portfolio TB research, there will be an additional impetus to intensify prioritized projects as long as current efforts by existing agencies and the research expertise they established are maintained, nurtured and linked with the new efforts.
- **As awareness on the global TB burden amplifies**, research implementation and investment should progressively shift from high-income low TB burden countries to middle and lower-middle income countries with high TB burden. Brazil, Russia, India, China and South Africa (BRICS), as well as new emerging economies in Latin America, Vietnam, Indonesia and Africa, could play a major role in this.



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Actions

The combination of high risk in product development and market failure has resulted in starving of the TB R&D pipeline. To meaningfully boost TB R&D in a manner that enables tangible progress in TB control, there is a need to increase public investment in research on diagnostics, treatment and prevention, linked with the wider socio-economic challenges of TB. Currently, high and medium TB burden countries back only a tiny fraction of TB R&D. If public funding for TB R&D is not increased, particularly among the BRICS that bear about half of new TB cases and deaths globally, TB and associated negative externalities will not be overcome. Activities are needed both at the national and global levels to advance urgently needed tangible progress in TB R&D:

National level:

A SOLID RESEARCH ENABLING ENVIRONMENT: Country level research is critical in developing and evaluating tools and approaches that most appropriately match context-specific TB prevention and control needs. To bring this to fruition, policy makers in high and medium TB burden countries should develop and/or implement existing frameworks that enable:

- Increased investment in health research at national level, with well-defined percentage contribution to TB research;
- Multi-sectoral collaboration to increase TB research capacity with a view to develop a sustainable workforce of TB researchers, as well as infrastructure, capable of conducting and using TB research;
- Reduced regulatory and structural impediments that make TB research unattractive - particularly the extensive amount of time needed to seek regulatory approval for clinical research - for example, by standardizing and expediting review process for TB clinical research applications.

Global level:

INNOVATIVE FUNDING STREAMS: Effective response to the urgent need for TB R&D solutions requires exploration of innovative collaborative or joint funding models to advance scientific discovery with high resource-needs. We propose the establishment of a Global Coalition for TB Research & Development to act as an engagement platform at the forefront of efforts to stimulate, harmonize and unite for R&D to end TB in the context of SDGs.

THE COALITION AIMS TO:

- Strategically leverage existing national and international mechanisms that support TB R&D, through a joint funding approach to support large-scale projects and approaches with highest public health impact, avoid duplication, and ensure efficient use of existing resources in a manner that aligns with the interests of investors, recipients and patients;
- Improve global coherence in TB R&D investment, based on pressing international TB R&D priorities, including in neglected domains like prevention and social determinants of health;
- Broaden the funder base and engage new funders and non-traditional recipients of R&D, and build a collaboration network among recipients;
 - Support national research regulatory agencies in developing a stable and consistent regulatory environment for TB R&D.



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ADOPTING A NEW PROACTIVE APPROACH TO TB R&D FUNDING AT BOTH COUNTRY AND GLOBAL LEVEL is essential to developing the knowledge base and tools necessary to identify, adopt and scale up innovative, cost-effective and sustainable best practices needed to end TB. Without innovation, we cannot achieve the SDGs. Considering that TB investment is dwindling, this policy brief urgently calls for high and medium TB burden countries, partners and funders of TB research to address TB R&D needs upfront, mirrored by adequate policy frameworks that can facilitate the use of complementary strengths to overcome scientific, organisational, regulatory and economic barriers critical to ending TB.

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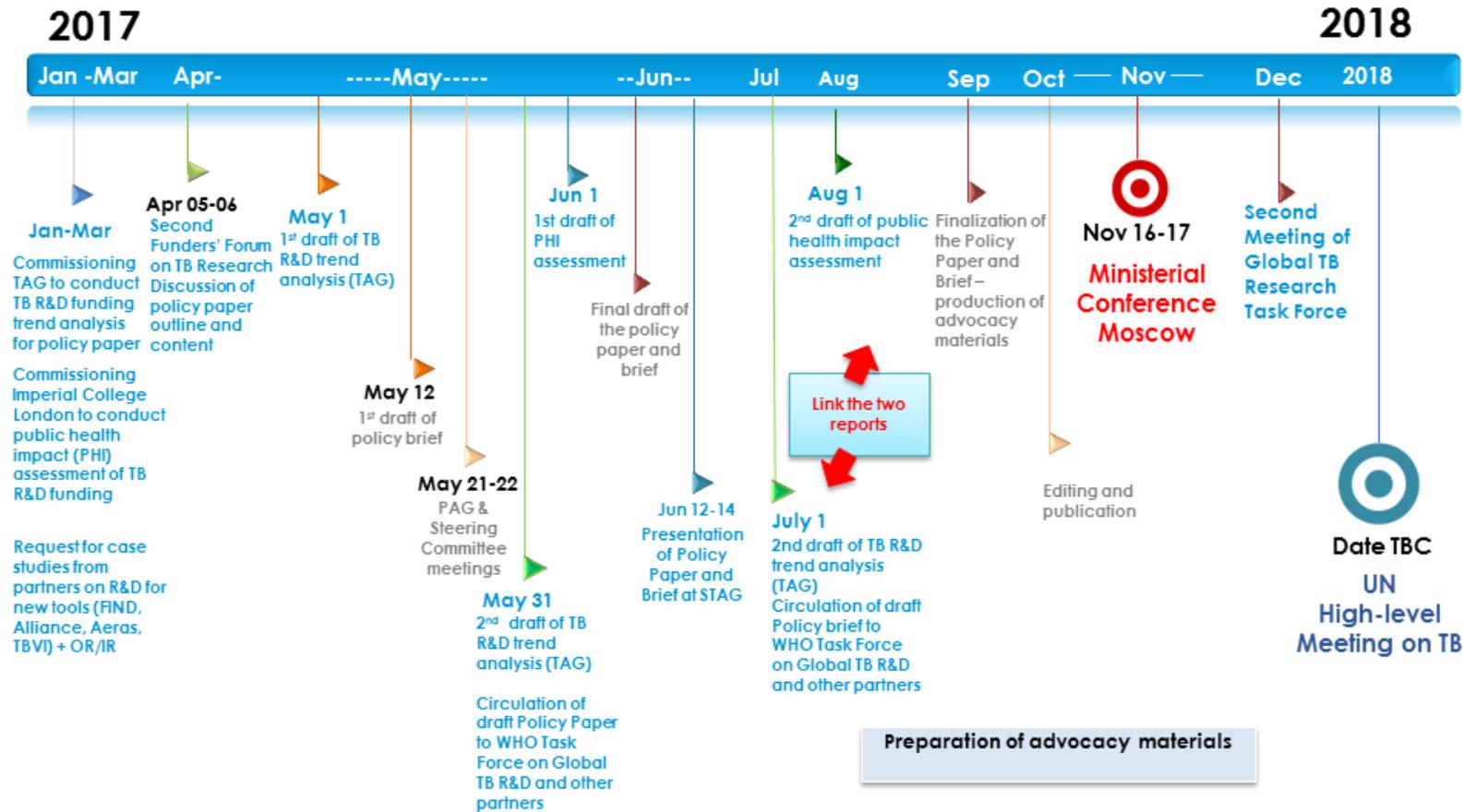
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KEY OUTCOME AREA 5

MONITORING AND EVALUATION OF TB IN THE CONTEXT OF THE SDGs

Tracking progress towards SDG Target 3.3 and other SDG targets that impact the TB epidemic, and establishment or strengthening of digital systems to collect, store and analyse large volumes of disaggregated data.

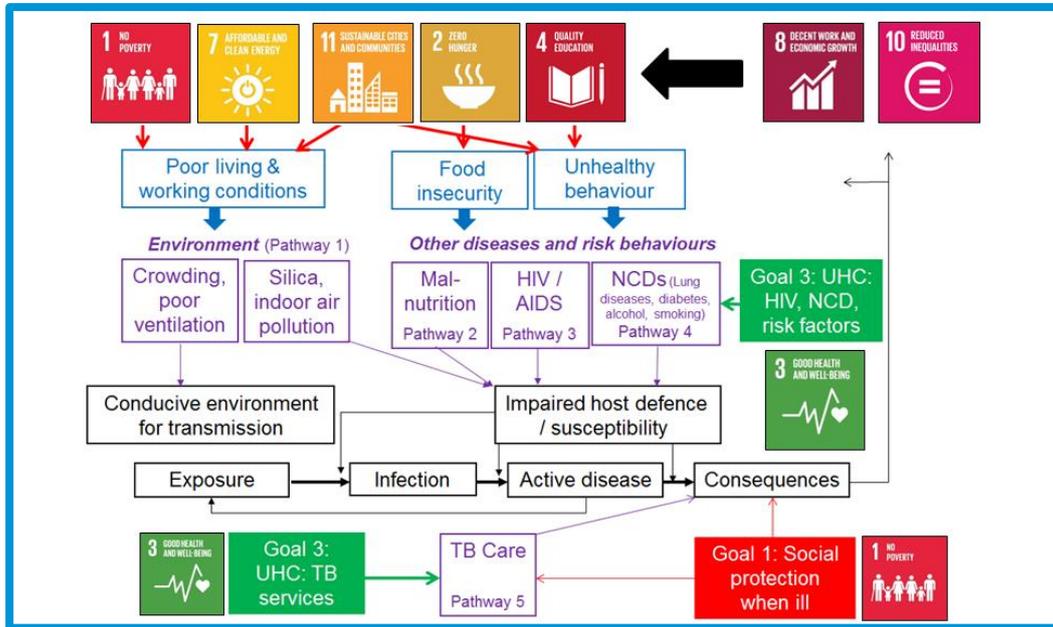
The Issue

- **TB monitoring and evaluation** needs to be expanded and intensified in the context of the Sustainable Development Goals (SDGs).
- **The SDGs and WHO's End TB Strategy** have set ambitious targets for reductions in TB incidence and the number of TB deaths. SDG Target 3.3 includes ending the TB epidemic by 2030; the indicator to track progress is TB incidence. The End TB Strategy includes targets for an 80% reduction in the TB incidence rate and a 90% reduction in the number of TB deaths by 2030, compared with 2015.
- **The third high-level target of the End TB Strategy** is that no TB patients and their households should face catastrophic costs as a result of TB disease by 2020 (to be sustained thereafter).
- **Achieving these SDG and End TB Strategy targets** requires provision of TB diagnosis and treatment within the broader context of universal health coverage (UHC, defined as access to essential health services with financial protection) and development and use of better medical technologies for TB diagnosis, treatment and prevention. It also requires multisectoral action to address the social and economic determinants and consequences of TB (Figure 1).
- **TB monitoring and evaluation** of TB-specific indicators is well established at global and national levels. This needs to be nurtured and constantly improved, as well as expanded to include analysis of other indicators, within and beyond those in health that will influence progress towards SDG and End TB Strategy targets, with findings used to inform multisectoral action.
- **To ensure that the TB-specific information required to reliably track the TB epidemic**, assess progress towards targets and promptly inform the response are available, greatly intensified efforts are required. Ideally, all countries should have national systems for electronic case-based reporting and national vital registration systems with coding of causes of death that meet coverage and quality standards, complemented by periodic surveys when appropriate.



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Figure 1: Links between SDGs and TB prevention and care



Challenges

- **The SDG framework includes targets and indicators** related to broader determinants of the TB epidemic, providing the basis for a TB-SDG monitoring framework.
- **A TB-SDG monitoring framework consisting of 14 indicators** under SDGs 1, 2, 3, 7, 8, 10 and 11 is proposed (box). These are indicators for which there is evidence of a direct link with TB incidence. Analysis of the status of and trends in these indicators can be used to identify and prioritize multisectoral actions needed at country level to end the TB epidemic.

Proposed TB-SDG monitoring framework: 14 indicators under 7 goals

SDG 3 (ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING)

- HIV prevalence; diabetes prevalence; prevalence of alcohol misuse disorder; coverage of essential health services (composite indicator, includes TB treatment coverage as one of 16 tracer indicators); percentage of total health expenditures that are out-of-pocket; government health spending per capita; prevalence of smoking among those aged ≥15 years

SDGS 1, 2, 7, 8, 10 AND 11

- SDG 1 (End poverty): proportion of population living below the absolute poverty line; proportion of population covered by social protection floors/system
- SDG 2 (End hunger): prevalence of undernourishment
- SDG 7 (Affordable and clean energy): prevalence of using biofuels for cooking
- SDG 8 (Sustained economic growth): GDP per capita
- SDG 10 (Reduced inequalities): Gini coefficient
- SDG 11 (Sustainable cities and communities): proportion of urban population living in slums, informal settlements or inadequate housing



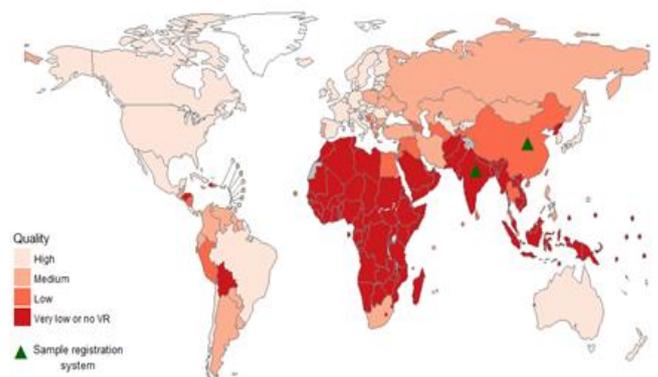
Opportunities

- The proposed TB-SDG framework requires little additional effort in data collection, since tracking of these indicators for national populations is already part of the SDG framework and associated national and United Nations (UN) monitoring processes.
- National systems for electronic case-based TB surveillance that meet coverage and quality standards have important advantages:
 - Can be used to directly measure TB incidence from national case notifications.
 - Allow for more complex analyses, including by age, sex and location (as called for under SDG 17), which enable adaptation and targeting of response efforts both geographically and for specific population groups.
 - Facilitate improved clinical management of patients.
 - Have potential to reduce staff workload.
- A WHO TB surveillance checklist (show cover page as graphic) that can be used to assess whether national TB notification systems meet quality and coverage standards, and to define actions needed to close identified gaps, already exists.
- Many countries already have electronic case-based surveillance systems for TB (Figure 2) and improved technology and information infrastructure is making them more feasible in all countries.
- National vital registration systems with coding of cause of death have been in place for more than a century in some countries, but need to be built or further developed in many others (Figure 3), as also called for under SDG 17. Standards for assessing quality and coverage, and guidance on the development of such systems, already exist.
- Some data on SDG indicators that are of direct relevance for patient care could be collected for TB patients specifically, through routine TB surveillance. These include nutritional status to inform need for food support programmes, and social assessment to facilitate access to existing social protection schemes. However, there is a risk of making routine TB surveillance far too complex, which needs to be avoided. Periodic surveys offer an alternative.
- A transition from aggregated paper-based systems for TB recording and reporting to case-based electronic surveillance systems requires careful planning. WHO guidance is available.

Figure 2: Countries with (dark green) and without (light green) national electronic case-based surveillance for TB in 2016



Figure 3: Quality of cause of death data from national vital registration in 2016





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Actions

National level:

ADHERE TO THE PROPOSED TB-SDG MONITORING FRAMEWORK and use it to analyze determinants of TB and identify and prioritize the multi-sectoral actions required to improve TB prevention and care.

ENSURE THAT THE HEALTH INFORMATION REQUIRED TO RELIABLY TRACK THE TB EPIDEMIC, assess progress towards targets and promptly inform the response are available, in particular by:

- Establishing (or sustaining) national electronic case-based surveillance systems for TB that meet quality and coverage standards;
- Improving (or sustaining) the availability of cause of death data from national vital registration systems that meet quality and coverage standards;
- Conducting surveys of costs faced by TB patients and their households every 3–5 years.

Global level:

WHO TO EXPAND GLOBAL TB MONITORING TO INCLUDE THE TB-SDG MONITORING FRAMEWORK, with regular analysis and reporting of findings in the WHO Global TB Report, and improved modelling of future trends in TB burden accounting for the impact of development indicators.

PROVIDE GUIDANCE AND SUPPORT TO COUNTRIES TO DIRECTLY TRACK THE TB EPIDEMIC and to analyse and use TB and other data to inform the response, under the umbrella of the WHO Global Task Force on TB Impact Measurement.



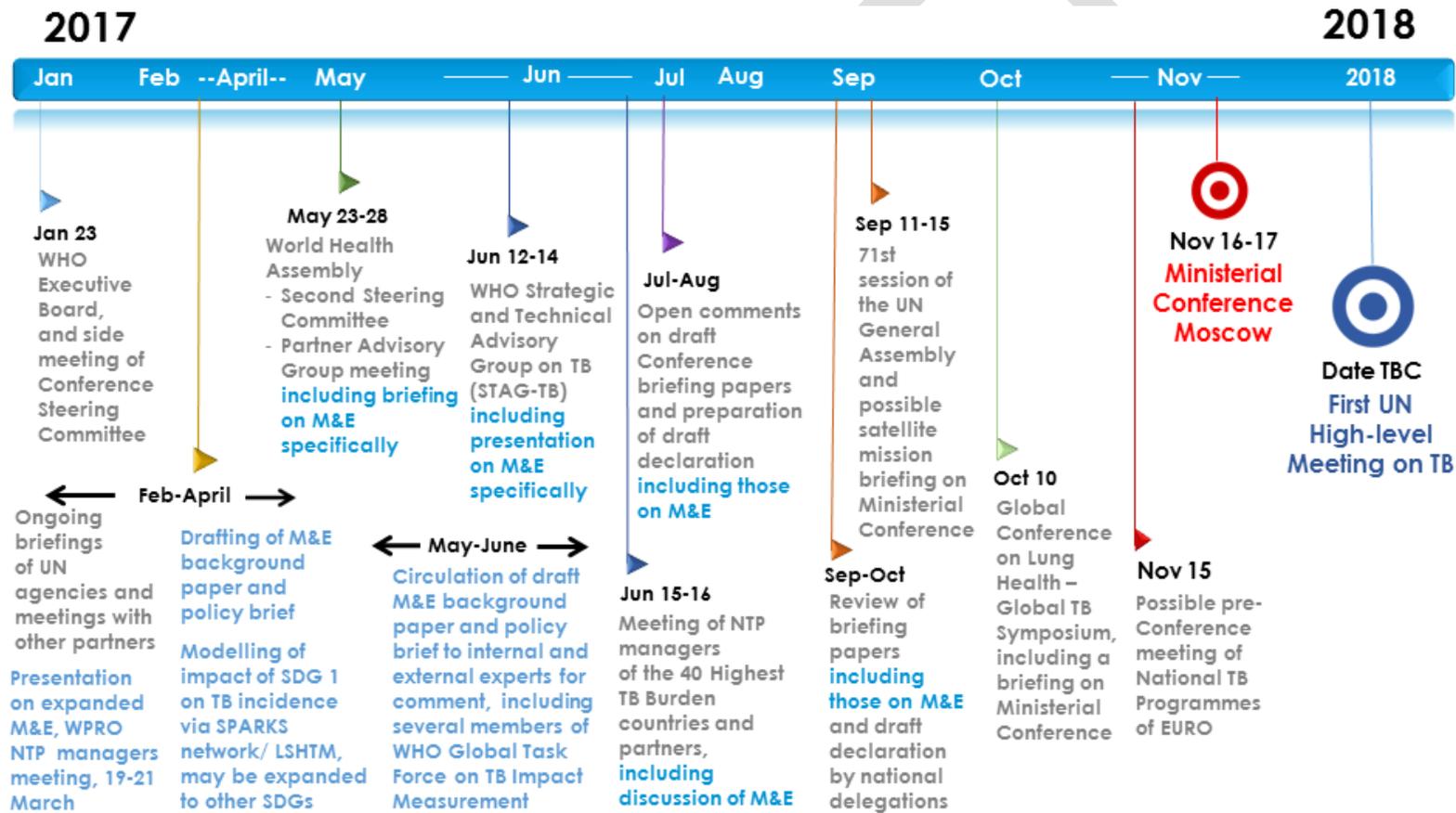
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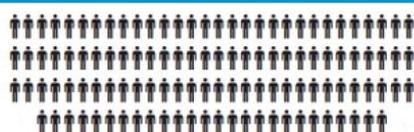


KEY OUTCOME AREA 6 ACTION ON AMR, HEALTH SECURITY AND MDR-TB

The Issue

- A devastating epidemic at the core of antimicrobial resistance (AMR) currently goes largely unnoticed and is therefore seriously neglected – drug-resistant TB, **the most common and lethal airborne AMR disease** worldwide. **Over 50%** of the estimated global MDR-TB burden occurs in previously untreated TB patients, indicating **high levels of transmission**.
- Drug resistance to the main first-line TB medicines – rifampicin, or rifampicin together with isoniazid (combined as ‘MDR-TB’ in this paper given the need for second-line treatment) – is especially devastating. MDR-TB patients need **prolonged treatment** (often up to two years) with **costly, highly toxic, and much less effective second-line medicines**, of which there is only a **limited number**. Moreover, in **up to 50% of MDR-TB patients**, second-line regimens are already compromised by **additional drug resistance** and **10%** have so-called **extensively drug-resistant disease (XDR-TB)**, drastically reducing their options for cure.
- MDR-TB continues to pose a public health crisis: In 2015, WHO estimated that **580,000 new cases and 250,000 deaths** occurred globally. However, country reports to WHO show that only **30%** of TB patients notified worldwide are even **tested** for drug resistance, only **22%** of those eligible **start MDR-TB treatment** and only **52%** of these **complete treatment successfully** (Figure 1); Moreover, a large proportion of XDR-TB cases are **newly transmitted** and **M/XDR-TB outbreaks** with **highly lethal outcomes** have resulted in public health emergencies in several countries.

*Figure 1:
The global
MDR-TB response,
2016*



480 000 people fell ill with MDR-TB in 2015. There were an additional **100 000** people with rifampicin-resistant TB who also required second-line treatment

132 000



MDR/RR-TB cases detected in 2015

125 000



patients started on MDR-TB treatment in 2015

52%

treatment success in MDR/RR-TB patients starting treatment in 2013



Challenges and opportunities

- Patients with MDR-TB face **agonising, prolonged suffering** and often **permanent disability** while on treatment, together with **devastating economic hardship, stigma and discrimination**. Health services are confronted by numerous **ethical, legal and human rights challenges**, given ongoing airborne transmission of the disease, with explosive outbreaks described in congregate settings.
- The global response to the MDR-TB crisis will determine if the targets of WHO's End TB Strategy are achieved; however, up to this point **the MDR-TB response has been dismal**. Drastically **increased political will** to prioritize serious gaps in health service delivery, underpinned by **increased funding** for universal diagnosis, effective treatment, and comprehensive patient support will be essential to avoid a major human catastrophe.
- The MDR-TB crisis demonstrates many of the **challenges** that will be faced by **broader AMR control efforts** – high burden and mortality; limited diagnostic coverage and treatment enrolment; poor treatment outcomes and formidable health systems challenges; inadequate infection prevention and control; suboptimal investment in disease management, research and development; and insufficient political commitment compounded by malaise and complacency;
- The MDR-TB response has highlighted several **critical elements** that are essential for the control of drug-resistant infectious diseases in countries - good quality surveillance, rapid diagnosis of drug resistance, rapid, appropriate treatment, adequate infection prevention and control, and good care delivery systems with trained health personnel. Moreover, **problems in treating MDR-TB can point to a country or institution's readiness to tackle AMR**.
- The **AMR response** at country, regional and global level could greatly benefit from the lessons learnt while facing the challenges by TB care and control and by adopting some of the solutions. Moreover, **innovations** in diagnostic platforms, logistics and digital technologies for sharing data can be used to **link TB and AMR programmes** at the country level. **Existing, cross-cutting systems** such as regulatory frameworks, surveillance systems, and infrastructure for laboratory services and infection control represent additional resources to governments implementing AMR plans.
- The MDR-TB crisis cannot be confronted with a business-as-usual approach. It needs to be addressed with a sense of urgency driven by **innovative funding** mechanisms, **multisectoral approaches** and **catalytic interventions**. At the **global level**, at least two high-level initiatives present ample opportunity to address MDR-TB within broader health agendas:
 - the **WHO Global Action Plan on Antimicrobial Resistance (AMR)**, which calls for inclusive, multisectoral and innovative partnerships to foster the development of antibiotics, responsible use of medicines, coordinated research and development of new drugs, diagnostics and vaccines (in close collaboration with industry), with strategies to ensure affordability and access for all;
 - The **Global Health Security Agenda (GHSa)**, an effort between nations, international organizations, and civil society to accelerate progress toward a world safe and secure from infectious disease threats and to promote global health security as a national and international priority (<https://www.ghsagenda.org>).
 - Established in 2014, the GHSa outlines the **capacities required for countries** to prepare for and respond to public health threats and reduce the risk of these threats crossing borders.



- Since its establishment, 55 countries have joined the GHSA and the **G7 leaders have committed to help countries** build the systems necessary to be aware of, track, and act against infectious disease outbreaks within their borders. These efforts cut across agencies, encompassing ministries of health, environment, agriculture, and security, and have received private sector support.
- **12 of the 30 high-burden MDR-TB countries** are already signatories to the GHSA,¹ which outlines 11 discrete **Action Packages** within a Prevent-Detect-Respond framework encompassing clear targets. The majority of the Action Packages are highly relevant to MDR-TB and AMR as well, including improving **laboratory capacity**, conducting real-time **surveillance and reporting**, **workforce development**, and **linking public health** with legal and other multisectoral responses.
- The list of **10 core tests** that should be available in signatory countries to the GHSA already includes TB diagnosis (currently listed as microscopy, which according to WHO standards for **TB diagnosis** has now been replaced by **rapid, molecular tests** such as Xpert MTB/RIF®). This means that signatory countries can mount a response under the GHSA without delay.
- Using the GHSA and AMR agendas, high-burden MDR-TB countries should be able to raise the visibility of the M/XDR-TB epidemic and elevate it to a public health crisis requiring an **'emergency response'**. This would allow governments to use existing legislative and other frameworks to invoke the necessary measures and access funding outside of conventional health budgets.
- Another opportunity would be to highlight **M/XDR-TB 'hot spots'** and apply existing frameworks for public health emergencies to **target specific vulnerable areas/settings** such as prisons, mines, health care services, etc.

Actions

National level:

DECLARE MDR-TB AS A NATIONAL PUBLIC HEALTH CRISIS requiring an **emergency response** and **sign up to the GHSA** or an **alternative local mechanism** that can provide equivalent support;

INVOKE EXISTING MECHANISMS TO URGENTLY ACCELERATE SPECIFIC, TARGETED AND COORDINATED ACTIONS using local or global frameworks such as the GHSA to access funding for an emergency response. This also means **increasing domestic budgets** for acceleration of MDR-TB containment efforts and **focused research efforts** undertaken with national and international institutions;

PREPARE URGENT MDR-TB EMERGENCY RESPONSE PLANS with a three-year target and budget, supported by interim indicators to establish baseline assessment and planning, measure progress, desired impact, and multisectoral commitments. Such plans should include diagnostic and

¹ Azerbaijan, Bangladesh, China, Ethiopia, India, Indonesia, Kenya, Pakistan, South Africa, , Ukraine, Vietnam, Zimbabwe



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treatment algorithms aimed towards **universal access to care and prevention**, including appropriate **infection control** measures. They should also include establishment of national **priorities for MDR-TB research**, engaging all relevant institutions.

Global level:

ESTABLISH URGENT AND PROMINENT SPACE FOR THE MDR-TB CRISIS within the global AMR agenda and the GHSA, including research and development towards innovative interventions (WHO with AMR and GHSA secretariats);

COMMIT TO INCREASED FUNDING AND FLEXIBILITY OF INVESTMENT, eg. a special funding line within the Global Fund to support countries accelerating the response to MDR-TB through national emergency plans (Multilateral donors);

TRACK PROGRESS IN THE MDR-TB EMERGENCY RESPONSE and develop a rapid-response approach to barriers detected (WHO and technical agencies providing support for scale-up of MDR-TB activities).



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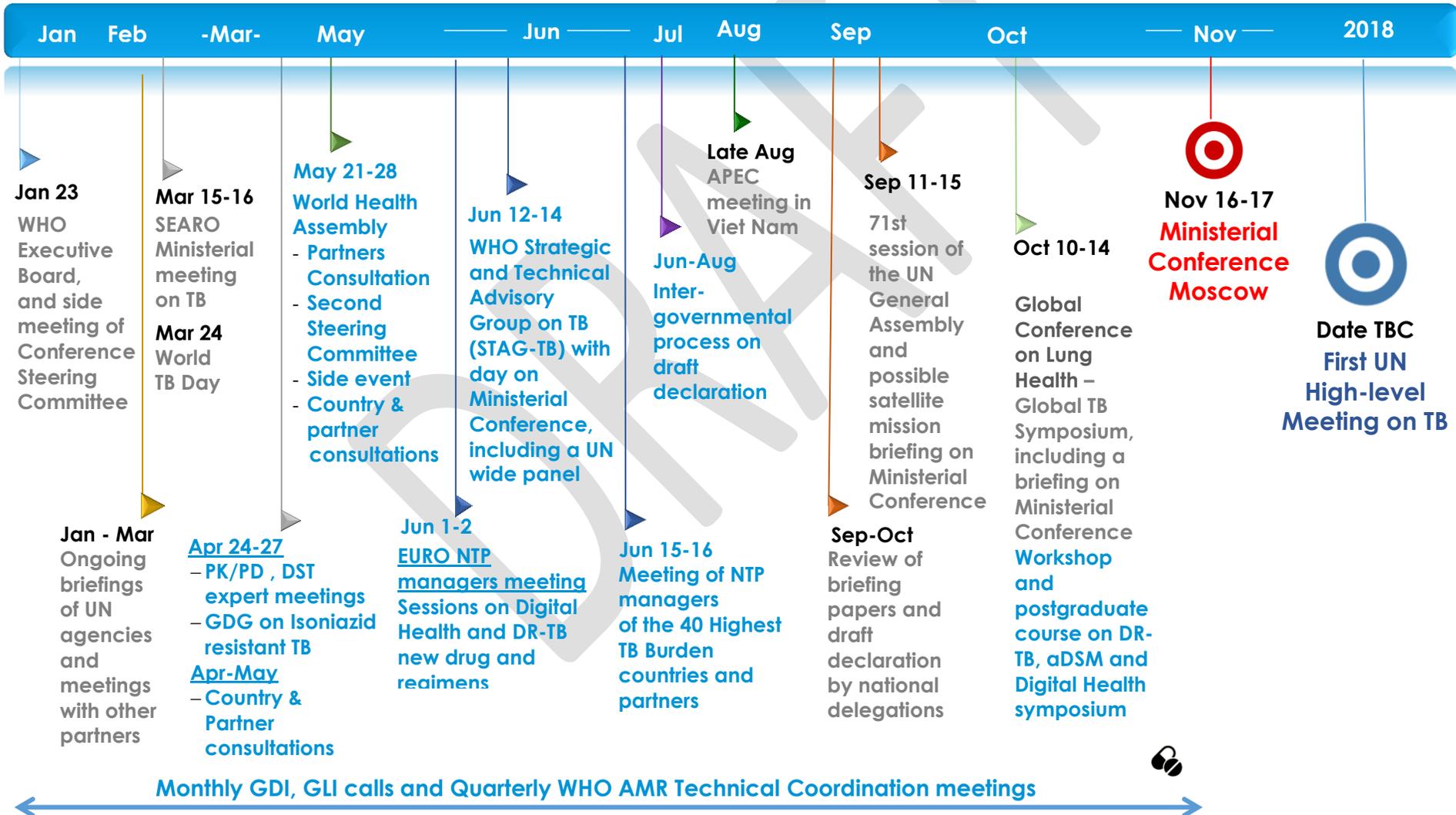
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KEY PARTNERS

- Global TB Drug Resistance Initiative
- Global TB Laboratory Initiative
- UNITAID
- FIND
- TB Alliance
- KNCV
- UNION
- MSF
- PIH
- URC
- MSH
- FHI360
- PATH
- Global Fund
- BMGF
- USAID
- European Respiratory Society
- American Thoracic Society
- Ministry of Health of the Russian Federation

- WHO
 - Service delivery and safety department
 - Research, ethics and knowledge department
 - Management of non-communicable diseases department



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KEY OUTCOME AREA 7

STEPPED-UP TB/HIV RESPONSE

Integrated care for all people affected by TB and HIV, with a special focus on eliminating TB deaths among people living with HIV.

The Issue

- **Context:** HIV is among one of the biggest risk factors for development of tuberculosis (TB) while TB is the leading cause of death among people living with HIV (PLHIV). Since release of the WHO policy on collaborative TB/HIV activities in 2004, revised in 2012, there has been impressive scale-up of the TB/HIV response globally, saving an estimated 6.5 million lives globally between 2005 and 2015. In 2015, 55% of the notified TB patients had known HIV status (81% in the African Region) and 78% of those co-infected started antiretroviral therapy (ART). Close to a million PLHIV newly enrolled in HIV care received TB preventive treatment in 58 countries.
- **Issue:** Despite global progress and the fact that HIV-associated TB is both preventable and curable, an estimated 1.2 million PLHIV developed TB in 2015, resulting in some 390,000 deaths. A third of all people estimated to have been living with HIV who contracted TB died from it in 2015. This contrasts strongly with the 15% of deaths among HIV-negative TB patients in the same year. Autopsy studies report up to 64% HIV-positive cadavers having TB, in 46% of which TB is undetected prior to death, highlighting further gaps.
- **Aim:** The overall aim of a stepped-up TB/HIV response is to eliminate excess TB-deaths among PLHIV – so that they are, at minimum, comparable with HIV-negative TB deaths - by the year 2020. It calls for an accelerated global response for effective TB prevention; early diagnosis of TB and MDR-TB through rapid adoption of new tools; and early treatment of HIV-associated TB including MDR-TB. Coordinated TB and HIV programming and integrated delivery of care are central to ensuring access to the right services and to eliminating excess TB deaths among PLHIV.

Challenges

- **Slow adoption of policies and implementation of key interventions** such as TB preventive treatment has undermined access to critical life-saving services. 21 of the 30 priority TB/HIV countries did not report data on provision of TB preventive treatment in 2015 with coverage in reporting countries varying widely from 2% in Indonesia to 79% in Malawi.
- **Slow roll-out and uptake of the latest diagnostic technologies** critical for TB diagnosis in PLHIV (e.g. Xpert MTB/RIF and LF-LAM) is a barrier to timely case detection. Close to 60% of estimated 1.2 million HIV-positive TB cases did not reach care in 2015. Only a third of estimated HIV-positive TB cases were started on ART.
- **Excessive verticality, uncoordinated TB and HIV planning** Excessive verticality, uncoordinated TB and HIV planning and separate TB and HIV service delivery, are creating barriers to early diagnosis and treatment of HIV-associated TB, hampering patient follow-up throughout the care continuum, and undermining successful TB treatment outcomes among people living with HIV.



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- **Inadequate ownership and funding allocation by HIV and TB programmes** is resulting in inequitable access to the vital services required by people affected by TB and HIV.

Opportunities

- **Scale-up of TB/HIV policy and tools** has made demonstrable impact on reduction of mortality from HIV-associated TB.
- **Large-scale adoption** by countries of the ambitious 90-90-90 targets for ending HIV and “Treat All” and the momentum set by the SDG targets including those on ending the AIDS and TB epidemics, present immense opportunities to ensure the integration of TB interventions as part of the comprehensive HIV care package.
- **New and shorter TB preventive treatment regimens** and fixed dose combinations promise to stimulate scale-up of TB preventive treatment.
- In the SDG multisectoral approach era, **unexploited platforms for integrating TB/HIV services** such as reproductive, maternal, neonatal and child health and harm reduction services present opportunities for expanding access further.
- **Initiatives** such as the single concept note for Global Fund financing have shown value in bringing TB and HIV programmes together for joint planning.

Actions

The global TB case fatality ratio (estimated deaths divided by estimated new cases) among HIV-negative TB patients was 15% in 2015, compared with 33% among HIV-positive TB patients. It is proposed that political leadership and momentum intensify efforts to eliminate excess TB deaths among people living with HIV. This means that national authorities should target and consolidate their efforts to substantially reduce case fatality ratios (CFR) and ensure that, at minimum, the CFR among people living with HIV does not exceed that of HIV-negative TB patients, namely 15%, by 2020. This would lead to a 55% global reduction from 2017-2020. In order to achieve this, the following actions will be necessary:

National level:

DEVELOP NATIONAL PLANS AND TARGETS TO SUBSTANTIALLY REDUCE CASE FATALITY RATIOS AND ELIMINATE EXCESS TB DEATHS AMONG PEOPLE LIVING WITH HIV BY 2020

through political momentum and scale-up of the Three E's (Effective TB prevention, Early diagnosis and Early treatment of HIV-associated TB/MDR/TB).

ENSURE QUALITY AND INTEGRATED CARE DELIVERY THROUGH JOINT TB AND HIV PROGRAMMING.

Key to joint programming is the establishment of functional and accountable joint coordinating bodies, and the alignment of critical components within the health system, including health information systems, laboratory and diagnostic services, procurement and supply chain management systems, health workforce, financing, as well as engagement of communities and key populations.

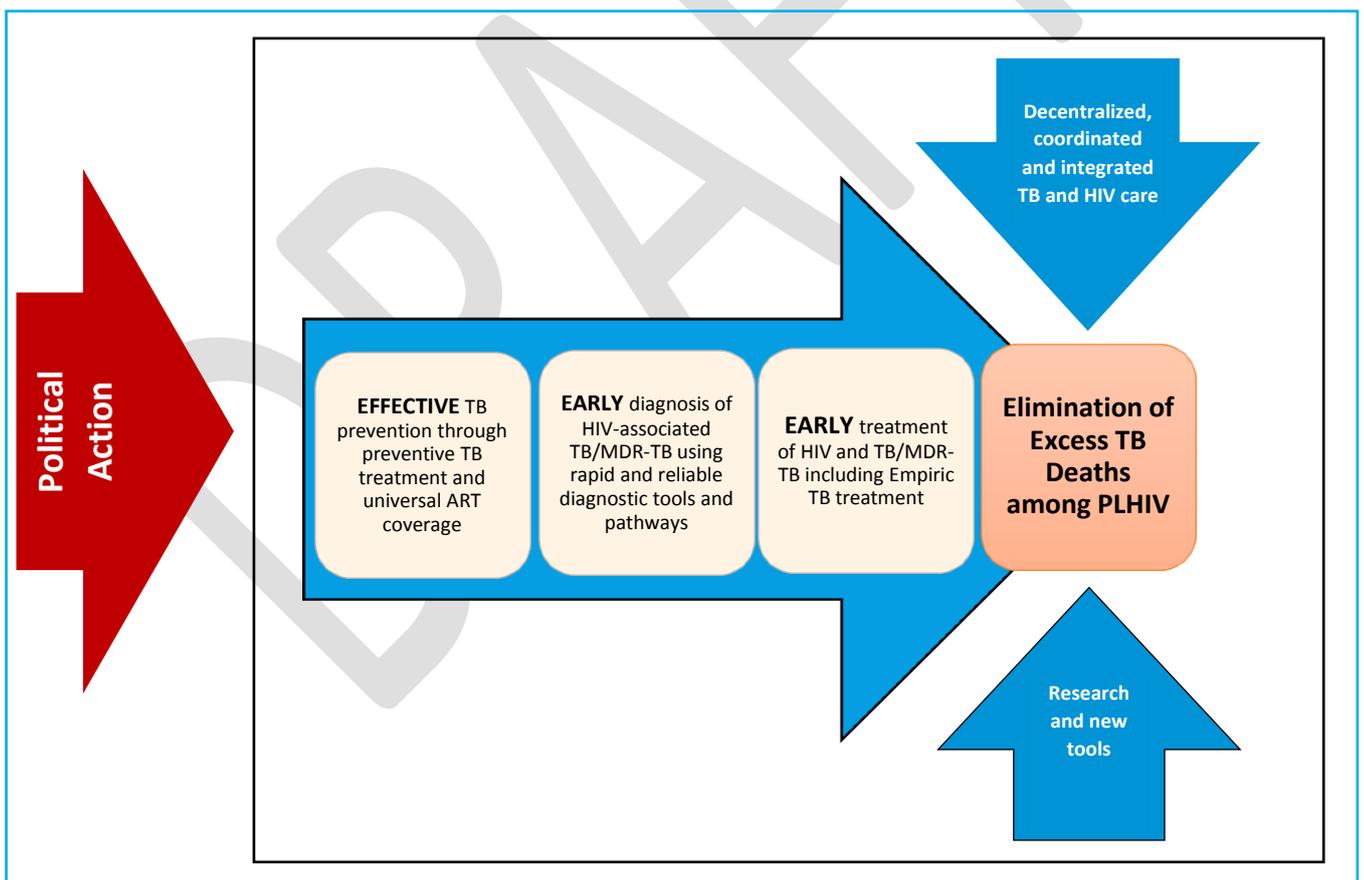


Global level:

COORDINATE TECHNICAL ASSISTANCE AND COUNTRY SUPPORT TO IDENTIFY BOTTLENECKS AND TRACK PROGRESS IN ACHIEVING ELIMINATION OF EXCESS TB DEATHS AMONG PEOPLE LIVING WITH HIV.

International organizations and partners to coordinate and ensure harmonization of technical assistance to support the scale-up of access to the Three E's, ensuring integrated care is a minimum requirement for joint programming. Research activities should also be harmonized to ensure equitable access to new tools that accelerate the elimination of excess TB deaths and assure effective prevention, early detection and co-management of HIV-associated TB/MDR-TB.

CREATE MECHANISMS FOR EXPERIENCE SHARING AMONG REGIONS AND COUNTRIES to promote and catalyse best practice, including community engagement.





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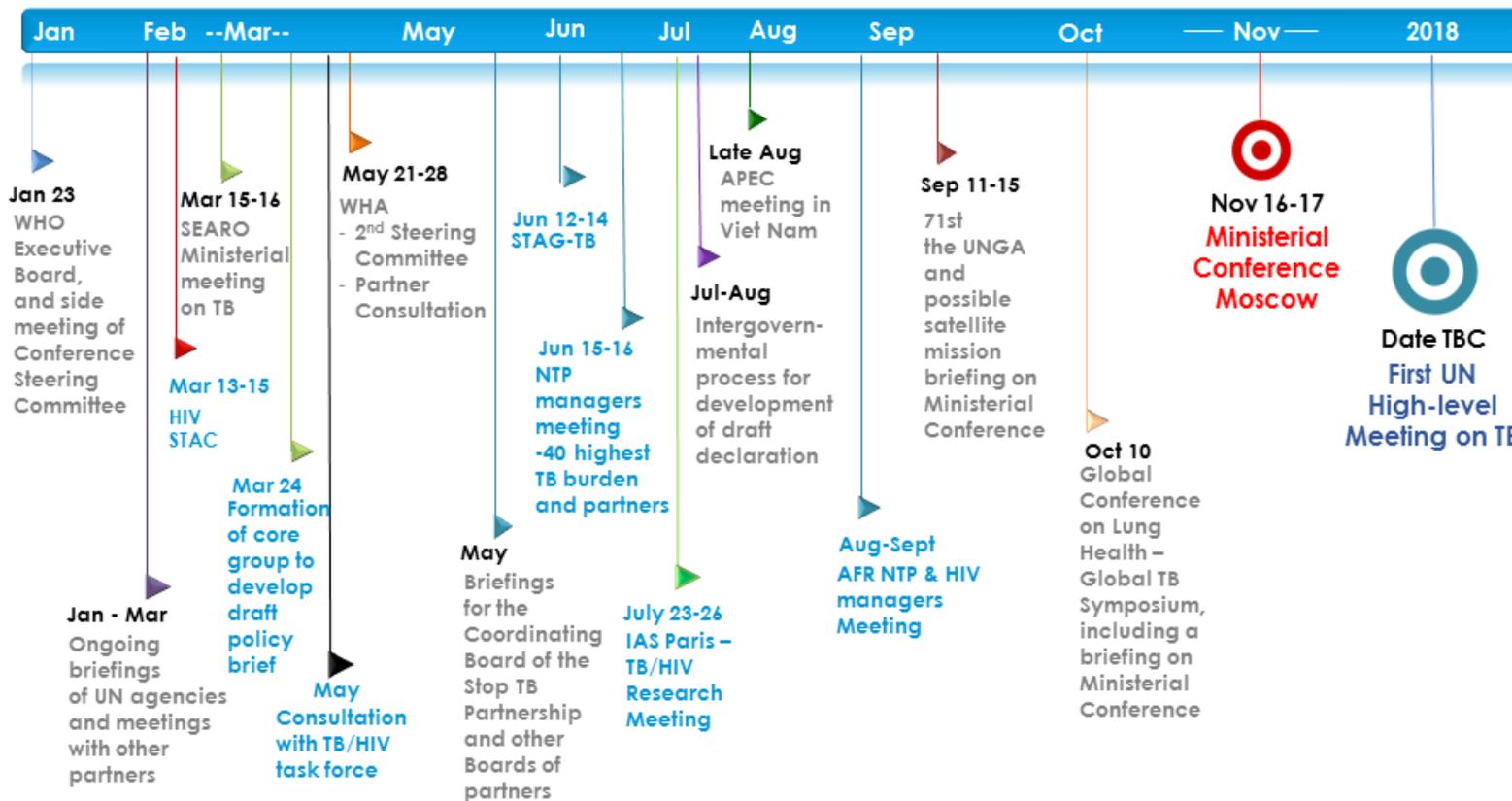
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Stakeholders for consultation

- **Salim Abdool Karim**, Centre for the AIDS Programme of Research in South Africa
- **Tsitsi Apollo**, MoH Zimbabwe
- **Constance Benson**, University California San Diego
- **Amy Bloom**, USAID
- **Sean Cavanaugh**, PEPFAR
- **Richard Chaisson**, Johns Hopkins University
- **Mark Cotton**, Stellenbosch University
- **Anand Date**, CDC
- **Bui Duc Duong**, MoH Viet Nam
- **Befina Durovni**, University of Rio de Janeiro
- **Wafaa El-Sadr**, ICAP, Colombia University
- **Serge Eholie**, Treichville University Teaching Hospital, Cote d'Ivoire
- **Ade Fakoya**, The Global Fund
- **Xia Gang**, MoH PR China
- **Shannon Hader**, CDC
- **Anthony Harries**, International Union against TB and Lung Disease
- **Diane Havlir**, University California San Francisco
- **Adeeba Kamarulzaman**, University of Malaya, Malaysia
- **Catherina Lambregts van Weezenbeek**, KNCV
- **Erica Lessem**, Treatment Action Group
- **Lynette Mabote**, ARASA
- **Natalya Nizova**, MoH Ukraine
- **Sabin Nsanzimana**, MoH Rwanda
- **Alasdair Reid**, UNAIDS
- **Kuldeep Sachdeva**, MoH India
- **Annette Sohn**, TREAT Asia
- **Natalya Vezhnina**, Expert on TB/HIV in prisons
- **Eliud Wandwalo**, The Global Fund
- International AIDS Society Research meeting attendees (names to be advised)
- WHO HIV Strategic and Technical Advisory Committee members
- WHO TB Strategic and Technical Advisory Group members
- AFR TB and HIV Programme Managers attending PM meeting in Aug/Sept 2017 (names to be advised)



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KEY OUTCOME AREA 8

SYNERGIES ACROSS THE RESPONSES TO TB AND NCDs: OPPORTUNITIES FOR INTEGRATED ACTION

Synergistic and joint actions against TB and noncommunicable diseases and their risk factors.

The Issue

- **Low- and middle income countries (LMICs)** are hardest hit by the TB and Noncommunicable disease (NCD) epidemics. Six LMICs accounted for 60% of new TB cases and over 75% of NCD deaths are in LMICs.
- Each year, **38 million people die from NCDs**, primarily from diabetes, cardiovascular diseases, cancers, and chronic respiratory diseases. Of these deaths approximately 15 million are premature (between the ages of 30 and 70) and could have been largely prevented. Moreover, NCDs, including mental health problems, cause immense long-term suffering and disability.
- NCDs, and NCD risk factors, are linked to TB in several ways:
 - Diabetes, tobacco smoking, harmful use of alcohol, environmental exposure to silica dust, and indoor air pollution increase the risk of TB. Given their high prevalence, a large part of the TB burden can be attributed to NCDs and NCD risk factors.
 - While obesity is increasing globally and favours diabetes, undernutrition remains prevalent in LMICs. Undernutrition is a prominent TB risk factor and complicates TB care.
 - As common TB risk factors for TB, the main NCDs are common comorbidities among people accessing care for TB. These conditions and risk factors complicate the management of TB and contribute to poor TB treatment outcomes, include death.
 - Moreover, TB can increase the risk of or aggravate NCDs, including chronic obstructive pulmonary disease, lung cancer, undernutrition, diabetes, mental health problems, and cardiovascular diseases.
- The intersecting epidemics of TB and NCDs share many underlying social determinants, such as issues related to poverty, living and working conditions and financial and social protection.
- Progress against TB therefore depends on advances in NCD prevention and integrated care.

Challenges and opportunities

Challenges

- Despite the existence of evidence and guidance, there are limited efforts for coordinated and combined planning, implementation and funding for joint TB and NCDs efforts.



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- Many people with NCDs go undiagnosed or are diagnosed too late. Unless health systems are strengthened to enable early diagnosis and high quality and affordable care, NCD outcomes will continue to be poor, with secondary effects on TB.
- Although there has been substantial progress across the world in TB treatment coverage and outcomes, countries need to move much faster to prevent, detect, and treat the disease if they are to further reduce transmission and meet global targets. Missed diagnosis of active TB among people with NCDs contributes to the problem. Without robust and well-integrated primary health services with bidirectional screening for TB and NCDs and effective referral chains as needed, gains will not be sustained or expanded further.
- One quarter to one-third of the world's population is latently infected with TB, and in many countries reactivation of latent infection to active disease is now a more important driving force behind TB than recent TB transmission. Unless NCDs are effectively prevented and managed, they will continue to contribute to sustained high rates of conversion from latent to active TB.

Opportunities

- The **Political Declaration** of the 2011 High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, notes the linkages between NCDs and some communicable diseases and promoted the inclusion of NCD responses in other programmes, including TB.
- The World Health Assembly-endorsed **Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020** recognizes the need to maximize the prevention, detection and treatment of NCDs and infectious diseases using common platforms and approaches. The WHO End TB Strategy, endorsed by all WHO Member States in 2014, also underscores this interaction and highlights the need for integrated, patient-centred care, support and prevention. They recognize the role of universal health coverage, social protection, poverty alleviation and other initiatives, including action on the social determinants of health.
- The **Sustainable Development Goals**, contains the ambitious 2030 targets to reduce by one third premature mortality from NCDs through prevention and treatment and to end the TB epidemic. Actions on several other SDGs will support NCD and TB prevention.
- The **2015 Bali Declaration** on TB and diabetes was a political milestone demonstrating the importance of joint action. The declaration represents multisectoral and multi-stakeholder commitment to jointly address the linked epidemics of TB and diabetes.
- The United Nations General Assembly will hold the first-ever **UN high-level meeting on TB** in 2018, and will also convene a comprehensive review of the progress achieved in the prevention and control of NCDs at the **Third UN High-level Meeting on NCDs 2018**. This is an opportunity to mobilize high-level political commitment and resources and engage partners to end this top infectious killer and curb premature mortality from NCDs, through complementary efforts and bold and innovative solutions.
- The above declarations, strategies, frameworks and plans set the stage for specific collaborative actions, including:
 - **Coordinated management.** Responses to TB and NCDs require long-term, well organized, people-centred disease management, in most cases through a comprehensive primary care focus. Improving primary health care through comprehensive NCD management will add to the capacity for TB management, particularly of co-morbidities. Within the primary health



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care setting, there is particular potential for combined health communication and community engagement strategies, coordinated opportunities for training of health workers, provision of coordinated or combined promotion, prevention, diagnostics, management and care, including case detection, protocol based management, bidirectional screening, adherence to medication and follow up, systematic patient and program monitoring, and strengthening of referral mechanisms, linking to the broader health system approach.

- **National plans and resources.** Although the number of countries which have operational national NCD and TB policies, with a budget for implementation, has increased, many countries, in particular LMICs, continue to struggle to move from commitments to actions. Recognizing the strong interaction between NCDs and TB and identifying opportunities for policy and programme coordination using common platforms and approaches can fast-track national responses.
- **Access to essential medicines and technologies.** The urgent need to increase access to safe, effective, affordable and quality-assured essential medicines and health technologies for NCDs and TB can be addressed through an intensified research and innovation strategy that builds on lessons-learned around enhancing discovery, development, medicines procurement, distribution, capacity building of providers and rapid uptake of existing and new tools, partnership, interventions and strategies.
- **National and international partnerships.** Effective public health responses to the threat posed by TB and NCDs require strong coalitions and partnerships within governments and through whole-of-society approaches. The building of results-oriented collaborative efforts and alliances between governments and non-State actors, while protecting public health policies from undue influence by any form of conflict of interest, are essential components of national TB and NCD roadmaps covering the period 2018 and 2030. This is of particular relevance since domestic resources are limited, and there are unmet country demands for technical assistance, knowledge, expertise and services, and bilateral and multilateral channels can strengthen national capacities.

Actions

National level:

Governments should commit to:

- **Strengthen political commitment, advocacy and resources** to prioritize, fund and enable coordination of national TB and NCD policy and programmes applying a combined approach that is people-centred and has a focus on primary and community care services with adequate health workforce and capacities;
- **Ensure that high-quality health services for TB and NCDs are accessible for all**, without causing financial hardship for patients and affected households;
- **Establish a high-level multisectoral and multi-stakeholder mechanism or commission**, with leadership from the health sector, to ensure accountability for integrated care, and guaranteeing participation and endorsement of all relevant stakeholders.



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Global level:

Governments should call for international partners to:

- **Enhance the provision of technical assistance** through bilateral and multilateral channels to strengthen national capacities to effectively coordinate and combine responses to TB and NCDs;
- **Call on international donors to increase coordination and alignment with country needs** and priorities, in particular to align international cooperation with national TB and NCD plans, with particular support to combined approaches;
- **Promote intensified research and innovation** to optimize implementation, scale-up and impact of combined approaches;
- **Promote and strengthen multi-stakeholder coalitions** and partnerships across the fields to support TB and NCDs interventions and services.

DRAFT

VISION: A WORLD FREE OF TB

Zero deaths, disease and suffering due to tuberculosis

GOAL: END THE GLOBAL TB EPIDEMIC

INDICATORS	MILESTONES		TARGETS	
	2020	2025	2030	2035
Reduction in number of TB deaths compared with 2015	35%	75%	90%	95%
Reduction in TB incidence rate compared with 2015	20% (<85/100 000)	50% (<55/100 000)	80% (<20/100 000)	90% (<10/100 000)
TB-affected families facing catastrophic costs due to TB (%)	0	0	0	0

TOP-TEN PRIORITY INDICATORS FOR MONITORING IMPLEMENTATION OF THE END TB STRATEGY AT GLOBAL AND NATIONAL LEVELS, WITH RECOMMENDED TARGET LEVELS

Indicators		Recommended target levels, at the latest by 2025
1	TB TREATMENT COVERAGE	≥ 90%
2	TB TREATMENT SUCCESS RATE	≥ 90%
3	PERCENTAGE OF TB-AFFECTED HOUSEHOLDS THAT EXPERIENCE CATASTROPHIC COSTS DUE TO TB**	0%
4	PERCENTAGE OF NEW AND RELAPSE TB PATIENTS TESTED USING A WHO-RECOMMENDED RAPID TESTS AT THE TIME OF DIAGNOSIS	≥ 90%
5	LATENT TB INFECTION TREATMENT COVERAGE	≥ 90%
6	CONTACT INVESTIGATION COVERAGE	≥ 90%
7	DRUG SUSCEPTIBILITY TESTING COVERAGE FOR TB PATIENTS	100%
8	TREATMENT COVERAGE, NEW TB DRUGS	≥ 90%
9	DOCUMENTATION OF HIV STATUS AMONG TB PATIENTS	100%
10	CASE FATALITY RATIO	≤ 5%

**costs faced are above 20% of annual household income.