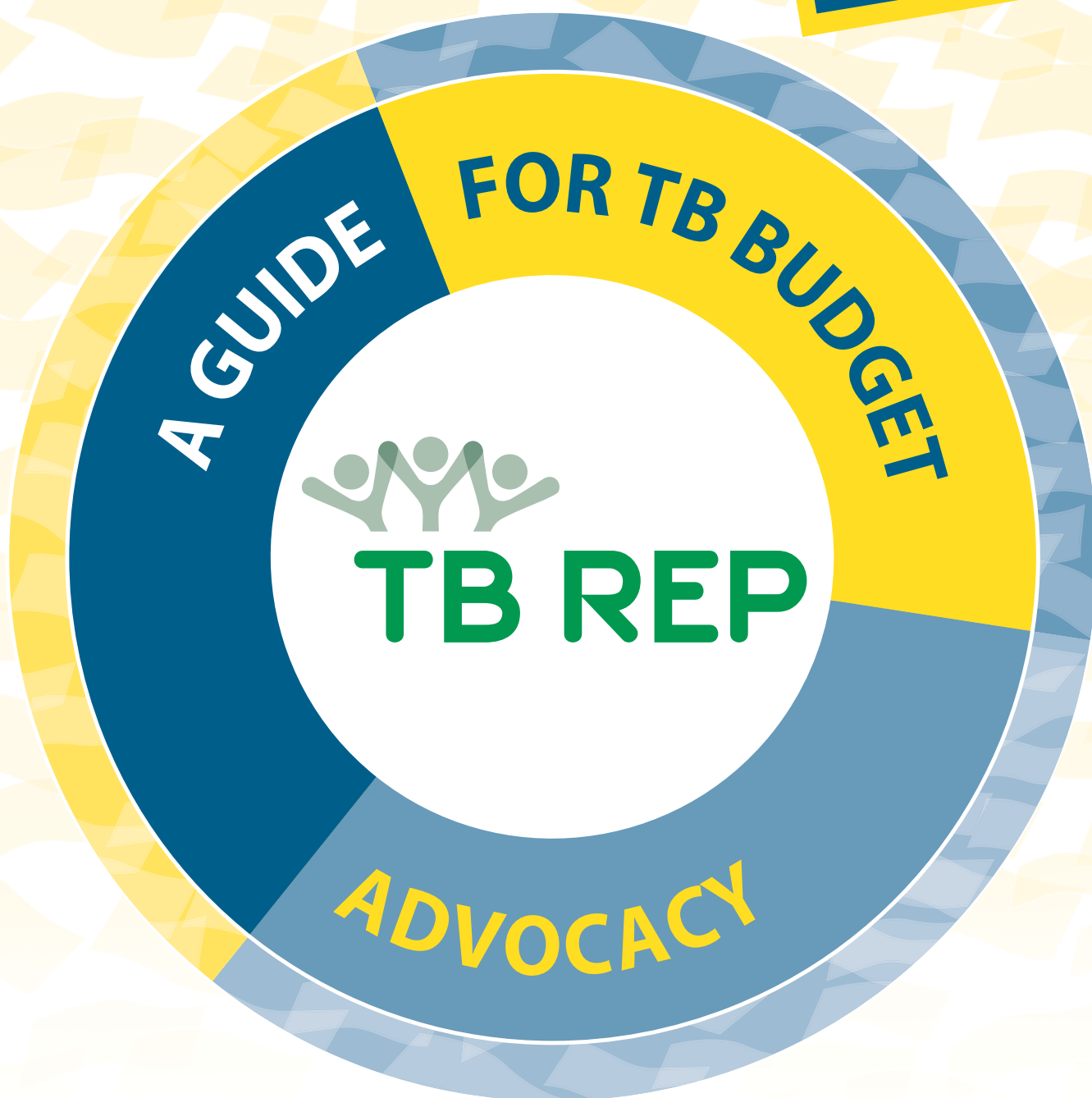


Armenia | Azerbaijan | Belarus | Georgia | Kazakhstan
| Kyrgyzstan | Moldova | Tajikistan | Turkmenistan
| Ukraine | Uzbekistan



Author: **Serebryakova Lela, PhDc, MSc**

«A Guide for TB Budget Advocacy» – TB Europe Coalition, 2019

Publication of this material has become possible due to the grant provided in the framework of the TB-REP 2.0 project which is funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and implemented by PAS Centre as the Principal recipient.

The opinion of the author, expressed in this publication, may not necessarily coincide with the point of view of the GF, Principal recipient and other partners of TB-REP 2.0 Project.



Contents

Introduction	2
1. Background	2
2. Key challenges in TB service financing in EECA	3
3. Budget Advocacy Targets	5
Setting targets (samples).....	6
Advocacy to fill up the funding gap: Azerbaijan	6
Cost of treatment and drugs	6
Increasing allocative efficiency of existing resources	6
4. ABCs of Budget Advocacy	8
Definition of budget advocacy	8
Role of TB CSOs in budget advocacy work	9
Types of budget advocacy work	10
Strategic partnerships of Budget Advocacy Work	10
Budget Cycle	11
Budget Analysis	11
Information about public budgets	12
Social Contracting – Enabler for Budget Advocacy Work	13
Case of Kazakhstan	13
5. Budget advocacy models for drug-resistant TB care	13
6. Conclusions and tips for CSOs who want to use budget advocacy for increasing funds to the TB program	15
Appendix 1: Simplified budget advocacy planning tool	16

Introduction

In response to the challenges related to early detection and treatment outcomes of drug-resistant TB, TB-REP 2.0 promotes integrated and people-centered TB care systems that address the needs of key and vulnerable populations. TB Europe Coalition, as a part of this multi-partner project, joins the community and civil society actors from 11 Eastern Europe and Central Asia (EECA) countries – Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kirgizstan, Moldova, Tajikistan, Turkmenistan, Ukraine and Uzbekistan and fosters their capacity to advocate and operationalize their role.

This document – A Guide for TB Budget Advocacy – aims to be a starting point for CSOs to engage with governments and advocate for fair allocation of funds for TB patients.

1. Background

Tuberculosis (TB) is one of the deadliest diseases in the world. Despite advances in medicine, **it remains among the top ten leading causes of death worldwide** (Figure 1). One in every four persons is infected with TB globallyⁱ, and only in 2017, 10 million individuals developed the disease. In the same year, TB took the life of 1.3 million men and women, among whom 234 000 were childrenⁱⁱ. **Multidrug-resistant TB (MDR-TB) is a public health emergency, and in 2017, 457 thousand individuals had MRD-TB.** Globally 3.5% of new TB cases and 18% of previously treated cases have drug-resistant TB, and the highest proportion is recorded in former Soviet Union countries.

Consequently, EECA is one of the focus regions for ending the TB epidemic, especially that of drug-resistant TB. The Russian Federation is among the top 20 high burden countries for TB and drug-resistant TB, which significantly influences the epidemiological situation in the region. Eight out of 11 countries included in the project (Azerbaijan, Belarus, Kazakhstan, Republic of Moldova, Tajikistan, Ukraine, Kyrgyzstan and Uzbekistan) are high MDR-TB countries.

Despite the fall of incidence and mortality rates globally, and specifically in the WHO European region (mortality rate falling by 5% among non-HIV positive adults and incidence rate falling by 2% a year), it is unlikely that all countries will be able to achieve global targets set for TB (Figure 2).

Figure 1: Top 10 Leading Cause of Death by GHE, WHO



Source: WHO GHE

Figure 2: Global Targets for TB

INDICATORS	TARGETS	
	SDG 2030	END TB 2035 ^{III}
Reduction in the number of TB deaths compared with 2015 (%)	90%	95%
Reduction in TB incidence rate compared with 2015 (%)	80%	90%
TB-affected families facing catastrophic costs due to TB (%)	Zero	Zero
<i>UN General Assembly High-Level Meeting on TB (2018) reiterates treatment, prevention and investment targets as following (among others)^{IV}</i>	<p>From 2019 to 2022</p> <ul style="list-style-type: none"> • Treat 1.5 million people with drug-resistant TB • 30 million people receive preventive treatment • Mobilizing sufficient and sustainable financing, reaching at least US\$ 13 billion a year by 2022 	

Ending TB is an ambitious goal, and EECA countries face significant challenges in this process:

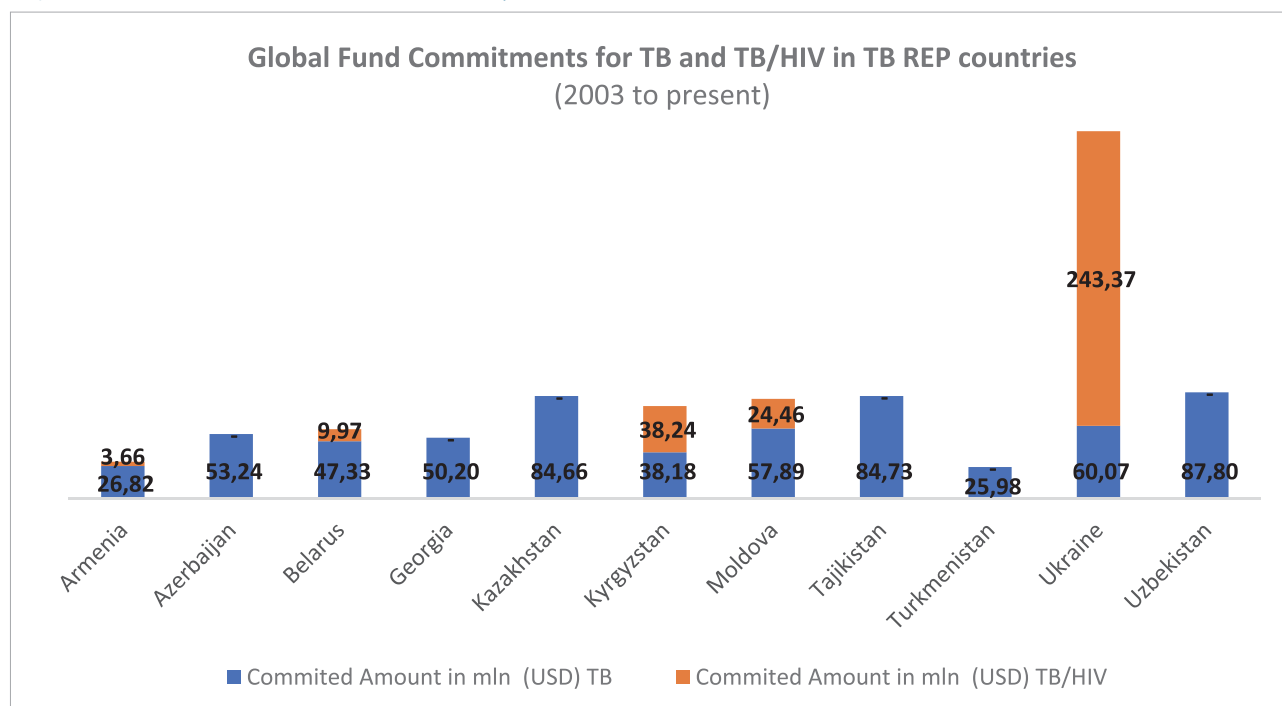
- **EECA has a challenging epidemiological profile** as the result of a high MDR-TB burden. An increasing number of individuals fall sick with resistant forms of TB, which includes rifampicin-resistant (RR-TB) forms, but over 82% of patients with MDR-TB. Treatment for MDR-TB is much more expensive than treatment of regular TB; besides, the length of treatment can cause significant disability and loss of productivity for those individuals and their families.
- **Treatment of drug-resistant TB is expensive.** The median cost per MDR-TB patient treated was US\$ 7141 in 2017, compared to US\$ 1224 for drug susceptible TB^V.
- **The transition from donor funding to domestic funding** is taking place in middle-income countries. The Global Fund, one of the lead funders of TB services in EECA is gradually withdrawing its support as the economies of those countries grow.

2. Key challenges in TB service financing in EECA

In 2018, over 38.9 billion USD was provided as donor support for TB worldwide, with Global Fund being the most significant channel of funds. Since 2002 it has committed US\$ 7.2 billion for TB and this funding enabled over 5 million people to complete treatment.

Global Fund's commitment for the EECA region has been substantial, as well. Since 2003, the amount committed for TB for the EECA region is 851 million USD and for TB/HIV coinfection – US\$ 325.5 million. 11 TB-REP countries consume over 65% of dedicated TB funding from the Global Fund in the region – US\$ 557.81 million for TB and 90% of funding for integrated TB/HIV activities US\$ 294.92 in these countries (Figure 3). However, there is a clear declining trend in allocation (Figure 5).

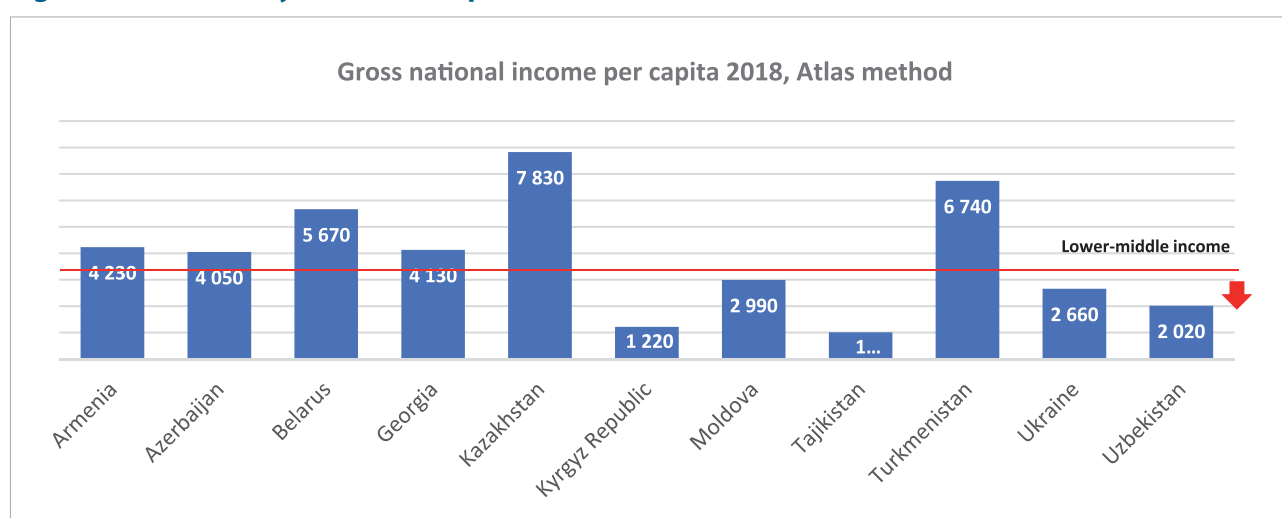
Figure 3: Global Fund Commitments by 11 countries in mln



Source: Global Fund Data Explorer

Economic growth and declining epidemic in TB-REP countries will make them ineligible for Global Fund support. In the last two decades, economies of countries in the EECA region has grown. Tajikistan is the only low-income country among TB-REP country group^{viii}. Kyrgyzstan, Moldova, Ukraine, and Uzbekistan are projected to remain among the Low-Middle Income country group for 2020, and Georgia is expecting to upgrade to upper-middle income (UMI) country group. All the other countries are UMI (Figure 4). As a result, Turkmenistan has received transition funding for 2017–2019, Armenia is scheduled to received transition funding for the period of 2020–2022 and Kazakhstan – after 2025^{ix}.

Figure 4: Countries by Income Groups (WB, Atlas Method)



Source: World Bank Open Data

In response to the Global Fund phase-out, countries should mobilize domestic resources to fund TB services.

3. Budget Advocacy Targets

National targets are effectively set as a part of national TB strategies. However, the disintegration of these targets into specific objectives of budget advocacy work is a separate process. Each country in the region strives to achieve integrated, patient-centered care and prevention, which entails:

1. Early diagnosis of tuberculosis, including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups.
2. Treatment of all people with tuberculosis, including drug-resistant tuberculosis, and provision of patients support services to increase treatment adherence.
3. Collaborative tuberculosis/HIV activities and management of co-morbidities.
4. Preventive treatment of persons at high risk, and vaccination against tuberculosis.

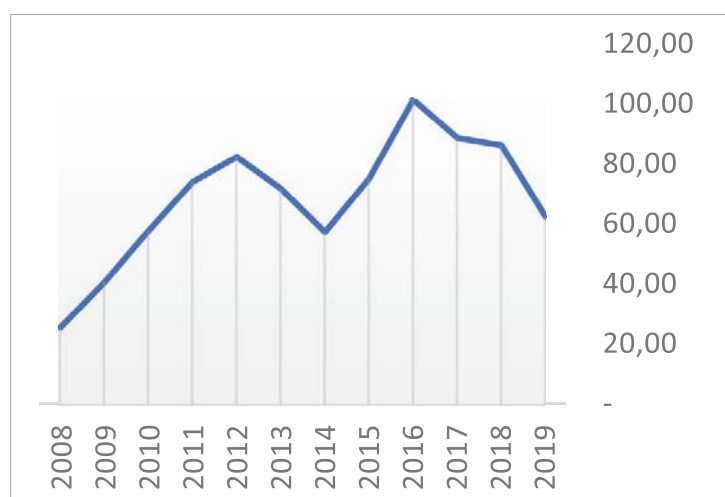
The role of CSOs is very instrumental in realizing core principles of patient-centered model of care through the whole continuum of care – from detection to linkage to care to successful completion of treatment^x.

Countries might have different ways to implement these activities, **and advocating for evidence-based interventions** is an essential aspect of successful budget advocacy work.

The general targets for budget advocacy work are:

- Replacement of donor funding with the ongoing transition from the Global Fund, ensuring domestic funding is an important target to ensure the sustainability of national TB response.
- Increasing coverage with prevention and treatment services to reach all individuals – "no one left behind."
- Ensure inclusion of CSOs in TB care provision and planning through enabling social contracting^{xi}.
- Focus on prevention of catastrophic healthcare expenditures due to TB and ensuring that anyone can access services without financial hardship, through tracking and monitoring of out-of-pocket spending for TB care.
- Diversify funding sources for national TB response through engaging with central, regional, and city governments – TB prevention and care is not only an issue of healthcare but also a significant social and economic burden of an individual, household, or a community. Diversified funding sources can be effectively used to cover not only healthcare needs, but additional services offered by CSOs or provide social (welfare) benefits to those in need.
- Optimize TB care by:
 - Advocating for evidence-based services and interventions, which are more cost-effective as well. The focus of such advocacy efforts could be out-of-hospital care models, intensification of use of video-assisted treatments and others.
 - Advocating for reduction of cost of treatment and drug prices: the same quality care can be delivered at lower costs. The data from service cost studies (such as by The Global Health Cost Consortium^{xii}) and comparison of drug prices show that cost and price ranges are widely distributed, signifying an essential area for optimization.

Figure 5: Global Fund Disbursed Funding for TB and TB/HIV for 11 countries



Source: Global Fund Data Explorer

SETTING TARGETS (SAMPLES)

Advocacy to fill up the funding gap: Azerbaijan

Azerbaijan has estimated to have a funding gap of US\$ 226 787 for the period of 2018–2020 after Global Fund support. The funding gap is projected for MDR TB detection and treatment too. This officially reported funding gap can become a budgetary target for the national budget advocacy work.

Cost of treatment and drugs

The cost of treatment depends on several factors, including cost of goods and supplies used for treatment (such as drugs), cost of human resources and infrastructure, and approach to treatment – clinical guidelines in place. As a result, the cost of treatment of a patient with the same underlying condition can vary significantly. The following figure from the WHO Global Tuberculosis Report 2018, reveals significant variation worldwide.

An essential part of the cost of treatment is the cost of drugs. An estimated cost of drugs for drug-susceptible TB is US\$ 33 per patient in Turkmenistan while treating the same patient would be twice as expensive in Georgia (US\$ 66) and nearly four times more costly in the neighboring country – Kazakhstan (US\$ 126). If Kazakhstan could treat its expected number of patients (2018) at prices available in Turkmenistan, the country would have saved US\$ 935 thousand.

MDR-TB: Case Detection and Diagnosis

	2018	2019	2020
<i>Funding need</i>	1,364,018	1,379,289	1,413,257
<i>Domestic sources</i>	759,420	901,786	1,077,380
<i>Funding gap*</i>	604,599	477,503	335,877

* Without Global Fund support

Program Target Gap:** **Detection of 588 individuals**

** After Global Fund support

MDR-TB: Treatment

	2018	2019	2020
<i>Funding need</i>	4,480,651	4,785,568	5,154,254
<i>Domestic sources</i>	3,436,657	3,773,974	4,206,260
<i>Funding gap*</i>	1,043,994	1,011,594	947,994

* Without Global Fund support

Program Target Gap:** **Treatment of 554 individuals**

** After Global Fund support

Source: Global Fund Data Explorer
(country application)

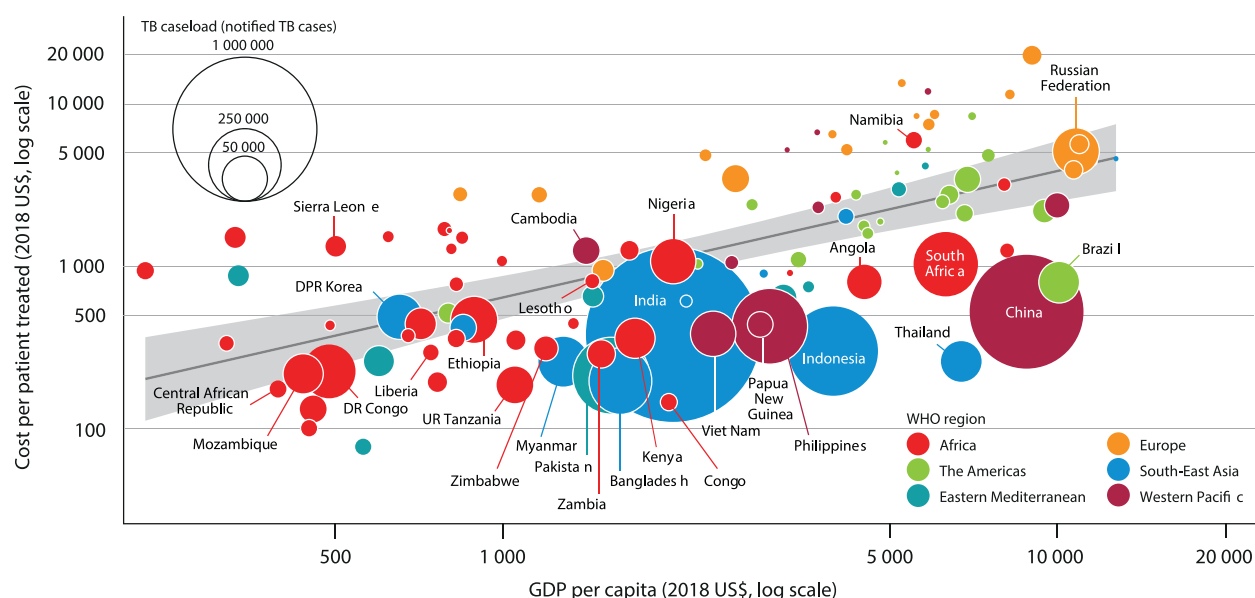
Treatment of MDR and XDR-TB is significantly higher than that of drug-susceptible TB. It is estimated to be US\$ 4 500 in Belarus and US\$ 1 509 in Ukraine (Figure 6).

Increasing allocative efficiency of existing resources

Resources for TB are finite and limited. Therefore, achieving the best possible results using the resources available – allocative efficiency – is the ultimate goal of TB response. Allocative efficiency is concerned with spending limited resources in the areas that are best able to maximize public value. Hence, the concern is not only getting the best results for money (i.e., technical efficiency) but to incorporate consumer preferences in the allocation. For example, spending money on end-of-life palliative care might not be the most efficient way to spend limited funds. Still, it meets public expectations and thus maximizes public value.

TB Optima is one of the instruments available to estimate allocative efficiency for TB resources.

Estimated cost per patient treated for drug-susceptible TB in 113 countries, 2017^a



^a Limited to countries with at least 100 patients on first-line treatment in 2017.

Source: Global TB Report, 2018

There are high-impact interventions available for TB care, such as:

- Transitioning from hospital care to outpatient treatment models.
- Substituting involuntary isolation to adherence support, such as provision of incentives for providers of ambulatory TB care.
- Mass screening versus enhanced active case finding among the high-risk population and enhanced contact tracing (as well as opposite for some settings).

- Improving diagnostic capabilities through scaling up rapid molecular diagnostics.

There are only two countries in the EECA region that have conducted allocative efficiency studies using TB Optima. These studies reveal and quantify potential to achieve global targets for TB.

Belarus

Allocative efficiency study commissions by the World Bank in 2015 proposed that if funding available for 2015 (US\$ 61.8 million) for TB is kept constant, but allocated differently, by 2035 it could achieve reduction of prevalence among general adult population by 45% and reduction of the total number of TB deaths by up to 60%. This changed allocation called transitioning from in-patient care to outpatient treatment, which would free up to 40% of resources to be spent on higher-impact programs.

Figure 6: Average cost of drugs budgeted per patient for MDR- and XDR-TB treatment, excluding buffer stock (US Dollars), 2018^{xiii}

Country*	MDR	XDR
Belarus	4500	7600
Georgia	3830	5000
Kazakhstan	3222	15615
Kyrgyzstan	3108	3872
Republic of Moldova	1899	6395
Tajikistan	2060	4860
Turkmenistan	1542	9149
Ukraine	1509	5455

*Data is available for selected countries only

Source: WHO End TB Strategy/TB Data^{xiv}

Moldova

Allocative efficiency study for Moldova was published in 2018. The study analyzed current investment level and modalities in TB and estimated that continuation of the current approach would result in 10% in TB incidence. However, if these resources are maintained, but allocated differently, incidence rates can be reduced by 20% by 2035 and gains can be magnified as reflected in TB prevalence and death reduction as well. One of the optimization strategies suggested is a transition from hospital care to ambulatory care. This strategy would free 24% of treatment expenditures, resulting in 2.4 million EUR savings, which should be allocated to other high-impact interventions. Nevertheless, even if current (2016) level of investment is maintained and optimized, it still not be sufficient to achieve End TB strategy targets by 2035.

4. ABCs of Budget Advocacy

Sustainable Development Goals, End TB strategy and UN high-level meeting Declaration on TB set goals for TB, which cannot be achieved without effective, cost-efficient, and sustainable services for people. One of the pillars of the WHO Global Strategy and Targets for Tuberculosis Prevention, Care and Control after 2015, is "engagement of communities, civil society organizations, and public and private care providers. "Therefore, community engagement is instrumental in the achievement of global TB targets. In addition, as the resources to end TB will not be sufficient, countries have to mobilize resources actively and adjust laws and policies to shift from expensive and inefficient models of care to community-based services.

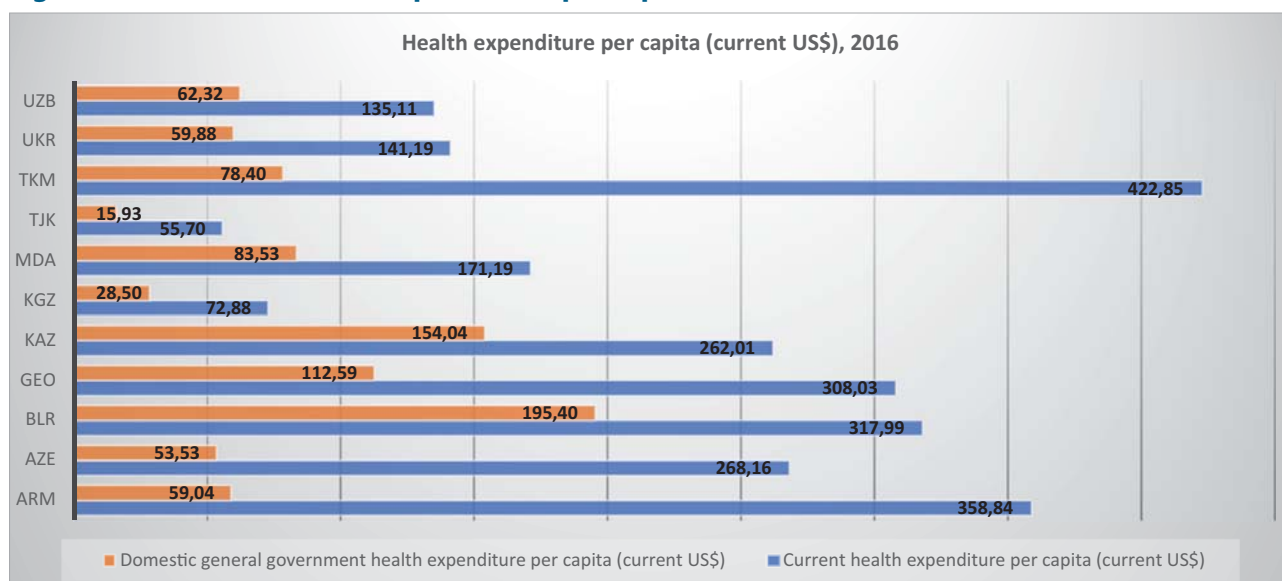
Definition of budget advocacy

Budget Advocacy is a collection of targeted activities to change public resource allocation. In other words, the government often spends public/budget funds in a way that does not meet the expectations and needs of specific groups. Communities and CSOs come together to change the way public funds are spent, and the activities they carry related to their budget advocacy efforts.

Since public budgets are scarce and limited, many services might be underfunded. This is especially true in low- and middle-income countries, where limited public budgets do not often cover essential goods and services for the population, including healthcare. If we look at

Figure 7, we will see that budgets fund only a fraction of costs that, on average, a person incurs for healthcare in a given year. For example, per capita spending for Kyrgyzstan in 2016 for health was US\$ 73, while the government covered less than half of these costs – US\$ 28.5. In Armenia, the same year, per capita spending was US\$ 359, and government sources funded about US\$ 60 per capita^{xv}. The limited public funds for health are often allocated for goods and services, which are not effective, cost-efficient, or meet the public demand. Budget advocacy aims to achieve (I) different allocation within these limited funds, and/or (II) different

Figure 7: Current Healthcare Expenditures per capita, 2016



Source: World Bank Open Data

allocation within general government revenues mostly to allocate more funding for health. Hence are some specific aspects of budget advocacy work:

- Budget advocacy **always targets public budget**, whether it a budget of your city, oblast or region, or a central budget, or even a debt or budget support^{XVI}.
- Public budgets are composed of funds **collected from citizens** (individuals or businesses); therefore, citizens have a say how these funds are allocated.
- Budget advocacy is about **changing allocation, which means that existing funds are re-distributed differently**. This work always includes two aspects of analytical work: looking at the revenue side – where funds are coming from and looking at the expenditures side – how these funds are spent.
- With budget advocacy work, one should keep in mind that spending public money on your request, **ultimately reduces spending on other things** (or a chance to spend money on some other request). Therefore, there is often a moral dilemma whether spending funds for specific cause should be priorities over other causes.

Public revenues and expenditures occur at different levels of the country. Tax and Budget codes serve as a starting point to decide on your advocacy targets.

Decision-making power regarding allocation from different revenues will be with different levels of government: if you are advocating to change allocation within the budget of your city, you should consider what types of local revenues the city has (usually from advertising, land tax, gambling; each country will have a different composition of public revenues.) as these revenues will be within the power of city government to allocate. If you are advocating that funds collected at central level should be allocated differently, it might be more useful to approach government at central level, rather than your city officials.

Role of TB CSOs in budget advocacy work

In democratic societies, we elect our ruling political leaders and bestow them with the power to manage our collective funds – public budget. However, the Government often forms priorities or ways of doing things that do not meet the needs and expectations of people. **Budget is the most critical policy instrument in the country, and it reflects the Government's social and economic priorities and commitments.** Hence, it is the role of civil society actors to engage actively with governments – local or national and work with them on tailoring a public budget to the needs of communities.

Health is one of the fundamental human rights, but very often, this right is not protected. Every individual should have a right to health and healthcare despite his or her ability to pay for the services. This is especially true in the case of drug-resistant TB as appropriate care can be unaffordable or inaccessible for individuals.

CSOs can play an essential role in making TB services affordable, accessible, and equitable for individuals and their work on budget advocacy is instrumental in this process:

- Affordability is about reaching services without financial hardship: reduction in user fees, or out-of-pocket payments; ensuring universal access to needed diagnostics and curative care and rehabilitation services.
- Access is about having services at your reach, which can be via having a clinic in your district, or mobile service, if you live in remote areas, using modern cellular technologies to save time traveling for daily treatment, or helping individuals finance their transportation costs.
- Equity is about understanding the different needs of different populations and responding to those needs. Most at-risk populations are often the ones most marginalized and most in need of support.

Some of the activities in which CSOs can engage are (non-exhaustive list):

- They can act as a bridge to key populations and help designing programs that meet the needs and preferences of these groups.
- They can provide differentiated care to different groups of the people, which will be tailored to their needs.

- CSOs/community organizations can provide psycho-social support to individuals on treatment or in need of treatment that can be essential for treatment uptake, adherence and successful completion of treatment, thus improving outcomes for individuals, their families, and society in general.
- They can provide prevention, referral, and treatment support for individuals with TB and therefore, strengthen the care and treatment provided by the clinics; and.
- CSOs can provide legal support to communities.

Types of budget advocacy work

Budget advocacy is a process, and there are three main types of activities included in this process:

- **Capacity building:** Budgets can be a scary document at first and getting information from the public sector – a challenging process. Building capacity among CSO actors by teaching them how to access and use this information in their advocacy efforts is an integral part of budget advocacy work.
- **Analytical work:** budget advocacy requires strong analytical skills. Conducting routine analysis of budget figures (local or central government) and making this work publicly available is a powerful tool to help others use this information for the benefit of communities, as well as to keep public officials accountable.
- **Support designing new solutions** such as regulations, programs, strategies, costing interventions, and provide input in the development of public programs.
- **Watchdogging** is a process of active monitoring on how the government implements its commitments and includes regular budget analysis, review of procurement processes, and generation of analytical reports.

Strategic partnerships of Budget Advocacy Work

CSOs engaged in budget advocacy work can significantly benefit from building strategic partnerships around the working process. Very often, budget advocacy work will require skills and resources, which are outside of the reach of TB CSOs, and strategic partnerships can help with this gap. There could be a few types of strategic partnerships:

Partnering with NTP is essential in order to gain access to information and to help CSOs understand the financial flows for TB services, structure of budgets per different care components and also provide opportunities for joint advocacy work to ensure that funds released as a result of transition from hospital based to outpatient model of care are kept and used for TB care, including for CSO involvement in service provision.

Partnering with “watchdog” CSOs: there are a number of CSOs who are highly experienced in tracking public expenditures and monitoring public budgets; They can bring in their expertise in budget analysis, while TB CSOs can enrich their work by explaining the importance to focus the analysis on TB.

Partnering with CSOs working on public governance, democracy, and the rule of law issues: a significant part of a budget advocacy process is about keeping governments accountable and transparent. In this process, access to public information can be significantly limited. Partnering with CSOs which focus their work on improving public governance and accountability can help TB CSOs to gain access to this information, especially if the request is denied, and the organization decides to follow this request through the court.

Partnering with CSOs, whose focus is also affected by the transition from donor funding, can help to pressure the government and keep it more accountable.

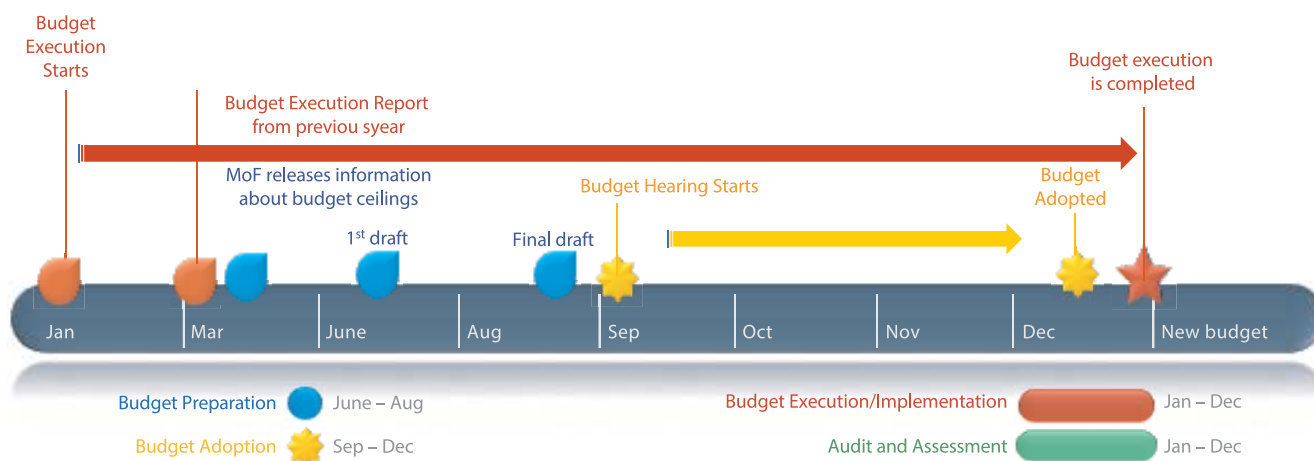
Partnering with other health and social issue CSOs can enrich your work with different approaches for budget advocacy and help you understand what ways government can fund the services.

Budget advocacy work should also **be ethical**. This means that interventions you are advocating for are evidence-based, you are aware and consider competing for needs by other key affected communities, and your working process is transparent and accountable (i.e., you do not bribe a public official to allocate funds for your cause).

Budget Cycle

Public budgeting is a cyclic process. The budget year usually follows calendar year starting in January and ending in December. However, many countries also follow a multi-year budget planning – Medium-term expenditure framework, which includes projection about public revenues and expenditures for three or more years. Figure 8 depicts a tentative budget calendar, although it will be different for central and sub-national levels.

Figure 8: Tentative budget calendar



The budget cycle is composed of four basic steps:

- Budget Preparation
- Budget Adoption
- Budget Execution/Implementation and
- Audit and Assessment

Those steps are consecutive but can be simultaneous. For example, Budget Execution starts in January and continues for one year, some of the assessment processes (like quarterly reporting) will be happening simultaneously, but audit will take place after the execution process is completed. During the execution process, budget preparation starts, and the budget is adopted for the next year.

For advocacy purposes, one needs to develop a plan which institutions interact with. For example, for the budget preparation stage, this would be a budgeting department of MoH or the Health Department of a local government office.

Budget Analysis

The first step of the budget advocacy process is a budget analysis or budget work. Since budget advocacy not only tells how much funds are needed for specific intervention but also where these funds should come from, analysis of revenue, as well as necessary expenditure.

This can be done retrospectively or prospectively from a budget execution standpoint.

- **A prospective analysis** will look at approved budgets and analyze it from the standpoint of how specific priorities are reflected in there in. This is an analysis of the Government's intentions. *For example, how much funds government intends to allocate for purchase of 2nd line TB drugs.*
- **Key Challenge:** Usually, a budget is approved as a law, and it is a public document; however, information is aggregated, and this level of aggregation is not informative for analysis of a specific cause, such as TB.
- **A retrospective analysis** looks at the executed budget. It provides information about how the intention of government was implemented. For example, adopted budget might contain information that the government intended to spend X amount on procurement of 2nd line TB drugs, however, this never happened because of (I) lack of funds (revenue side of the budget did not materialize), or (II) lack of proper planning and management (i.e., public tenders failed to identify qualified supplier).

- **Key Challenge:** Information about budget execution is often not publicly available. By its nature, this is public information and can be requested from the executive branches of the government. However, in our region, access to executive budget information is especially limited. This can also include information about prices of certain goods and supplies (i.e., TB drugs), which government might not release based on the argument of confidentiality of commercial information.

A robust analysis is to link findings from prospective and retrospective analysis as it uncovers where key pitfalls are for achieving stated objectives of the government policies.

In addition, three specific types of analysis can be identified:

- **Analysis of strategic and policy documents** can be very informative. Usually, the National TB Response is guided by the multi-year National Strategic Plan for TB (NSP TB), which can also include the budget. This budget is different from the budget approved annually but should serve as a guiding document. Since governments pledge to execute strategic objectives stated in NSP TB, public budgets should ensure their execution.
- **Analysis/monitoring of public procurements** is a part of the budget execution process, however, monitoring of tenders and other forms of public procurements requires specific experience and skills and can be powerful tool to reveal inefficiencies, such as procurement of drugs and supplies for very high prices, which in effect will reduce funds available for other interventions.
- **Monitoring of budget plan implementation** is a part of a budget execution process. A budget plan stipulates the distribution of annual amounts to specific interventions and timeline. During the execution process, activities might not follow the plan. As a result, funds allocated for certain activities might be re-programmed during the year and used for other activities. A reprogramming process with a public budget is a formal process. Conducting ongoing monitoring of budget plan implementation can show these potential "savings" for some activities, and this can serve as an entry point to advocate that these funds are allocated for your cause. *For example, after a public tender, the unit cost of TB drugs was lower than expected, and a public purchasing agency effectively saved budget funds on procurement. This can be an excellent moment to advocate that the funds are re-programmed to purchase some other pharmaceutical goods^{xviii}.*

Information about public budgets

Open Budget Surveys are a good starting point to explore how transparent and accountable a budget process is in your country. However, not all countries take part in the survey and, at this moment, information is available from Azerbaijan, Georgia, Ukraine, Moldova, Kyrgyz Republic, Kazakhstan, and Tajikistan. It enables CSOs to access essential information about budgets, what documentation is available, and what are their chances of successfully budget advocacy. Countries with lower-ranking will simply have less information available for budget analysis.

Reviewing and understanding a country's legislation is also an essential process. This process starts with the Budget Code. In addition, several essential budget documents can help to understand process and commitments. Those include:

- Pre-Budget Statement.
- Executive's Budget Proposal.
- Enacted Budget.
- Citizens Budget.
- In-Year Reports.
- Mid-Year Review.
- Year-End Report.
- Audit Report.

Finding out the publication calendar of these documents and getting acquainted with them can be a foundation for meaning budget analysis.

Social Contracting – Enabler for Budget Advocacy Work

Social contracting is a mechanism of transfer of public funds to non-state actors, such as CSOs, to deliver social goods and services. Budget advocacy is a process of changing public allocation, and **in the case of TB services in EECA region, this often means advocacy for more community engagement in service delivery. Therefore, having functioning social contracting mechanisms in place can be a first step of budget advocacy process.**

Unfortunately, not every country has a supportive environment for social contracting. Countries may have legal, regulatory and structural barriers that can prevent CSOs from accessing public funds for service delivery. Legal and regulatory barriers are easier to identify, although structural and hidden barriers, which are embedded in the environment (such as stigma, lack of belief or capacity among CSOs that they can manage public funds, or lack of trust from public officials and many more), can also influence access to public funds for CSOs. Therefore, when legal and regulatory barriers to social contracting are resolved, it is important to monitor access to social contracting by collecting information about funds transferred to CSOs from public budgets (central or local/municipal).

Case of Kazakhstan

A study commissioned by TB-REP project in Kazakhstan has revealed a current status of social contracting in the field of TB. Kazakhstan has a significant experience in applying the mechanism of social contracting in the field of TB prevention and control, which can be exemplary for EECA countries:

- Over the past 3 years (2017–2019), significant financial resources have been allocated for the purchase of services from CSOs through social contracting mechanism (about US\$ 177,000). However, there is a need to make these allocations sustainable, advocate for increased allocation and increase predictability for government allocations for CSOs and allow long-term contracts.
- A policy of using social contracting, as well as the role of CSOs in the field of prevention and control of TB, is not explicitly stated in official documents; having clear policy on CSO contracting and stated priorities for TB services can help CSOs to better navigate the process of contracting.
- The procedures for social contracting can be confusing as the criteria for selection of service providers are not always clearly stated, and competition is driven by the price; making social contracting more “CSO-friendly” and developing instruments, such as standards for services and costing, can help CSOs to be more active in the field.

5. Budget advocacy models for drug-resistant TB Care

Budget Advocacy for drug-resistant TB can be carried out using at least four models as follows:

Model 1: Advocacy for changing allocation via identification of new revenue sources outside of health/social sector

Healthcare services are often underfunded or rely heavily non-public spending, such as private/out-of-pocket expenditures. Identification of new potential revenues to the health sector (revenue side analysis) can be an entry point for budget advocacy work, especially since many countries have already estimated the funding gap for TB care services.

Example 1: 10 by 20 Campaign by Harm Reduction International

Harm Reduction International has launched a global campaign aimed at 10% redirection of funding from drug control to harm reduction. If this change happens by 2020, the result would be:

- End AIDS among people who inject drugs by 2030.
- Cover annual hepatitis C prevention needs for people who inject drugs. Globally. Twice over.
- Pay for enough naloxone to save thousands of lives every year from an opioid overdose.
- Dramatically increase harm reduction interventions in prisons, where coverage is lower, and rates of HIV and HCV are higher than among the general population.
- Strengthen networks of people who use drugs to provide peer services and campaign for their rights.

Source: <https://www.hri.global/10by20>

Example 2: Development Initiative for Social and Human Actions from India successfully advocating for an increase in central allocation to tribal (local) budgets

The success of this advocacy work hinges upon a careful analysis of the public budget in India. The NGO discovered 172 mathematical errors in the 22 budget documents. This information was used as an instrument during public budget hearings to push the Ministry of Finance to increase allocation to tribal budgets, which cover the needs of local populations.

Source: <https://www.internationalbudget.org/wp-content/uploads/A-Taste-of-Success-Examples-of-the-Budget-Work-of-NGOs.pdf>

Модель 2: *advocacy for increasing allocation via identification of potential cost-savings within the health/social allocation (increasing efficiencies within the sector)*

Finding potential sources of funding within the health sector is easier than from outside of the sector. On the one hand, changing allocation within a sector or within spending (e.g. staff costs, procurement of good and supplies) or budgetary/programmatic priority (e.g. protection of people from infectious diseases) is technically easier for public agency, and, on the other hand, this is a familiar field for health CSOs. Therefore, they would generally have better access to information for analysis and to decision-makers for advocacy purposes.

One of the common entry points in this process is advocacy for reallocating potential “savings” in the program within one budget year (e.g., if a particular drug was purchased at lower prices than initially budgeted). As a rule, those leftover funds will be re-programed in 2nd or 3rd quartiles, and it is essential to act fast. In some countries, reprogramming savings from tenders is not allowed, but tracing these economies is still an effective way to frame advocacy messages.

One of the common targets for this type of advocacy is funding for unused healthcare infrastructure or savings from public tenders.

Model 3: *Advocacy for increasing efficiencies within tb sector (e.g., by replacing inefficient services with efficient ones)*

As noted, allocation within a sector and especially within a program, such as a TB program can be easier to reach target for two basic reasons: on the one hand, changing allocation within a TB program is technically more feasible (e.g., replacing one drug with another formulation), and, on the other hand, since TB CSOs work in this field, that have more expertise to trace ineffectiveness within a sector.

Example 1: All-Ukrainian Network of People Living with HIV/AIDS has successfully advocated for optimization of public procurement lists for TB drugs in 2018.

Public procurement lists for Anti-TB drugs in Ukraine are compiled in accordance with the methodology approved by the decree N1179 of the Minister of Health from 21 July 2019. The expert group develops the list and volume of TB drugs to be procured. Analysis of the 2018 procurement list has revealed that budget line for procurement of Carbapenems, including both Meropenem and Imipenem/Cilastatin combination. A daily dose of Meropenem is 2.8 times cheaper than that of combined formulation, while these drugs have the same indication, clinical effect and side-effects. **Replacement of the Imipenem/Cilastatin combination with Meropenem has generated reduction to the budget for procurement by 100.7 million hryvna (US\$ 4 177 676).**

The savings have been initially allocated for procurement of Bedaquiline, but after the large donation of this drug, the sum was directed for the procurement of Delamanid, within the same programming year.

Source: <https://www.facebook.com/161266363960672/posts/1957273134359977/>

Example 2: Optimization of TB hospital infrastructure in favor of out-patient care in Belarus

Newly available regimes for MDR TB treatment allow for shorter treatment and can be performed in an outpatient setting. In 2017, Belarus used TB bed projection tool development by the TB-REP project. MoH has decided to pilot patient-centered model of care in the Brest region and reduced TB hospital bed capacity per the projections using the tool. The resulting 33% reduction of hospital beds has freed qualified medical staff to engage in out-patient care. Funds saved were pooled to bring care more close to patients, by allowing new out-patient treatment models (such as video DOT); importantly, the reimbursement model for providers was changed from per bed payment to per case payment and providers acquired a flexibility to use funds for incentivization of more desirable models of care, such as payment of nurses to provide case management support.

Source: <https://www.pas.md/en/PAS/Studies/Details/117>

Model 4: advocacy for increasing allocation for the tb sector in general (e.g., by offering economic benefits due to tb burden reduction).

MDR-TB treatment is a complicated and costly process. It leads to catastrophic economic and social costs that patients incur while seeking help and while on treatment. Interventions targeted at prevention of MDR-TB (case management, improved supply-chain management of TB drugs, availability of new drugs) can generate a significant return on investments (ROI) made by the public sector through reducing mortality and morbidity and resulting disabilities.

Developing estimates for the economic costs of MDR TB (or a model to estimate these costs) or overall mortality and morbidity due to TB can be used during budget advocacy process with public officials and can be a basis to argue high return on investments in TB.

Example: Advocacy for changing nutrition-specific allocation in Nigeria

There is a field-specific budget advocacy tool for nutrition-related activities developed by Action Against Hunger international, Save the Children and the Scaling Up Nutrition Civil Society Platform in Senegal. CSOs in Nigeria have followed this tool to conduct budget analysis in 2013 and identify nutrition-related spending and programs. Based on this analysis, four line-ministries have nutrition-specific programs and expenditures – Ministry of Health, Ministry of Education, Ministry of Agriculture, and Ministry of Water. The analysis covered two years, and it showed that the share of the Ministry of Education has dramatically increased during this period.

The results were used for budget advocacy at both national and state levels. In Gombe, the CSOs coalition for nutrition and other stakeholders for nutrition have conducted series of advocacy meetings with the members of the State House of Assembly and the State Executive Council for an increase of nutrition budget, releases of funds, and creation of nutrition budget lines.

The impact of these efforts have resulted in the creation of nutrition budget lines for all LGAs in the State, an increase in the State nutrition budget from N5 million (US\$ 332 515) to N55 million.

(US\$ 3 657 668) and later N120 million (US\$ 7 980 367) for 2016 and release of N17 million.

(US\$ 1 130 552) by the State Government as counterpart funding for the ongoing nutrition program in the State Community Management Acute Malnutrition (CMAM).

Source: <https://www.actioncontrelafaim.org/en/publication/nutrition-budget-advocacy-handbook-for-civil-society/>

6. Conclusions and tips for CSOs who want to use budget advocacy for increasing funds to the TB Program

TB is a global challenge, and obligations to address issues posed by TB are reflected in international declarations and commitments. Situation in EECA is challenging due to several factors:

- There is a challenging epidemiological situation: countries in EECA have a high burden of TB; this is especially true for MDR/XDR-TB, and the resistance is further growing. Treatment of drug-resistant forms of TB is more expensive and ensuring adherence is difficult due to side effects. It poses a significant economic and social burden and causes a high level of premature mortality, morbidity, and disability.
- The financial sustainability of the national TB response is under pressure due to the transition from major donors and the limited capacity of domestic governments to take over and further expand responsibilities to cover needed services.
- Introduction of new drugs and new models of care – patient-centered, integrated approaches that provide improved outcomes of treatment is currently in progress and might be challenged by outdated treatment models requiring lengthy hospitalization with limited patient support.

CSOs and communities have a significant role to play in improving the wellbeing of TB patients and ensuring the sustainability of national TB services. **Budget Advocacy – targeted activities to change public resource allocation** is a tool for CSOs to ensure patient-centered integrated and sustainable TB care in their communities and countries.

Budget advocacy starts with **scoping work** to learn more about the current status of domestic budget allocation, which aids CSOs to formulate **priorities for budget advocacy work**. Ethical advocacy focuses on evidence-based interventions that meet patient and community expectations and provide cost-effective solutions to TB care challenges. Budget analysis is a process that informs TB Budget advocacy. Reliable data on TB expenditures help to develop substantiated arguments for changing the current allocations for advocacy.

There are at least **Four Models** to approach budget advocacy work for TB:

- **Model 1:** Advocacy for changing allocation via identification of new revenue sources outside of health/social sector.
- **Model 2:** Advocacy for increasing allocation via identification of potential cost-savings within the health/social allocation (increasing efficiencies within the sector).
- **Model 3:** Advocacy for increasing efficiencies within TB sector (e.g., by replacing inefficient services with efficient ones).
- **Model 4:** Advocacy for increasing allocation for the TB sector in general (e.g., by offering economic benefits due to TB burden reduction).

Budget advocacy work follows the national budget cycle and, therefore, is a multi-year process. By taking steps in this process, CSOs improve the credibility of their work, find stakeholders in their local and national governments and, form strategic partnerships with CSOs from other fields and as an end result, transform national TB programs to be more responsive to the needs of patients and communities.

Appendix 1: Simplified Budget Advocacy Planning Tool

	Objectives/targets	Resources	Stakeholders
Scoping	Formulate initial objectives.	Collect general information about the availability of resources: <i>TB Budgets, donors, health budget, the general financial outlook of the country.</i>	Ministries of health, social care, and financing; Local health and social service authorities; Strategies, national policies and priorities (incl. MTEF, budget reports, etc.)
Analysis	The specific objective should be formulated: e.g.: <i>Example 1: increase food allowance for MDR-TB patients from X to Y</i>	Identify sources of funding: Note: find comparable spending from the public budget to formulate powerful advocacy messages. e.g.	Ministries of health, social care, and financing; Local health and social service authorities; Strategies, national policies, and priorities (incl. MTEF, budget reports, etc.) and others.

	Objectives/targets	Resources	Stakeholders
Analysis	amount; Example 2: allocate X amount from the city budget for MDR-TB case management for 20 patients through CSOs.	Example 1: Increase allocation for social assistance program by X amount; Bonus: Analysis of representation costs of local/municipal governments showed that XX amount was spent by the municipality on hospitality services. The requested allocation is only 0.01% of this spending.	
Intervention	Formulate advocacy messages.	Costing and budgeting exercises as needed.	Follow the budget cycle.

Notes:

ⁱ <https://www.cdc.gov/tb/statistics/default.htm>

ⁱⁱ WHO TB Fact Sheet (2018) <https://www.who.int/news-room/fact-sheets/detail/tuberculosis>

ⁱⁱⁱ WHO End TB Strategy https://www.who.int/tb/End_TB_brochure.pdf?ua=1

^{vi} UN High-level Declaration on TB (2018) <https://www.who.int/docs/default-source/un-high-level-meeting-on-tb/unhlm-tb-web-flyer-120x120.pdf>

^v WHO Global TB Report 2018.

^{vii} Global Fund funding is aggregated based on a few components – HIV, TB, TB/HIV, etc. The information reflected in this segment includes data on TB component since TB/HIV component was mostly used for coinfection treatment, and based on international reporting standards, these were reported as HIV. However, currently, this component remains as a sole funding source for some EECA countries.

^{viii} Among different donors, understanding of EECA region is different. The Global Fund Data Explorer module has proposed a somewhat different classification of countries according to regions (see details under Geographic groupings at <https://data-service.theglobalfund.org>): **Eastern Europe** including Belarus, Bulgaria, Czechia, Hungary, Moldova, Poland, Romania, Russian Federation, Slovakia and Ukraine, and **Central Asia** including Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan. Considering that this is not the common grouping used for EECA, in this analysis, we referred to regional grouping used by GF for EECA investment guidance “Turning the Tide”

HIV and Tuberculosis” (available at https://www.globalfundadvocatesnetwork.org/wp-content/uploads/2015/03/Global-Fund-Investment-Guidance-for-EECA_en.pdf Accessed on 16 October 2019) to include Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Kazakhstan, Kyrgyzstan, Kosovo, Georgia, Macedonia, Moldova, Montenegro, Romania, Russian Federation, Serbia, Uzbekistan, Ukraine, Tajikistan, Turkmenistan.

^{xix} Country income groups are based on GNI calculation by the World Bank using Atlas method. Most of the countries are upgraded over time, meaning that they become richer; however, a country can be downgraded as well, and this was a case of Tajikistan, who became LMI in 2015–2018 and Georgia (UMI in 2017).

^{ix} https://www.theglobalfund.org/media/5641/core_projectedtransitionsby2025_list_en.pdf (as of 2018)

^x A patient-centered approach to TB care, WHO 2018 <https://apps.who.int/iris/bitstream/handle/10665/272467/WHO-CDS-TB-2018.13-eng.pdf?ua=1>

^{xi} A global consultation of social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society (2017) https://harmreductioneurasia.org/wp-content/uploads/2019/03/OSF_Social_Contracting_Report_FINAL_English_Cover.pdf

^{xii} <https://www.ghcosting.org/pages/data/ucsr/app/>

^{xiii} <https://www.who.int/tb/country/data/download/en/>

^{xiv} Cost and expenditure data for specific countries downloaded from the national data repository for Global TB Report <https://www.who.int/tb/country/data/download/en/>

^{xv} World Bank Open Data <https://data.worldbank.org>

^{xvi} Budget support is a particular type of international aid, which is issued directly to the national treasury, and the Ministry of Finance is responsible for the allocation. Budget support might come with conditionalities regarding spending, but in general, the public/government sector has more freedom to allocate the funds per its priorities compared to donor-funded projects.

^{xvii} Public budget calendar in 11 project countries follows the calendar year, and this is true in most of the countries in the world, although there are some exclusions, when budgets are approved for more than one year or budget year does not start on 1 January.

^{xviii} You should keep in mind national regulations about “savings”/economies within a budget plan, as some countries do not allow reprogramming of savings after the tenders. In addition, budget plans include a description of economic categories, such as goods, or services, or payment of salaries, or capital expenditures. Funds initially budgeted for “goods” (i.e., drugs), will be easier to be re-programmed and used for purchasing drugs, than for covering salaries (if you are advocating for additional staff positions within NTP).

^{xix} A return on investment (ROI) analysis is a way to calculate your net financial gains (or losses), taking into account all the resources invested and all the amounts gained through increased revenue, reduced costs, or both. It is widely used in other sectors, but healthcare sector also uses this approach to develop and present economic arguments in support of an increased level of funding for certain interventions.

