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# **The Road to Sustainability: Transition Preparedness Assessment Framework**

**VERSION 2.0**

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## ACRONYMS

|        |   |
|--------|---|
| AIDS   | Acquired Immune Deficiency Syndrome               |
| ART    | Anti Retroviral Treatment                         |
| ARV    | Anti Retroviral                                   |
| CBO    | Community Based Organization                      |
| CCM    | Country Coordination Mechanism                    |
| CIS    | Common Independent States                         |
| CSO    | Civil Society Organizations                       |
| CN     | Concept Note                                      |
| DAH    | Development Assistance for the Health             |
| DOT    | Direct Observed Treatment                         |
| EECA   | Eastern Europe Central Asia                       |
| EEI    | Enabling Environment Index                        |
| FLD    | First Line Drugs                                  |
| GDP    | Gross Domestic Product                            |
| GARP   | Global AIDS Response Progress                     |
| GNI    | Gross National Income                             |
| HDI    | Human Development Index                           |
| HIS    | Health Information System                         |
| HIV    | Human Immunodeficiency Virus                      |
| BBS    | Integrated Biological and Behavioral Surveillance |
| IDI    | In-Depth Interview                                |
| IHME   | Institute for Health Metrics and Evaluation       |
| KP     | Key Populations                                   |
| LMIC   | Lower Middle Income Country                       |
| MTEF   | Medium Term Expenditure Framework                 |
| MDR    | Multi Drug Resistance                             |
| MoH    | Ministry of Health                                |
| MSM    | Men who have Sex with Men                         |
| NASA   | National AIDS Spending Assessment                 |
| NGO    | Non Governmental Organization                     |
| NSP    | National Strategic Plan                           |
| NTP    | National TB Program                               |
| ODA    | Official Development Assistance                   |
| OST    | Opioid Substitution Therapy                       |
| PEPFAR | The President's Emergency Plan For AIDS Relief    |
| PHC    | Primary Health Care                               |
| PMTCT  | Prevention of Mother-to-Child Transmission        |
| PWID   | People Who Inject Drugs                           |
| SLD    | Second Line Drugs                                 |
| SW     | Sex Worker  |
| TERG   | Technical Evaluation Reference Group              |

|        |  |
|--------|--|
| TGF    | The Global Fund                                    |
| TB     | Tuberculosis                                       |
| TPAF   | Transition Preparedness Assessment Framework       |
| UMIC   | Upper Middle Income Country                        |
| UNAIDS | Joint United Nations Program on HIV/AIDS           |
| USAID  | United States Agency for International Development |
| VCT    | Voluntary Counselling and Testing                  |
| WB     | World Bank   |
| WHO    | World Health Organization                          |

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## Introduction

Following a period of exponential growth in aid provision for the health sector, the economic crisis, and resulting decline in the growth of development assistance for the health (DAH) sector, revealed a level of unpreparedness in certain countries and donors to cope with limited resources. Aid assistance grew just 3.9% from 2012 to 2013, a drop from the the rapid rates experienced over 2001–2010, which topped 10% annually (IHME, 2014). This trend is coming at a time of rapid economic growth in a large part of the developing world, which is rendering these countries ineligible for development assistance. Indeed, an OECD study/report found that, by 2030, 28 developing countries — a population of 2 billion people — will exceed the income threshold for official development assistance (ODA) eligibility (Sedemund, 2014).

These changes demonstrate the importance of planning for decreased external funding for all countries currently receiving aid for the health sector. Past experience shows that programmes that were created to respond to health challenges, but are discontinued without proper planning for handover, leave unmet needs and are a waste of human, monetary and technical investments. Prematurely ending these programmes can also lead to decreased community trust and a lack of support for future programmes (Heller, 2005; Shediac-Rizkallah and Bone, 1998).

Since its foundation in 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria (referred to from now on as the ‘Global Fund’) has invested nearly US\$4billion a year to support programmes addressing these diseases in over 140 countries (Global Fund, 2015a). The Global Fund currently measures a country’s eligibility for funding according to the disease burden (measured as disease prevalence and not in DALYs<sup>1</sup>) and income. This method has been criticised for failing to consider other important metrics related to real disease burden, equity and programme success/achievements. In addition, the problems associated with the current methods of classifying countries eligible for aid have been recognised by a number of international organisations and development agencies — including the Global Fund, which recently created an Equitable Access Initiative<sup>2</sup> to explore new ways to classify country’s funding needs and capacities (Global Fund, 2015b).

Furthermore, health focus area estimates by Institute for Health Metrics and Evaluation (IHME) highlight a minor shift away from communicable disease spending on HIV/AIDS, TB, and malaria within total DAH (IHME, 2014). It is clear that, as one of the most important funders for global health, changes in how the Global Fund allocates resources to recipient

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<sup>1</sup>DALY denotes disability adjusted life years a measurement used to estimate a disease burden caused by a given disease or a condition

<sup>2</sup>The Equitable Access Initiative is composed by GAVI, Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, the World Bank and the World Health Organization.

countries influences how countries will continue to implement activities that were previously donor-funded. This is particularly relevant for the Eastern Europe and Central Asian (EECA) countries, which are still burdened by fast-growing HIV/AIDS and TB epidemics. Adding to the problem is the resistance of some governments to develop outreach initiatives to target the most vulnerable populations, which are considered 'undesirable' by many societies, such as men who have sex with men, commercial sex workers and injecting drug users (Kazatchkine, 2014). In addition, the weak institutional NGO and civil society capacity in these countries hinders their ability to hold governments accountable to commitments made to addressing these diseases.

The "Transition from the Global Fund Support towards Programmatic Sustainability Research in four EECA countries" project, implemented by Curatio International Foundation (CIF), seeks to generate prospective evidence, using the *Transition Preparedness Assessment (TPA) Framework* developed by the project. The purpose of this is to provide information for an adequate transition planning process by identifying strategic and operational issues that will assure the sustainability of HIV and TB programmes, currently supported by the Global Fund and other donors. This framework is not meant to provide a comprehensive overview of Global Fund grants in the country; rather it is specific to assessing the elements that should be in place early on as a disease programme prepares for transition. Primarily, the framework would be used by country officials seeking to address key areas for planning a successful transition from Global Fund financing. This is useful since it will provide a picture of country readiness for a scenario without Global Fund support, as well as strengthening on-going efforts towards sustainability by enhancing political will, mobilizing resources and ensuring an adequate distribution of roles with concrete measures for accountability. Furthermore, by recognizing that transition is a process that should be observed over time, this framework provides the basis to evaluate transition preparedness at different moments in time in order to redirect efforts, if necessary. In addition, it is expected that this research will support the work of the Global Fund by developing tools to evaluate a country's readiness for transition, which can inform the Global Fund's assistance to recipient countries to prepare for sustainable transition scenarios in the short, medium and long-term.

Creating this work required the development of a conceptual framework and an assessment tool that serves as a practical guide for the Global Fund and countries to support a smooth transition away from donor support and ensure that the gains achieved through this collaboration are sustained. Therefore, this framework is meant to be a flexible tool that can be adapted to the situation in each country while providing guidance on key elements that should be present for all adequate transitions. The initial version of the TPA Framework was piloted by the Curatio International Foundation in four EECA countries: Belarus, Bulgaria, Georgia and Ukraine. The framework was refined following this pilot exercise and is presented below.

This report presents the TPAF, which resulted from a review of the sustainability literature research published over the past twenty years, primarily in the health sector. Therefore, the report starts by providing a brief summary of relevant findings based on the literature

review, followed by the TPAF description. The report then presents findings of the pilot exercise and limitations. A final section is focused on recommendations and on the use of the TPAF.

## What is sustainability?

The ultimate goal of the transition from donor support is to reach sustainability in the national response. However, sustainability has been defined in a variety of manners in the literature. For our purposes, it is useful to review how the main Global Health Initiatives, funding initiatives to disburse additional funds for specific health needs, have approached sustainability.

The Global Fund defines sustainability as the endurance of a system or process, derived from the Latin word 'sustinere' meaning to 'hold up' (Global Fund, 2014). They also refer to the Brundtland Commission (1987) definition, which explains that "sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs".

The United States Agency for International Development (USAID) and the US President's Emergency Plan for AIDS Relief (PEPFAR) define sustainability as "the capacity of a host country entity to achieve long-term success and stability and to serve its clients and consumers without interruption and without reducing the quality of services after assistance ends (USAID, 2013)". They view country ownership as a key step to the sustainability of development initiatives. In these institutions, ownership is "characterized by government, communities, civil society and private sector [being] able to lead, prioritize, implement and be accountable for a country's health response (USAID, 2013)".

Gavi, the Vaccine Alliance's definition of sustainability encompasses the co-financing of vaccination schemes as the government 'commitment' and government ownership of vaccination programmes (Saxenian et al., 2014).

Other words used to refer to sustainability found in the literature are: 'continuity' (Sherirer, 2005), 'routine' (Greenhalgh et al., 2004), 'maintenance' (Gruen et al., 2008; LaPelle, Zapka&Ockene, 2006; Shediak-Rizkallah& Bone, 1998), 'permanence' (O'Loughlin et al., 1998), 'institutionalisation' (Shediak-Rizkallah& Bone, 1998) and 'incorporation' (Bracht et al., 1994; Pluye, Potvin& Denis, 2004; Stefanini& Ruck, 1992).

For the purposes of this document we use The Global Fund definition of sustainability and transition.<sup>3</sup> **Sustainability** is defined as ***“as the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support***

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<sup>3</sup> The Global Fund Sustainability, Transition and Co-financing Policy. Board Decision. GF/B35/04 – Revision 1. 35th Board Meeting. 26-27 April, 2016



**efforts for elimination of the three diseases, even after the removal of external funding by the Global Fund and other major external donors".** However, before reaching sustainability, countries will necessarily experience a transitional period, during which they set the foundations for durable continuity for the donor supported programs. Therefore, **transition** is defined as **"the mechanism by which a country, or a country-component, moves towards fully funding and implementing its health programs independent of Global Fund support while continuing to sustain the gains and scaling up as appropriate"**.

It is important to note that promoting effective transition away from donor support towards sustainability does not mean that programme components will necessarily continue unchanged over time since the programme should naturally respond to external and internal changes. Rather, a successful transition would involve the existence of effective mechanisms to sustain gains achieved through the support of the Global Fund (or donor) and the appropriate response to emerging changes.

## Types of sustainability

These definitions tell us that sustainability is a multi-faceted concept that can be put into operation in a number of ways. The main types of sustainability found in the literature are:

- *Technical sustainability*: The continuous provision of quality, facility-based services according to national standards (Torpey et al., 2010) and/or delivering quality preventive, community-driven (or provided) services.
- *Programmatic sustainability*: The effective management, coordination and implementation of services (Torpey et al., 2010).
- *Operational sustainability* is a term that has been used to encompass technical and programmatic sustainability (Torpey et al., 2010)
- *Financial sustainability*: Adequate and ongoing funding to reach service provision targets and objectives (Torpey et al., 2010).
- *Fiscal sustainability*: The ability of a government to sustain current spending, tax and other policies in the long run without threatening government solvency or defaulting on liabilities or expenditures (Krejdl, 2006).
- *Organizational sustainability*: The capacity to achieve goals and increase long-term stakeholder value by integrating economic, environment and social opportunities into its strategies (Sheidiac-Rizkallah & Bone, 1998).
- *Social sustainability*: Long-term demand for services by the users (Torpey et al., 2010). This type of sustainability is related to the viability of services. For example, if a disease is eradicated there would be no demand from patients to allocate resources to combat this disease
- *Political sustainability*: The political will to continue a policy, which is frequently related to political pressures (Pavignani & Colombo, 2009).

Among these types of sustainability, the Global Fund considers financial and programmatic sustainability as their main areas of concern, although how they define and use these concepts is not completely clear. **Programmatic sustainability is frequently defined as the non-fiscal capacity of a government to sustain programmes. It could potentially include technical, organizational and political sustainability.** Understanding how resources will be collected, allocated and sustained to continue the operation of existing programmes; how programmes that are currently managed through extensive technical assistance will operate; how access to goods, currently priced at below market prices with the help of voluntary pooled procurement, could be assured, etc. is a clear concern for graduating countries and the Global Fund. However, equally important is the ability of these countries to manage these programmes without outside support.

In our framework, we focus on programmatic sustainability analysis, which entails assessing a country's technical, organizational and political sustainability issues in relation to their HIV, TB and Malaria programmes. While, this invariably requires understanding aspects of fiscal and financial sustainability, which were referred to earlier, our framework does not delve into an in-depth analysis of fiscal space in order to avoid duplication of the ongoing work at the World Bank, which is also supported by the Global Fund. Rather, the Global Fund should build on both efforts by focusing on programmatic sustainability, which is one of the identified bottlenecks in transition and is discussed in this document, and merge it with the financial and fiscal sustainability work undertaken by the World Bank.

## Capitalising on previous transition experiences

In addition to the theory and available evidence that guides sustainability, important lessons can be learned from the experiences of countries that have moved away from donor support. This section summarises three such examples: the Avahan programme, GAVI graduating countries and findings from the Global Fund sustainability report.

### The Avahan programme

The Avahan programme was funded by the Bill and Melinda Gates Foundation to address the spread of HIV/AIDS in India. This programme started in 2003 as a standalone programme funded through a series of grants to NGOs who run programmes in six different states. In 2007, the programme started to plan and refine a transition strategy to transfer ownership to the country stakeholders and institutionalise it within the Indian government response (Bennett et al., 2011).

This was done by employing three strategies: Enhancing government capacity and political will by supporting the technical and managerial skills of government officials; supporting NGO capacity through the provision of capacity development support; encouraging service alignment; and supporting community capacity by strengthening management and governance structures (Sgaier et al., 2012).

The main findings show that the transition mechanism should be built into the design of the programme itself from the very beginning, with a dedicated financial budget (Bennett et al., 2011). This should be a planned and gradual process that takes into account the time and funding necessary to implement budgetary changes; develop a political commitment to transition, as well as trust and communication between partners; and install appropriate management, governance and accountability systems (Bennett et al., 2015).

A collaborative and coordinated approach was also a critical component for the effective take-over of roles, as well as aligning the programme with government policies, although in this case, this took some time. It is also important to note that reassuring country stakeholders that the programme would continue under the same vision and commitment was a key challenge identified in the transitional process (Sgaier et al., 2012).

### **Early experiences from Gavi graduating countries**

Gavi, the Vaccine Alliance has provided vaccines, supplies and programmatic support in over 75 developing countries since 2000. Their graduation from aid has been designed by increasing domestic co-financing of the vaccines while Gavi funding slowly decreases over several years. In order to achieve this, they sign a contract with the Ministry of Health and the Ministry of Finance at the start of funding to ensure enforcement of this commitment to co-financing. By taking this approach, they believe the country will be able to fully fund the vaccines in a sustainable manner once Gavi support ends.

In 2014 they published an article detailing the results of a pilot conducted in 2012 in Bhutan, Republic of Congo, Georgia, Moldova and Mongolia. In this project, they supported transition planning for sustainability in the four countries by developing country assessments of readiness to graduate. This also involved meeting and negotiating with national officials to ensure a smooth transition process (Saxenian et al., 2015).

Findings suggest that, in addition to financial sustainability, other challenges such as vaccine procurement policies and practices, market intelligence (such as forecasted vaccine prices), national regulatory capacity, and the lack of reliable data, in addition to other issues, can have an effect on the ability of a country to successfully graduate from Gavi support. Therefore it is critical to consider scientific innovation, vaccine delivery and coordination with broader health financing trends and donor practices when planning for transition out of Gavi aid. National champions with influence at the decision-making level were also found to have an important role in the transition process (Saxenian et al., 2015).

Following from this experience, Gavi engages with countries prior to and during graduation by assessing potential bottlenecks for sustainability. This allows them to mitigate these challenges during transition; develop transition plans with clear timelines and targets; establish transition grants to support countries that are within five years of graduation; and utilise a monitoring plan to ensure that the implementation of required activities is advancing towards graduation. Transition assessments take place at least 2-3 years before graduation and, during this time, Gavi may provide support for activities critical for successful transition (Gavi, 2015).

## **The Global Fund sustainability review**

The Technical Evaluation Reference Group (TERG) report was published in 2013 and involved a sustainability review of programmes supported by the Global Fund to identify issues that affect a programme's sustainability and inform the development of a sustainability strategy for the Global Fund (Continental Development Alliance Consultants, 2013).

The TERG report found that, in addition to classifying a country's preparedness for transition based on income classification, demographic, economic, disease burden and programme financing factors should be considered.

This report also reviewed the experiences of 12 countries and found that enablers of sustained transition included:

- High levels of domestic health financing
- Clear policies and strategies for strengthening health systems
- Political will to prioritise national health investments
- An effective institutional framework for the coordination, management and implementation of existing programmes
- Good collaboration with other development partners prior to and during transition
- Involvement of the Global Fund during planning, implementation and monitoring of transition

## **Learning from previous sustainability frameworks**

The findings outlined above demonstrate how countries have dealt with the transition from funding in various ways. However, in addition to lessons learned from empirical research, it is necessary to assess the elements required for a transition in a systematic manner so the framework can be used in other contexts.

We can find in the literature several efforts to systematically analyse the transition of health programmes towards sustainability. The literature shows that there are two main approaches to evaluating transition. These frameworks either take the programme cycle as the basis for understanding sustainability or address sustainability by measuring whether the identified enablers of sustainability have been reached.

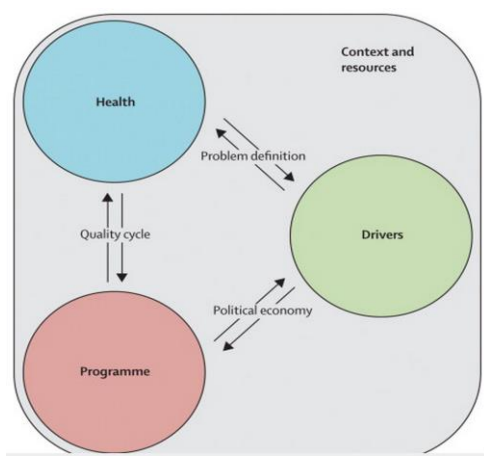
While theoretical frameworks have been tested on health programmes, a distinction can be made between general frameworks evaluating transition and sustainability and those that were generated for a specific financing mechanism. The strength of applied frameworks is that they are adapted to the financing mechanism or programme and are thus able to specify key components that need to be addressed. Therefore, we have also included two examples of frameworks that track enablers of sustainability, which have been developed for other financing mechanisms, namely PEPFAR and the Gavi vaccine alliance, demonstrating practical approaches to assessing sustainability.

## Frameworks based on the programmatic cycle

The first approach relates to how a programme works and, consequently, how it will continue to function following the end of external funding.

- a) Gruen and colleagues (2008) emphasise the drivers or relationships between programme components. They describe a health programme as a complex adaptive system that depends on a number of interactions between the population's health concerns, the programme components and drivers, within a sociocultural, political and geographical context (see **Figure 1**). This is also highly dependent on the resources available and the type of health system a country has. The interactions among various programme elements, drivers and context are very dynamic and determine programme outcomes. The outcomes themselves have an effect on the programme and the overall context so this can be seen as a cyclical process.

**Figure 1. A system for sustainable health programmes**



Source: Gruen et al. (2008).

- b) The framework proposed by Olsen (1998) is based on the interaction of factors within the programme cycle, which include:

1. Contextual factors that can be divided into general factors related to the general political and economic situation in a country and specific factors related to the population's health and health services.
2. Activity profile is the kind of services delivered, the choices that determine technologies used and the level of care, etc.
3. Organizational capacity represents the ability of the responsible entity to conduct the tasks. The aim of the organisation, its technical expertise and demand for its services determine the nature of the organizational capacity. Related to this are the decision-making processes, division of labour, coordination of work, and leadership.

## Frameworks based on enabling factors for sustainability

The frameworks that focus on the programme cycle are useful for understanding the process of reaching sustainability. The frameworks presented below measure sustainability by focusing on specific elements that have shown to lead to successful transitions. In this section, we also include two examples from other financing agencies, PEPFAR and Gavi Vaccine Alliance, and highlight how they have applied these enabling factors in their own transition assessments.

Schell and colleagues' (2013) developed a framework that suggests a number of factors that can be related to a programme's ability to sustain its activities and benefits over time. This framework focuses on nine domains: Funding stability; political support; partnerships; organisational capacity; programme adaptation; programme evaluation; communications; public health impacts; and strategic planning (see **Figure 2**)

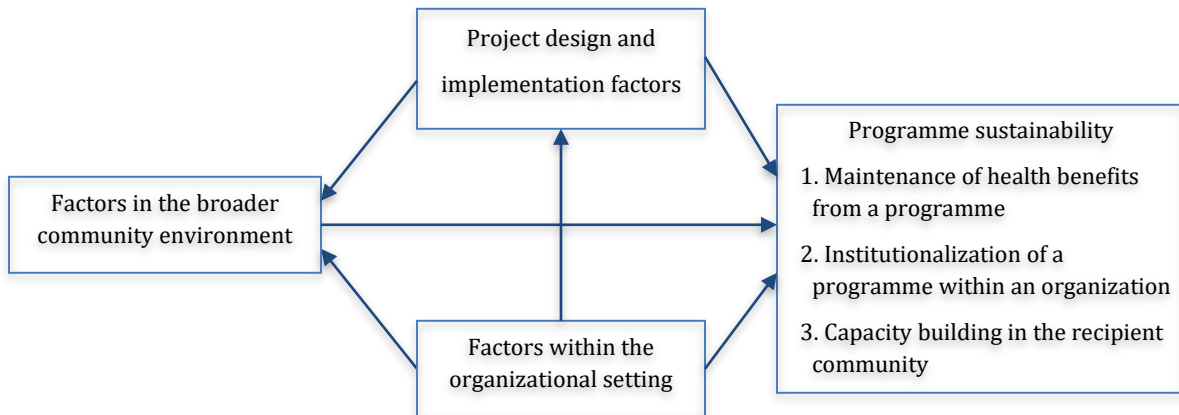
**Figure 2. Schell and Colleagues' Graphic Framework and Definitions**



Source: Schell et al. (2013)

b) The Sheidiac-Rizkallah and Bone (1998) framework provides a basic view of sustainability by organising enabling factors into clusters without further details about what each step involves or how they are related (see **Figure 3**). This framework is divided into the broader community environment; project design and implementation factors; factors within the institutional setting; and the programme sustainability.

**Figure 3 Sheidiac-Rizkallah& Bone framework for conceptualising programme sustainability**



Source: Sheidiac-Rizkallah& Bone (1998)

c) Using an applied approach, PEPFAR has developed a number of frameworks to assess the transition of the HIV/AIDS programmes they have helped finance. The most recent guiding framework reflects their definition of sustainability based on country ownership (PEPFAR, 2015). The new PEPFAR Country Operational Plan (COP) requires countries to assess five areas of sustainability:

- Availability of current data for decision making;
- Local leadership in service delivery;
- Domestic health financing and resource mobilization;
- Accountability for and transparency of results and spending;
- An enabling environment defined as the policies, laws, regulations and effective planning and coordination that support programme implementation

It is important to note that PEPFAR requests countries complete sustainability indices and dashboards to evaluate the sustainability of their HIV responses. Through this process, they seek to identify potential challenges to sustainability (PEPFAR, 2013).

d) Gavi, the Vaccine Alliance developed a framework, based on the sustainability literature, to assess a country's readiness to graduate successfully and to elaborate transition plans for each country. This framework is specific to their work (though it can still be adaptable to other contexts) and combines programmatic approaches with specific elements for sustainability (Saxenian et al., 2014). It focuses on three domains:

- Service delivery platforms (government, NGO and private sector providers) that are accessible to the entire population

- Sound policies and institutions (ministries of health, networks of non-government providers, medical associations, etc.)
- Adequate and predictable funding to cover the costs of vaccines, personnel, cold chain and other inputs. The system also requires a range of other resources, such as skilled workers, know-how, funding, political commitment and accountability mechanisms.

These two types of frameworks, based on the programmatic cycle and enabling factors for sustainability, have their strengths and weaknesses. The programmatic cycle shows how transition is determined by the interaction between the context in the country, actors and programme, which allows you to track how these interactions take place throughout the different stages of planning, allocating resources, distributing responsibilities and conducting the programme activities. The enabling factors for sustainability approach to understanding transition directly measure the elements that have shown to lead to successful transition without establishing relationships between these within their corresponding context. A hybrid approach that follows the enablers of sustainability, within the programme cycle that is applied to the Global Fund, means that the nuances related to the specificities of the Global Fund can be tracked and ultimately addressed. This means that key bottlenecks can be identified and targeted within the transition process, which establishes the path for more durable change and grounded solutions that can lead to effective programmatic sustainability.

## **Transition Framework**

The review of the frameworks presented in the previous section demonstrate that there is value in measuring transition towards sustainability by focusing on specific elements that have been proven to influence sustainability, in addition to placing these within the wider programmatic cycle and a country context. A hybrid framework that includes the programmatic cycle and the enablers of sustainability approaches would allow for tracing enablers of sustainability within the existing institutional mechanisms. This could lead to a greater degree of successful transition, and, therefore, programmatic sustainability, given that roles, resources and capacity needs would be clearly delineated. This reduces the level of uncertainty about the distribution of roles, which is a clear difficulty of transition since these responsibilities are linked with different stages of the existing programme.

Since programmes are complex and adaptive systems in which specific enablers of sustainability over time lead to better and durable results, this hybrid framework is essential in order to bring together the contribution of the individual approaches/frameworks that was discussed earlier. Our proposed framework takes into account the manner in which programmes operate and adds the elements of how programmes are planned, rolled-out and implemented by allowing us to assess the necessary steps towards a sustainable disease programme scenario. By tracking the main enablers for sustainability within the programmatic cycle, and understanding what may be

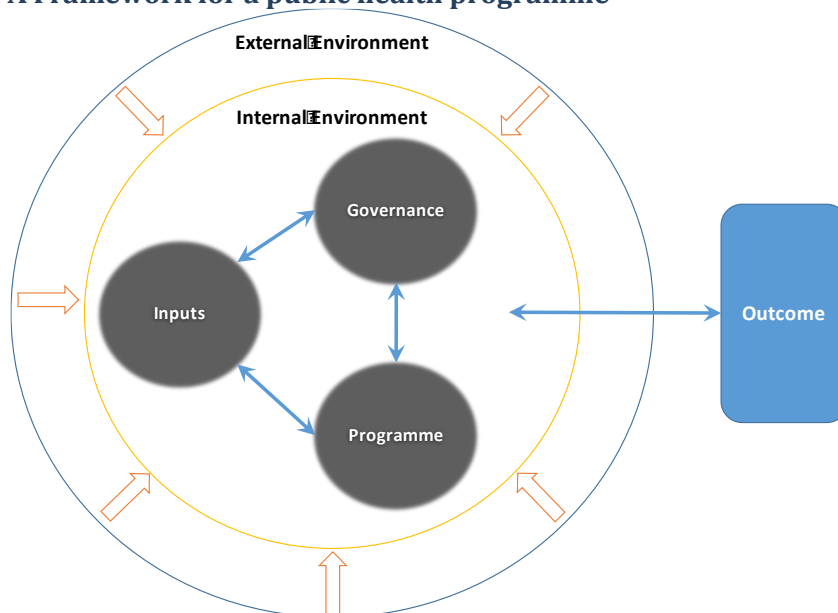


required within each of the steps of the programme planning and implementation, we are able to provide a clear context-specific roadmap for sustainability.

This approach is unique since we go beyond identifying whether an enabler for sustainability is present or not by placing these within the broader programme, operational and country context. This allows for a greater understanding of what is required within the institutional process to maintain these positive factors over time.

Based on this literature review, we identified two overarching domains: the external environment made up by the political and economic environment and the internal environment where we identify the inputs, governance and programmes. By analysing these external and internal environments, we can gauge a country's readiness and/or identify the steps required to reach the proposed outcome, which could be defined as a successful transition from Global Fund support to programme sustainability (see **Figure 4**).

**Figure 4. TPA Framework for a public health programme**



Source: Authors' creation based on Amaya, A.B., Caceres, C.F., Spicer, N. and Balabanova, D. (2014).

Both domains are formed by wider components that include those factors that enable transition. In the case of the internal domain, this is divided further into sub-domains, made up by the programme components. These sub-domains organize the enablers for sustainability based on the part of the programmatic cycle they address (see **Figure 5**). The framework elements are:

### **External environment**

This is defined as those factors that are outside of the health sector but having significant impact on the health response and its outcome. The political and economic environments are priority areas for the transition of disease-specific programmes.

- An enabling political environment

Widely characterised by a stable political environment where political will exists to prioritise and sustain investments in health, in this case specifically on the HIV/AIDS and TB response. An enabling political environment can also be measured by the existence and continuous advancement of the legal frameworks necessary to ensure the respect of the rights of affected communities and ensure the continuity of disease-specific programmes, as well as uphold the rule of law. Another important element considered is the existence of mechanisms to enable the government to contract civil society organizations since these actors frequently provide the majority of services within the countries, generally in the area of prevention.

- An enabling economic environment

Generally defined as a national economic environment that makes sustained and predictable investments in health possible at a level that is comparable to the population's need. This is assessed by evaluating GDP trends in the country and the share of general government revenues as the percentage of GDP. Fiscal space is a critical element of the economic environment and obtaining an adequate measurement requires a more granular approach. As noted earlier, our proposed framework will not address this issue in depth since this work is already being conducted by the World Bank in collaboration with the Global Fund.

The initial TPA framework, prior to the pilot in four countries, included an enabling social environment, defined as the existence of a good social environment where unemployment, inequality and poverty levels are addressed; as well as an examination of other external factors, defined as the existence of appropriate planning and risk management mechanisms to address environmental and social challenges, in addition to responding to unexpected events, such as ethnic and military conflicts, as well as natural disasters. Although these two components are helpful in providing an overall picture of the country, following the pilot exercise they were removed since they were not identified as key areas that may explain transition readiness.

### **Internal environment**

The internal environment includes those factors that are specific to the health sector and its programmes. This involves all of the actors working directly within the health system. The following are the internal environment sub-domains:

- Inputs

The inputs entail the resources currently available for the disease-specific programme. The inputs are critical elements within any programme. Programmes cannot be continued without appropriate resources. This is why resources are frequently one of the most highly discussed topics when considering sustainability. These resources are subdivided into financial resources, human resources and health information systems.

Financial resources are the adequate and predictable monetary resources in the country to sustain the programme. This can be explained by the budgetary commitment to the specific diseases, commodities, investments on prevention and allocative efficiency studies, etc. This component is highly associated with an enabling political and economic environment. According to the country structure, the allocation of financial resources is frequently determined at higher levels of the government outside of the health sector. Demonstrating health needs and results achieved by programmes, and advocating for continued resources, are key to an effective transition.

Human resources are the service providers (among these specialists, primary doctors, nurses, community workers, social workers, among others) who promote prevention; provide care; treatment; or support to HIV and TB affected-populations. These human resources may work within disease-specific units or may provide general primary health services or even managerial cadre. The availability of well-trained and appropriately distributed human resources, along with systems necessary for human resources production and re-training (i.e. continuous education), is crucial for programme success. This is even more crucial in a transition scenario due to the importance of continuing care for patients with TB and HIV, in particular given the risk for declining investments in human resource development and retention, frequently funded by grants (Bowser, 2014). Human resource availability can be assessed by measuring the adequacy of human resources by considering their number, geographic distribution and staff turnover. Another measure important for transition is the number of donor-provided trainings that have been institutionalized within the educational system; the policy for training civil society personnel; and the alignment of donor-funded salaries (top-ups) with the national pay-scale.

Adequate, reliable and quality data is vital for any programme. Data provides insight into the successes and weaknesses of the programmes, allowing for readjustments and, at times, demonstrating the need to discontinue inadequate programmes. This data is expected to be provided by health information systems, as well as by studies which vary from country to country. These information systems can be paper-based, electronic, web-based or a mix of these. Data on HIV and TB is important to evaluate if the disease-specific programmes are responding to population needs. We assess this area by inquiring on the level of integration of the advanced routine statistical reporting in the national system, specifically for the diagnosis, treatment and coverage for both diseases; and the availability of adequate and quality surveillance data production that is supported by national resources and is not donor dependant.

Commodities are important inputs that need to be sustained in any health programme. However, the need for commodities is context dependant and may decrease or grow over time, which is why we have not addressed the quantity of commodities directly. While the budgets allocated for commodities are covered in the financial resources component, procurement, which is more closely related to the processes that need to be sustained, is addressed in the programme sub-domain.

## □ Governance

This sub-domain includes the actors/institutions involved at an organisational level, how they make decisions, their roles and motivations towards the adequate transition of the HIV/AIDS and TB programmes and their relationship with other actors (including fostering effective partnerships with these actors). Identified enabling factors related to governance are sub-divided into governance-specific factors and accountability.

Governance-specific factors include a strong political commitment to the disease treatment and fostering political support for the programme; effective leadership/management ensured through a legally empowered organization and the existence of champions that advocate for and/or manage the disease-specific programmes; and appropriately coordinating all parties involved in the programme through a dedicated, legally empowered and well-functioning coordinating body.

Developing and enforcing accountability mechanisms to ensure commitments are held are one of the key drivers for sustainability. This entails communicating performance results through a public domain, including reporting expenditure data along with programme results and results in the key affected populations. Moreover, a large proportion of efforts to hold actors accountable are conducted by non-state actors, including civil society organizations. Therefore, it is crucial to have an enabling environment for civil society organizations to operate.

## □ Programme

This sub-domain encompasses the activities included within the health programme and the operational capacity to implement these activities. This sub-domain is composed by service delivery, organizational capacity and transition planning components. Within service delivery we look at integration for certain services (e.g. integrating PMTCT in PHC and/or maternity care, or integrating TB in PHC, etc.), service coverage and treatment outcomes, which are also captured under services. One could argue that the latter should be (or could be) used as outcome measurements for the programme. However, these indicators allow us to understand how the programme is currently functioning and incorporating mechanisms developed through Global Fund financing and are therefore important when assessing transition.

Concerning the organizational capacity to provide services, we found that management of the national disease programmes; procurement mechanisms; and the existence of appropriate monitoring and evaluation mechanisms, including adequate analytical capacity, is crucial for the effective transition of these disease programmes.

An important part of the programme is setting guidelines to prepare for future decrease in external funding. The appropriate tracking of the transition process requires transition planning through strategies that align the programme with national policies that are informed by international guidance and/or evidence; programme management arrangements to assure appropriate transfer of responsibilities; and an effective monitoring and evaluation of the transition.

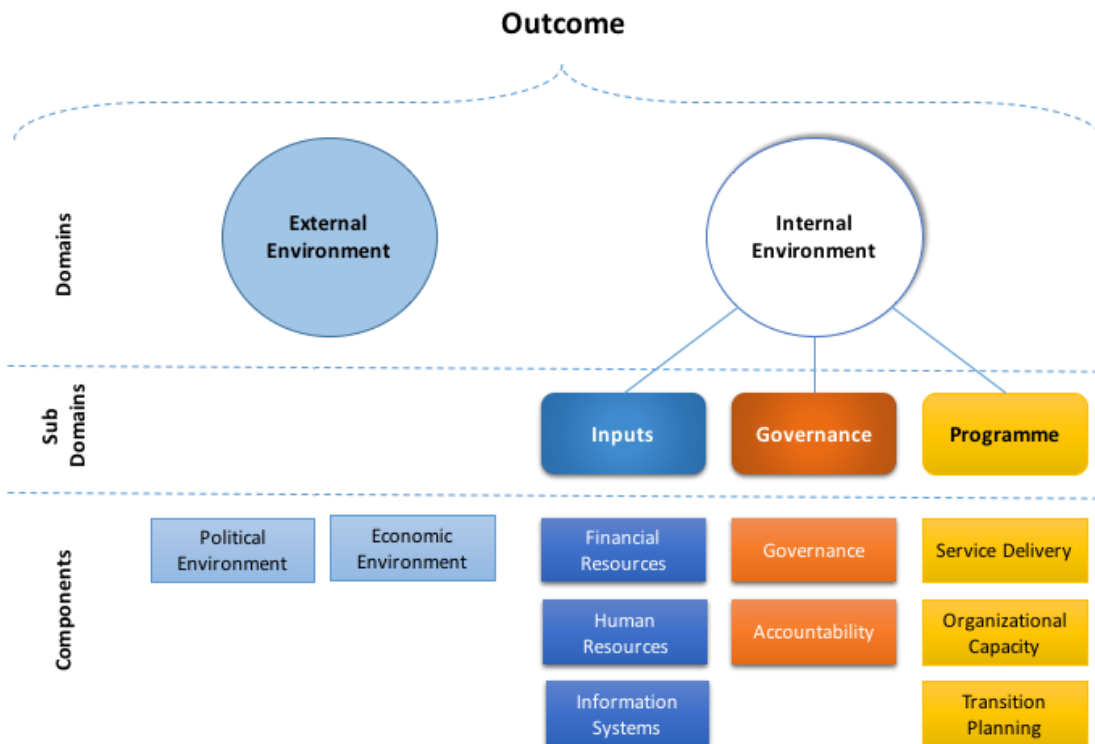
## Outcome

The final expected outcome of this process is the successful transition of HIV and/or TB programmes (and/or its elements) in a post-Global Fund scenario when programme outcomes (i.e. public health gains) are either retained and or enhanced. Operationally this is understood as the capacity and mechanisms developed to sustain or enhance the programme response, i.e. programme outcomes, through the interaction of enabling internal and external factors.

As previously mentioned, this does not mean that programmes will necessarily continue as they were originally conceived since they will respond to external and internal forces. Rather, a successful transition would include the existence of effective mechanisms and adequate capacity to sustain gains achieved through Global Fund support, as well as the resources to appropriately respond to emerging changes.

As **Figure 4** shows, these components continuously interact with each other. The external environment will determine the resources and support available to undertake the programme independently. At the same time, decision-making at the level of governance is closely related to available resources and existing policies. Moreover, if a programme is deemed successful or if it responds to clear needs, it will influence how decision-makers and/or advocates prioritise that programme. Finally, all of these components have an effect on the potential for successful transition to sustainability i.e. durable programme outcomes.

**Figure 5. TPA Framework components**



Source: Authors' creation.

## Operationalizing the framework

Each framework component was operationalized into indicators for each domain and its components. Indicators were chosen following the 'SMART' criteria (Drucker, 1955). These are indicators that are:

- **Specific**, focused and clear;
- **Measurable**, which means they are quantifiable and reflect change;
- **Attainable**, indicators that are reasonable in scope and achievable within a set time-frame;
- **Relevant**, meaning pertinent to our objective of evaluating transition; and
- **Time-bound/Trackable** where progress can be charted over-time.

Other considerations for selecting indicators were: indicators should be valid and reliable; measurable; influenced by action; and sensitive to changes in other societal domains such as socioeconomic, environmental or public policies (Parrish, 2010). Moreover, to avoid duplication of efforts, the existing indicators from other monitoring and evaluation frameworks, such as the PEPFAR Sustainability Index Dashboard (PEPFAR, 2014) were selected when appropriate.

Chosen indicators sought to respond to each of the framework components. This resulted in 132 indicators and included quantitative indicators available from public databases; and qualitative and quantitative indicators that would need to be collected through desk research, from local sources and with the help of interviews. Each indicator was defined, a measurement method was proposed and source identified, which was presented in a matrix.

Following the pilot exercise, we had a basis on which to evaluate useful indicators that could be used to explain the situation of each country regarding transition preparedness and were also feasible to collect with relatively minimal resources and a limited timeframe. The matrix was simplified to contain 105 indicators. These indicators were used to assess possible risk for transition using a scoring system 2=low or no risk, 1=medium/moderate risk and 0= high risk. More details about the conventions for score assignment are provided in Annex 1, which explains the use of quantitative and/or qualitative information for scoring purposes. Countries were scored on each indicator. A summary score for a country was also established, which helped identify the overall risk for transition and more importantly, the critical areas (components) that may pose the highest risk and should be addressed during the transition process. Scores were assigned individually by two researchers and thereafter discussed within a group to arrive at a final judgment. Weighting was not applied during the scoring approach because it was felt that identifying areas of possible risk for transition was more important than giving higher priority to a certain area. The research team felt that prioritization of bottlenecks that may hinder transition should occur through country dialogue and not through weighting.

**Table 1** illustrates how this tool assesses country readiness for transition. The table provides a two-dimensional view, i.e. provides overall assessment of transition preparedness for a given country, when all scores are summarized on the bottom line of a table. It also helps single out programme level bottlenecks that may impede transition and therefore need attention. Finally, most indicators are the same across TB and HIV/AIDS, although there are some indicators which are disease specific and therefore, when used with other general indicators, help evaluate the risk for the given disease programme.

Following the country transition assessment, the analysis and interpretation of results will allow prioritization of key activities for the transition plan. To allow for good targeting of activities, this assessment should be made by component and not overall domains or sub-domains. In this sense, areas highlighted in green are components that have shown progress prior to transition. These components should be maintained at current or higher levels but given the lack of risk they do not need to be included in the transition plan. Components with moderate risk (dark yellow) should be included in the transition plan, but only for monitoring and in case risks increase, actions should be taken. Areas highlighted in light red or dark red are those that are considered high risk. These components warrant to be included in the transition plan as risk mitigating activities and after prioritization by the stakeholders through a feasibility lens need acted upon i.e. implemented. Clear steps to address these areas should be developed early on with milestones set from the start to measure progress over time.

**Table 1. Illustration of the TPA Framework**

| Component                       | Disease | Indicators | Measurement | Programme-level bottlenecks that should be |                                     |                                 | Component Assessment |
|---------------------------------|---------|------------|-------------|--|-------------------------------------|---------------------------------|----------------------|
|                                 |         |            |             | Low risk<br>X criteria are met             | Moderate risk<br>X criteria are met | High risk<br>X criteria are met |                      |
| External Environment            |         |            |             |  |                                     |                                 |                      |
|                                 |         |            |             |  |                                     |                                 |                      |
| Internal Environment            |         |            |             |  |                                     |                                 |                      |
|                                 |         |            |             |  |                                     |                                 |                      |
| Overall Country Risk Assessment |         |            |             |  |                                     |                                 |                      |

General country assessment on readiness for transition

## Illustration of the framework using the pilot results

As part of the research project, this framework (HIV and TB modules) was piloted in Belarus, Bulgaria, Georgia and Ukraine. These four Eastern European and Central Asian (EECA) countries share important similarities, such as being middle-income economies that have emerged in a post Soviet-era as independent states and have faced, to a degree, comparable transition challenges. They all received funding from the Global Fund early on yet their upper-middle income status and generally low HIV prevalence (with the exception of Ukraine) has signalled the gradual end of support from the Global Fund.

The project entailed several phases: A pre-fieldwork review of the literature, which included quantitative data collection from public databases; the fieldwork stage that primarily entailed qualitative data collection and, where necessary, quantitative data was also collected; data analysis; re-financing the framework; and the formulation of conclusions and recommendations.

The desk review of the literature allowed the researchers to become more acquainted with the latest developments in HIV/AIDS and TB in the countries, as well as to start to collect quantitative data guided by a matrix. This matrix divided the different framework components into quantitative and qualitative indicators and an interview guide was developed from this.

Following the desk review, and prior to fieldwork, the researchers were trained on the use of the framework and were asked to follow the interview guide as closely as possible. This exercise resulted in 20 to 36 semi-structured interviews in each country. The interviewees were key stakeholders from the government or directly working with Global Fund grants. These were identified based on their relationship with these grants, as well as through the snow-ball technique, meaning interviewees nominate other potential interviewees. The interviewees included government officials, donor representatives, international organizations, and members of civil society, among others. Once in the countries, the researchers took the opportunity to request additional data from country officials that is not available online.

The pilot did not result in any major changes to the framework and its dynamics, since the interviewees and fieldwork researchers considered the domains and components to be useful for organizing the elements necessary for transition. However, as explained earlier, the pilot did result in removing two components of the external environment and streamlining the indicators.

Qualitative and quantitative data were analysed and discussed within each country research team. The qualitative and quantitative results were triangulated with the findings from the review of the literature. Country-specific findings were then discussed with the entire team of researchers to reach cross-country conclusions and recommendations.



**Table 2** presents an illustration of the use of this framework by providing a summary of the main country findings based on the pilot exercise. Detailed country findings and recommendations are presented in respective country case study reports and another report which provides a synthesis of the four country findings.

**Table 2. Illustration of TPA Framework: Summary of main pilot findings**

| Domain/Sub-domain/Component            | Belarus      | Bulgaria     | Georgia      | Ukraine      | Component Assessment |
|--|--------------|--------------|--------------|--------------|----------------------|
| <b>External Environment</b>            |              |              |              |              |                      |
| Political                              | Dark red     | Light green  | Light yellow | Light yellow | Light yellow         |
| Economic                               | Light green  | Light green  | Light green  | Light yellow | Light green          |
| <b>Internal Environment</b>            |              |              |              |              |                      |
| <i>Inputs</i>                          |              |              |              |              |                      |
| Financing                              | Light yellow | Light yellow | Light yellow | Dark red     | Dark red             |
| HR                                     | Dark red     | Light yellow | Light yellow | Light yellow | Light yellow         |
| HIS                                    | Light yellow | Dark red     | Light yellow | Light yellow | Light yellow         |
| <i>Governance</i>                      |              |              |              |              |                      |
| Governance                             | Light green  | Light yellow | Light yellow | Dark red     | Light yellow         |
| Accountability                         | Light yellow | Light yellow | Light yellow | Light green  | Light yellow         |
| <i>Programme</i>                       |              |              |              |              |                      |
| Service delivery                       | Light yellow | Light yellow | Light yellow | Light yellow | Light yellow         |
| Organizational capacity                | Light yellow | Light green  | Light yellow | Dark red     | Light yellow         |
| <b>Transition preparedness</b>         | Dark red     | Dark red     | Dark red     | Dark red     | Dark red             |
| <b>Overall country risk assessment</b> | Light yellow | Light yellow | Light yellow | Light red    |                      |

**Legend**

- Low risk = Dark Green - >85%
- Moderate to Low risk = Light Green - 70-85%
- Moderate risk = Dark yellow - 50-69%
- Moderate to High risk = Light yellow - 36-49%
- High to moderate risk = Light red - 25-35%
- High risk = Dark red - <25%



## Limitations

While the framework was generally viewed as useful by the country participants, including policy-makers and programme implementers, its comprehensive approach to transition may have made it too ambitious given the strict timeframes (under the contract with the Global Fund for this research project) associated with piloting a framework in countries. Although an overarching framework that provides detail on the country as a whole is ideal, in practical terms this framework should be broad enough to explain the external influences associated with transition (included in the external environment), while being specific enough to provide detail on the level of preparedness of the HIV and TB programmes for transition in a post-Global Fund scenario.

Several limitations and challenges emerged when implementing this framework in the field. These challenges were related to 1) Possible interviewee bias; 2) Availability of data; 3) Time required to conduct the interviews; and 4) The appropriateness of certain indicators in assessing transition readiness in the countries.

1. **Possible interviewee bias.** This is a consideration that should always be taken into account when collecting qualitative data since some interviewees may be motivated to create a positive impression of their institution/country instead of providing an objective view on the situation. Associated with this is the possibility for recall bias. This exercise sometimes required interviewees to respond to questions concerning past events that may have led to some recall bias. However, this was addressed by triangulating interviewee findings with the available quantitative data and other interviewee responses. Moreover, the work of researcher teams was useful in cross-checking facts and reaching final conclusions.
2. **Availability of data.** This is a limitation encountered when implementing any monitoring and evaluation system. Data limitations were, at times, associated with inadequate information on the disease-specific programmes in countries, some of which may have a different method of reporting data - or do not collect and/or have the critical data necessary for the national response planning and management. This was resolved by conducting interviews to collect information that was not available, as well as by triangulating data with the interview results and literature.
3. **Time required to conduct the interviews.** The initial matrix, which served as the basis for the developing tools for qualitative research, included guidance on how to collect a large volume of qualitative and quantitative information. This resulted in lengthy interviews that, in some cases, required follow-up meetings with the respondent. The simplified version of the matrix, with its new scoring method, has sought to correct this limitation.

4. ***Appropriateness of certain indicators in assessing transition readiness in the countries.*** Several indicators were not relevant for certain countries, due to the political structure of the government or the availability of grants for both diseases, or due to other factors. We have developed a tool that could be generic for all Global Fund recipient countries but we are aware that certain indicators may not be applicable in some settings. This is why it is crucial to use this tool in a flexible manner and to ensure that the research is conducted by trained people, who are able to assess the appropriateness of certain indicators for the given context.

Other challenges that may emerge when conducting the transition preparedness assessment are the following:

1. ***Lack of political buy-in from stakeholders.*** If the relevant stakeholders are not convinced of the value of the transition preparedness assessment exercise, it could be difficult to ensure reliable results. This may be related to a number of issues, including an attempt to avoid creating a negative view of their institution or a lack of interest in planning for transition and sustainability. The researchers should be trained to respond to these concerns and to reiterate that their participation is anonymous and confidential.
2. ***Lack of resources to conduct the exercise.*** This difficulty is associated with the lack of resources to implement the framework or could be related to time-constraints within the institutions. Overall transition preparedness assessment is estimated to require six to eight person-weeks<sup>4</sup> of effort from a consultant(s) with good qualitative research skills and a strong understanding of health systems and policy-related issues for the given diseases. Having HIV and TB epidemiology expertise is critical to understanding the programme outcomes and to identify challenges for transition. Such skills would allow for the preparedness assessment to take place in an engaged and participatory manner.
3. ***Interaction with other donors.*** Countries frequently receive funding from several sources. Situations, such as a scenario where Global Fund grants are nearing completion but other donor funding is still in circulation, will undoubtedly have an effect on the validity of the results of this transition assessment. This limitation can be addressed by communicating to other donors the intention to conduct this assessment early on and to determine possible influences of their funding on the disease-programmes under study. This limitation should also be noted in final country recommendations.

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<sup>4</sup>This estimate denotes only the level of effort, not a calendar period

## Recommendations

The results of the HIV and TB modules pilot exercise led to a number of recommendations related to methodology, such as how to apply the framework, as well as recommendations associated with programme elements that should be taken into account when transitioning out of Global Fund support for HIV and TB. The flexibility of this tool means that it can serve both to conduct a rapid assessment of transition preparedness, which can be conducted by country or regional experts by prioritising certain elements, and it can be expanded to provide an in-depth overview of the country, which could be led by teams of external researchers. Malaria module has been developed as a next step of the TPA Framework, however it has not been piloted in the field.

Main recommendations based on the TPA framework are presented below:

### Global Fund recommendations:

1. ***Evaluate transition preparedness from the start.*** Transition should not be considered the end goal but rather as a gradual process that should be taken into account early on to avoid wasting resources and time, as well as to set the foundation for sustainability. It is critical to continuously consider transition and transition programme elements early on, according to the context, instead of transitioning the whole programme towards the end of the eligibility period for a given country. Therefore, we recommend the transition readiness assessment take place not only among countries that are already transitioning from Global Fund support, but also in other middle- and low-income countries that are still eligible for Global Fund support. Evaluating transition readiness among this group of countries would provide a picture of how things are working within the country so issues can be tackled effectively and some programme elements can be transitioned earlier.
2. ***Assure availability of resources necessary for the transition preparedness assessment.*** This is an exercise that, according to the country where it is undertaken, may entail a moderate amount of financial and human resources. Therefore, providing resources for preparedness assessment should be seen as a valuable investment to maximize future resource efficiencies during or in a post-Global Fund scenario. Similar to other funding mechanisms, the Global Fund can support countries to conduct transition preparedness assessments and help them achieve key milestones to ensure a successful transition through the regular grant process or by establishing separate transition-specific grants.

### Country-level recommendations:

3. ***Develop partnership and commitment to transition.*** It is crucial that all stakeholders be involved in the transition exercise in order to determine what works well, and what is not working, in the countries. Demonstrating the value of this exercise can be instrumental in developing a long-term commitment to sustainability.

#### **Framework implementation recommendations:**

4. ***Prioritise indicators based on country needs.*** This tool is meant to provide a comprehensive and rather high level view on a country's level of preparedness for transition and, ultimately, post-Global Fund sustainability for TB and HIV programmes. However, the indicators should be adapted based on the specific country context, data availability and stakeholder characteristics.
5. ***Form independent teams to conduct the fieldwork.*** It is crucial that the readiness assessment be undertaken by impartial actors who are able to interact with a variety of stakeholders and present reliable final recommendations that can enhance the work of the countries and the Global Fund. Taking a regional approach and involving people who have prior knowledge of the region (with or without partner support), and its dynamics and sensitivities - in addition to conducting an in-depth review of the relevant literature - would lead to more accurate results, as well as facilitate work in the field. Furthermore, the pilot exercise demonstrated the usefulness of sending at least two interviewers to the field to cross-check results. This provides another layer of data verification and allows the teams to adapt to emerging key themes.
6. ***Conduct pre-fieldwork trainings.*** While this recommendation is quite common, in practice it does not always take place. People who are comfortable with qualitative and quantitative analytical methods will be able to do this assessment, as long as they are adequately prepared in the tool application and possess the health system and TB/HIV/AIDS related epidemiology expertise. Familiarity with the tool will allow the interviewees to react to new themes and focus the interview on the key areas. Developing online training modules on the use of the tool would allow for scalability of trainings at low cost.
7. ***Consider piloting the framework in other regions*** i.e. Sub-Saharan Africa and/or Asia to test its applicability in other regions beyond EECA.

## Annex 1 TPA Framework guidance

### Abbreviations:

H – HIV/AIDS

TB- Tuberculosis

G – General for both diseases

IDI – In-Depth Interviews

DR – Desk review

A - Accountability

E - Economic

F - Financial

Gov – Governance

HR – Human Resources

HIS – Health Information System

P – Political

S- Service delivery

O- Organizational capacity

The following table lists the indicators for measuring country readiness for the transition. It should be used in combination with the *In-depth Interview Guide with a Stakeholder Map* and *TPA Excel tool*. Detailed instructions of the TPA Framework application is provided in the *TPA User Manual*.

The table includes measurement methods, data sources and assignment criteria for **Low**, **Moderate** and **High risk for transition**.

The categories are given a standard colour and are converted into numerical values so each component can be scored and included in the overall Risk Assessment Score.

**For each indicator** the colour and numerical score is assigned in the following way:

- Low risk = Green = 2
- Moderate risk = Yellow = 1
- High risk = Red = 0

**For each Component** percentages are calculated based on total scores possible and the amount of scores earned and respective colours are assigned:

- Low risk = Green -  $\geq 70\%$
- Moderate risk = Yellow - 36-69%
- High risk = Red -  $\leq 35\%$

**For Overall Country Risk Assessment** similar calculations are used and the following colours are assigned:

- Low risk = Dark Green -  $> 85\%$
- Moderate to Low risk = Light Green - 70-85%
- Moderate risk = Dark yellow - 50-69%
- Moderate to High risk = Light yellow - 36-49%
- High to moderate risk = Light red - 25-35%
- High risk = Dark red -  $< 25\%$



HIV/AIDS Modular TPA Framework

| Component letter Code       | Indicator Code | Indicators   | Measurement   | Data source   | Risk assessment criteria   |
|-----------------------------|----------------|--|---|---|--|
| <b>External Environment</b> |                |  |   |   |  |
| P                           | PG1            | Existence of political will to prioritize health investments   | Trend analysis of the last 5 years<br><br><i>DEFINITIONS</i><br>High share of government spending on health out of General Government Expenditure. High share if more than a mean for income group countries for the most recent year available. E.g. for 2013:<br><br>For LMIC ≥ 11%<br>For UMIC ≥ 12%<br>These indicators might not be applicable during economic crises, therefore trend (share) before the crises should be considered when country has gone through a recent economic crisis.<br>Yes / No qualifiers | <a href="http://www.worldbank.org">www.worldbank.org</a>  | <ul style="list-style-type: none"> <li>• Low risk: Both indicator are met</li> <li>• Moderate risk: At least one indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>  |
|                             | PG1.1          | Increasing trend or stable high share of government spending on health out of General Government Expenditure   |   |   |  |
|                             | PG1.2          | Increasing trend of the share of government spending on health out of Total Health Expenditure   |   |   |  |
| P                           | PH2            | Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with disease. | <i>DEFINITION</i><br>Law that criminalize drugs; Laws that criminalize methadone use or needle exchange; Anti-homosexuality laws; Anti-prostitution laws; HIV testing disclosure policies; Laws.<br>Yes / No qualifiers   | Qualitative (IDI)   | <ul style="list-style-type: none"> <li>• Low risk: No legal barriers and strong rule of law</li> <li>• Moderate risk: Certain legal barriers OR no legal barriers but moderate or weak rule of law</li> <li>• High risk: High restrictive legal environment</li> </ul> |
|                             | PH3            | Rule of Law  | <i>DEFINITION</i><br>Rule of law index for last year available. The Index ranges from -2.5 (weak) to 2.5(strong). The categories below are based on countries percentile distribution<br><ul style="list-style-type: none"> <li>• Strong rule of law: from 0.56 to 2.5</li> </ul>   | Worldwide Governance Indicators ( <a href="http://www.govindicators.org/">http://www.govindicators.org/</a> ) |  |



|                             |       |   |  |  |  |
|-----------------------------|-------|---|--|--|--|
|                             |       |   | <ul style="list-style-type: none"> <li>Moderate rule of law: from -0.60 to 0.55</li> <li>Weak rule of law: from -2.5 to -0.61</li> </ul>   |  |  |
| P                           | PG4   | Government ability to contract with CSOs - Existence of general regulation for CSO contracting in the economy | Yes / No qualifiers  | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>Low risk: Both indicators are met</li> <li>Moderate risk: Only PG4 is met</li> <li>High risk: Neither indicator is met</li> </ul>               |
|                             | PG5   | CSO contracting is being practiced in any sector  |  |  |  |
| Component score             |       |   |  |  |  |
| E                           | EG1   | Favourable economic indicators  | Trend analyses for last 5 years  | <a href="http://www.worldbank.org">www.worldbank.org</a>             | <ul style="list-style-type: none"> <li>Low risk: Both indicators are met</li> <li>Moderate risk: At least one indicator is met</li> <li>High risk: Neither indicator is met</li> </ul> |
|                             | EG1.1 | Increasing in GDP per capita  | EG1.1 GDP per capita growth (annual %) stable increase over the 5-year period  |  |  |
|                             | EG1.2 | Increasing or stable high share of General Government Revenues as % of GDP                                    | EG1.2 General Government Revenues as % of GDP increasing or stable trend for past 5 years; High share if more than a mean for income group countries for the most recent year available. E.g. For 2012:<br>LIC – 15.7%<br>LMIC – 21.4%<br>UMIC – 28.9% |  |  |
| Component score             |       |   |  |  |  |
| <b>Internal Environment</b> |       |   |  |  |  |
| <b>Inputs</b>               |       |   |  |  |  |
| F                           | FH1   | Budgetary commitment to disease   |  | DR: National budgets; NASA or NHA, where available                   | <ul style="list-style-type: none"> <li>Low risk: All three indicators are met and at least FH1.2.1</li> <li>Moderate risk: At least two indicators are met</li> </ul>                  |
|                             | FH1.1 | Increasing public expenditure on Disease Specific Programme   | Trend analyses for last 5 years<br>Yes/No qualifiers   |  |  |

|   |       |   |  |   |  |
|---|-------|---|--|---|--|
|   | FH1.2 | Share of public funding in Disease Specific Programme budget  | Share of public funding for last year in total disease funding/budget. (Ref: PEPFAR sustainability index tool modified)<br>1.2.1 $\geq 75\%$<br>1.2.2 50 - 74%<br>1.2.3 $\leq 49\%$  |   | <ul style="list-style-type: none"> <li>High risk: Less than two indicators are met</li> </ul>  |
|   | FH1.3 | Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NSP    | Yes/No qualifiers  |   |  |
| F | FH2   | Prevention priority   | <i>DEFINITIONS</i><br>Key Populations - specific populations that are key to the epidemic and response, as defined by NSP  | DR: National budgets; NASA or NHA where available | <ul style="list-style-type: none"> <li>Low risk: Both indicators are met</li> <li>Moderate risk: At least one indicator is met</li> <li>High risk: None of indicators are met OR data not available</li> </ul> |
|   | FH2.1 | Increasing total public spending on HIV prevention for Key Populations  | Data for the last 5 years, or at least three data points for the latest years available  |   |  |
|   | FH2.2 | Increasing share of public spending in total spending (donors and Gov.) on HIV prevention for epidemiologically priority groups | Yes/No qualifiers  |   |  |
| F | FH3   | Allocative efficiency   | <i>DEFINITIONS</i><br>HIV allocative efficiency studies are trying to answer the question 'how can HIV funding be optimally allocated to the combination of HIV response interventions in a way that will yield the highest impact in the shortest period of time? Types of studies: | DR: National budgets or NHA, where available      | <ul style="list-style-type: none"> <li>Low risk: Both indicators are met</li> <li>Moderate risk: FH3.1 indicator is met</li> <li>High risk: Neither indicator is met</li> </ul>                                |
|   | FH3.1 | Existence of allocative efficiency studies  | <ul style="list-style-type: none"> <li>Investment case</li> <li>The HIV allocative efficiency analysis through the application of the mathematical modelling tool called Optimization &amp; Analysis Tool (Optima)</li> </ul>  |   |  |
|   | FH3.2 | Budget allocations are informed by allocative efficiency studies  | Yes/No qualifiers  |   |  |

|                 |       |  |   |  |  |
|-----------------|-------|--|---|--|--|
| F               | FH4   | Treatment / input financing from public sources  | <p><i>DEFINITIONS</i><br/>Case detection / diagnostic include screening and confirmatory tests.<br/>ART drugs include First line and Second line drugs</p> <p>Qualifiers:<br/>Fully funded /Partially funded / Not funded<br/>Share of public funding:</p> <ul style="list-style-type: none"> <li>• &gt;=80% - Fully funded</li> <li>• 30-79% - Partially funded</li> <li>• &lt;=29% - Not funded</li> </ul> <p>(ref. PEPFAR sustainability index tool, modified)</p> | <p>DR: National budgets; NASA or NHA where available</p> <p>Qualitative (IDI) validated through document review, where necessary</p> | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are at least partially funded by public sources</li> <li>• Moderate risk: One indicator Not funded</li> <li>• High risk: More than one indicator not funded</li> </ul> |
|                 | FH4.1 | Case detection / diagnostics   |   |  |  |
|                 | FH4.2 | ART drugs procurement  |   |  |  |
|                 | FH4.3 | Adherence support  |   |  |  |
| F               | FH5   | Prevention financing from public sources   | <p>Qualifiers:<br/>Fully funded /Partially funded / Not funded</p> <p>Share of public funding:</p> <ul style="list-style-type: none"> <li>• &gt;=80% - Fully funded</li> <li>• 30-79% - Partially funded</li> <li>• &lt;=29% - Not funded</li> </ul> <p>(ref. PEPFAR sustainability index tool, modified)</p>   | <p>DR: National budgets; NASA or NHA where available</p> <p>Qualitative (IDI) validated through document review, where necessary</p> | <ul style="list-style-type: none"> <li>• Low risk: At least one fully and other partially</li> <li>• Moderate risk: Both partially</li> <li>• High risk: One partially OR not funded</li> </ul>  |
|                 | FH5.1 | Funding of Low Threshold Services (excluding OST) from public sources  |   |  |  |
|                 | FH5.2 | Funding of OST services from public sources  |   |  |  |
| Component score |       |  |   |  |  |
| HR              | HRH1  | Sufficient human resources addressing a specific disease – HIV/AIDS- (quantities, geographic distribution and aging) | <p>Qualifiers:</p> <ul style="list-style-type: none"> <li>• Sufficient</li> <li>• With some limitations</li> <li>• Severe shortage</li> </ul>   | Qualitative (IDI) validated through document review, where necessary   | <ul style="list-style-type: none"> <li>• Low risk: Sufficient</li> <li>• Moderate risk: With some limitations</li> <li>• High risk: Severe shortage</li> </ul>   |
| HR              | HRH2  | Donor supported trainings for health personnel institutionalized in national education                               | <p><i>DEFINITIONS</i><br/>Institutionalization: training is part of formal educational curriculum and is financially supported by the government and delivered by the state/non-state institutions charged</p>  | Qualitative (IDI) validated through document review, where necessary   | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are met</li> <li>• Moderate risk: Two indicators are</li> </ul>  |

|                 |       |  |   |   |  |
|-----------------|-------|--|---|---|--|
|                 |       | system   | with such responsibility in a given country.<br>Qualifiers:<br>Yes / No <ul style="list-style-type: none"> <li>• 100% institutionalization - Yes</li> <li>• less than 100% institutionalization - No</li> </ul>   |   | met <ul style="list-style-type: none"> <li>• High risk: Less than two indicators are met</li> </ul>  |
|                 | HRH3  | Existence of policy for production/training of CSO personnel (non medical, social service) | Qualifiers:<br>Yes / No   |   |  |
|                 | HRH4  | Donor funded HR salaries aligned with national pay-scale                                   | Qualifiers:<br>Yes / No / NA  |   |  |
| Component score |       |  |   |   |  |
| HIS             | HISH1 | Routine statistical reporting integrated in the national system                            | <p><i>DEFINITIONS</i><br/>Components of the Routine statistical reporting: 1) HIV testing; 2) PMTCT; 3) AIDS related mortality; 4) Adult treatment; 5) Pediatric treatment</p> <p>Qualifiers: Fully integrated / Partially integrated / Not integrated</p> <ul style="list-style-type: none"> <li>• Fully Integrated -Complete harmonization of the routine statistical reporting into the national system.</li> <li>• Partially integrated - One component not included in the national system</li> <li>• Not integrated - More than one components not included in the national system</li> </ul> | Qualitative (IDI)<br>Observation of the databases | <ul style="list-style-type: none"> <li>• Low risk: Fully integrated</li> <li>• Moderate risk: Partially integrated</li> <li>• High risk: Not integrated</li> </ul> |

|     |         |  |  |   |  |
|-----|---------|--|--|---|--|
| HIS | HISH2   | Advanced statistical reporting                                   | <p><i>DEFINITIONS</i><br/>Components of the Routine statistical reporting: 1) HIV testing; 2) PMTCT; 3) AIDS related mortality; 4) Adult treatment; 5) Pediatric treatment</p> <p>Qualifiers: Fully advanced / Partially advanced / Not advanced</p> <ul style="list-style-type: none"> <li>Advanced - Web based or electronic at national and subnational levels with disaggregation (age, gender, geography, population types)</li> <li>Partially advanced- Electronic &amp; paper based; or Limited disaggregation;</li> <li>Not advanced - Completely paper-based with or without disaggregation.</li> </ul> | Qualitative (IDI)<br>Observation of the databases | <ul style="list-style-type: none"> <li>Low risk: Advanced</li> <li>Moderate risk: Partially advanced</li> <li>High risk: Not advanced</li> </ul>   |
| HIS | HISH3   | HIV Second generation surveillance                               | <p><i>DEFINITIONS:</i><br/>Rigorous methodology for Biomarker Behaviour Surveillance Studies = probability sampling methods such as Respondent Driven Sampling, Time Location Sampling, etc. are being used and data comparability across waves is assured.</p> <p>Yes/No qualifiers</p>   | Qualitative (IDI)                                 | <ul style="list-style-type: none"> <li>Low risk: Both indicators are met</li> <li>Moderate risk: HISH3.1 indicator is met</li> <li>High risk: None of indicators are met</li> </ul>  |
|     | HISH3.1 | Rigorous methodology used  |  |   |  |
|     | HISH3.2 | Implemented timely (according to NSP)                            |  |   |  |
| HIS | HISH4   | HIV Second generation surveillance financing from public sources | <p>Qualifiers:<br/>Fully funded /Partially funded / Not funded</p> <p>Share of public funding from the total cost of latest BBS or PSE surveys:</p> <ul style="list-style-type: none"> <li>&gt;=80% - Fully funded</li> <li>30-79% - Partially funded</li> <li>&lt;=29% - Not funded</li> </ul> <p>(ref. PEPFAR sustainability index tool, modified)</p>   | Qualitative (IDI)                                 | <ul style="list-style-type: none"> <li>Low risk: Both indicators are at least partially funded by public sources</li> <li>Moderate risk: At least one indicator not funded</li> <li>High risk: Both indicators not funded</li> </ul> |
|     | HISH4.1 | BBS funding from public sources                                  |  |   |  |
|     | HISH4.2 | PSE funding from public sources                                  |  |   |  |

| Component score |         |   |   |   |   |
|-----------------|---------|---|---|---|---|
| Governance      |         |   |   |   |   |
| Gov             | GovH1   | Strong political commitment to diseases   |   | Qualitative (IDI)   | <ul style="list-style-type: none"> <li>• Low risk: GovH1.1.and GovH1.3 indicators are met</li> <li>• Moderate risk: GovH1.2 and GovH1.3 indicators are met</li> <li>• High risk: Neither OR only GovH1.2 indicator is met<br/>If GovH1.3 NA</li> <li>• Low risk: GovH1.1 indicator is met</li> <li>• High risk: GovH1.2 indicator is met</li> </ul> |
|                 | GovH1.1 | NSP with legal and enforceable power in a given country context   | <p><i>DEFINITIONS:</i><br/>Current Strategic plan, legally empowered with validity of at least 6 months.</p> <p>Qualifiers:<br/>Yes / No</p>  |   |   |
|                 | GovH1.2 | NSP in preparation or without legal and enforceable power   | <p><i>DEFINITIONS:</i><br/>If NSP validity less than 6 months new Strategic plan preparation should be in process</p> <p>Qualifiers:<br/>Yes / No</p>   |   |   |
|                 | GovH1.3 | HIV/AIDS as a priority in National Health Strategy document   | <p><i>DEFINITIONS:</i><br/>High level national document such as National Health Strategy or National Development Plan, legally approved in accordance to existing laws of a country, identifies disease as a priority</p> <p>Qualifiers:<br/>Yes / No / NA</p>                                      |   |   |
| Gov             | GovH2   | Strong leadership   | <p><i>DEFINITIONS:</i><br/>Individual leader or 'champion' – a person who advocates the disease-specific programme (encouraging sustained financing, commitment and transparency) and/or who pushes the programme plans forward</p> <p>Yes / No qualifiers<br/>If not effective qualify as "No"</p> | Qualitative (IDI)<br>Responses to GovH2.2<br>Triangulated across diverse group of respondents | <ul style="list-style-type: none"> <li>• Low risk: Both or at least GovH2.1 indicator is met</li> <li>• Moderate risk: Only GovH2.2 indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>  |
|                 | GovH2.1 | Legally empowered leading organization to effectively manage the functioning of the given disease programme |   |   |   |
|                 | GovH2.2 | Individual leader(s) advocate for disease specific programme  |   |   |   |
| Gov             | GovG3   | Strong coordination mechanisms  |   | Qualitative (IDI)   | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are met</li> <li>• Moderate risk: Two indicators are met</li> </ul>   |
|                 | GovG3.1 | Coordinating body adequately placed within the government   |   |   |   |

|                 |         |   |   |   |   |
|-----------------|---------|---|---|---|---|
|                 |         | hierarchy and legally empowered within the national government structure to assure adequate coordination across the sectors | Yes / No qualifiers   |   | <ul style="list-style-type: none"> <li>• High risk: One indicator is met</li> </ul>   |
|                 | GovG3.2 | CSOs have a legally determined seat in the coordinating body  |   |   |   |
|                 | GovG3.3 | Coordinating body functions effectively   | Effective functioning if: meets regularly, considers issues raised by different stakeholders, makes documented decisions that are considered/acted by the government and other players  |   |   |
| Component score |         |   |   |   |   |
| A               | AH1     | Programme performance results are available and accessible through public domain  | <p><i>DEFINITIONS</i></p> <p>Epidemiological data: Prevalence and incidence rates/new cases.<br/>Program performance report may include M&amp;E process indicators according to the Disease specific M&amp;E Plan</p> <p>For AH1.1 new cases – at least annually<br/>For AH1.2- 1.4 - at least biennial<br/>For AH1.5 - at least every 3 years</p> <p>Yes / No qualifiers</p> | Qualitative (IDI) validated through literature review         | <ul style="list-style-type: none"> <li>• Low risk: At least four indicators are met</li> <li>• Moderate risk: At least three indicators are met</li> <li>• High risk: Less than three indicators are met</li> </ul> |
|                 | AH1.1   | Epidemiological data including for KP   |   |   |   |
|                 | AH1.2   | Programmatic performance, monitoring reports  |   |   |   |
|                 | AH1.3   | Programme expenditure data  |   |   |   |
|                 | AH1.4   | Programme Evaluation reports  |   |   |   |
|                 | AH1.5   | NSP and other periodic reviews  |   |   |   |
| A               | AG2     | Enabling Environment for Civil Society engagement   | <p><i>METHODS DESCRIPTION:</i></p> <p>The EEI measures conditions that affect the capacity of citizens (whether individually or collectively) to participate and engage in civil society. The EEI not only measures the governance and policy factors that directly affect civil society, it also looks at the socio-economic and socio-cultural conditions. The</p>          | <a href="http://civicus.org/eei/">http://civicus.org/eei/</a> | <ul style="list-style-type: none"> <li>• Low risk: Enabling</li> <li>• Moderate risk: Enabling with Limitations</li> <li>• High risk: Not Enabling</li> </ul>   |

|                  |       |   |   |  |  |
|------------------|-------|---|---|--|--|
|                  |       |   | <p>EEI is made up of 71 secondary statistical data sources. Over 70% of the sources are from the years 2010 and 2011.</p> <p>Qualifiers: Not enabling / Enabling with limitations / Enabling</p> <ul style="list-style-type: none"> <li>• Not enabling - EEI 0-0.38 - there are laws and policies that restrict civil society from playing an oversight role</li> <li>• Enabling with limitations - EEI 0.39 - 0.50 - there are no laws and policies that restrict civil society from playing an oversight role, but in practice it is not accepted by the government</li> <li>• Enabling - EEI &gt; 0.51-0.76 there are no laws or policies that restrict civil society from playing an oversight role, and civil society is actively engaged in providing oversight</li> </ul> <p>(Ref: PEPFAR sustainability index tool)</p> |  |  |
| Component score  |       |   |   |  |  |
| <b>Programme</b> |       |   |   |  |  |
| S                | SH1   | Treatment   | <p>Last 5 years analysis, or at least three data points for the latest years available<br/>Sustained - reaching and maintaining at high levels - &gt;=90% (Ref. Fast-Track treatment targets)</p> <p>SH1.1 Coverage based on all registered cases</p> <p>Qualifiers: Increasing (or sustained) / stable / worsening</p>   | <p>DR: Clinical data; GARPR reports</p> <p>Qualitative (IDI)</p> | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are increasing (or sustained)</li> <li>• Moderate risk: At least one indicator is increasing (or sustained) and other stable</li> <li>• High risk: At least one indicator is worsening</li> </ul> |
|                  | SH1.1 | Coverage (%) trend for ART                              |   |  |  |
|                  | SH1.2 | Treatment outcome for ART (adherence rate at 12 months) |   |  |  |



|   |       |   |   |   |  |
|---|-------|---|---|---|--|
| S | SH2   | Integrated services   | For high prevalence countries PMTCT services are provided by PHC and maternity facilities; For concentrated epidemics and low prevalence countries PHC facilities provide HIV testing for pregnant women.<br>High level of integration - $\geq 50\%$ of facilities<br>Partial integration - 21 - 49% of facilities<br>Limited to no integration - $\leq 20\%$ of facilities<br>(Ref. PEPFAR sustainability index tool, modified)  | DR: Operations Research<br><br>Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: At least one partially and one high level</li> <li>• Moderate risk: At least one partially and other limited</li> <li>• High risk: Both limited OR no integration</li> </ul>              |
|   | SH2.1 | Integrated PMTCT with PHC/Maternity care  |   |   |  |
|   | SH2.2 | Integrated HIV and TB services  |   |   |  |
| S | SH3   | Key populations reach with preventive services  | <p><i>DEFINITIONS</i></p> <p>Key populations – One or two populations key to epidemic’s dynamics as defined by NSP<br/>For generalised epidemics instead of Key populations use general population<br/>At least three data points<br/>Rigorous BBS - surveys with rigorous probability sampling methods such as Respondent Driven Sampling, Time Location Sampling.<br/>NEP – Needle exchange program</p> <p>Qualifiers: Increasing (or sustained) / stable / worsening<br/>If data is not based on Rigorous BBS data is considered as not valid and qualify as “worsening”</p> | DR: BBS studies<br><br>Qualitative (IDI) validated through document review, where necessary         | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are increasing</li> <li>• Moderate risk: At least one indicator is increasing and others stable</li> <li>• High risk: At least one indicator is worsening</li> </ul> |
|   | SH3.1 | Coverage with voluntary testing based on rigorous BBS data  |   |   |  |
|   | SH3.2 | Coverage with NEP based on rigorous BBS data  |   |   |  |
|   | SH3.3 | Coverage with OST based on rigorous BBS data  |   |   |  |
| S | SG4   | CSOs contracting in health  | Yes / No qualifiers   | Qualitative (IDI) validated through document review, where necessary                                | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: SG4.1 indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>  |
|   | SG4.1 | Existence of detailed rules and procedures for contracting CSOs for health service delivery (includes medical and other health related social services) |   |   |  |
|   | SG4.2 | Government already contracts CSOs for various health service provision using public   |   |   |  |

|                 |       |   |  |  |  |
|-----------------|-------|---|--|--|--|
|                 |       | funds   |  |  |  |
| Component score |       |   |  |  |  |
| 0               | OH1   | Strong management of the National Disease Programme Management Entity                                   | National Disease Program Management Entity is not assessed if it serves as Principal Recipient (PR).                                       | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: At least two indicators are met</li> <li>• Moderate risk: One indicator is met</li> <li>• High risk: None of indicators are met</li> </ul>              |
|                 | OH1.1 | Existence of National Programme management capacity assessment OR staff performance evaluation practice | If more than one entity is assess separately.<br>OH1.1 evaluation practice - at least once in every second year<br><br>Yes / No qualifiers |  |  |
|                 | OH1.2 | Closely integrated TGF PR and National Programme Management   |  |  |  |
| 0               | OH2   | PSM   | Yes / No qualifiers  | Qualitative (IDI)  | <ul style="list-style-type: none"> <li>• Low risk: At least four indicators are met</li> <li>• Moderate risk: Three indicators are met</li> <li>• High risk: Less than three indicators are met</li> </ul> |
|                 | OH2.1 | TGF funded procurement is conducted using national system   | OH2.3 Low frequency - not more than one over for last year<br>OH2.4 Rare - not more than once for last year                                |  |  |
|                 | OH2.2 | Supply chain management integrated into the national system   |  |  |  |
|                 | OH2.3 | Low frequency of emergency procurements for drugs   |  |  |  |
|                 | OH2.4 | Rare stock outs for drugs   |  |  |  |
|                 | OH2.5 | If national procurement – paying no more than 5% above the international benchmark price                |  |  |  |
| Component score |       |   |  |  |  |
| 0               | OH3   | M&E   | <i>DEFINITIONS</i>   | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators at high level</li> </ul>  |
|                 | OH3.1 | Existence of analytical capacity at MoH/main  | OH3.2 information use at national/ subnational   |  |  |

|                        |       |   |  |  |   |
|------------------------|-------|---|--|--|---|
|                        |       | public health agency reflected in availability of analytical reports that are produced with defined periods                       | levels.<br>Recent data: Based on a program / strategic plan development cycle for a disease in the country.<br><br>Qualifiers: High / Moderate / Limited or None |  | <ul style="list-style-type: none"> <li>• Moderate risk: One indicator at moderate and other high, or both at moderate level</li> <li>• High risk: At least one indicator limited OR None</li> </ul>                     |
|                        | OH3.2 | Information use for evidence-based programme planning and management, e.g. NSP uses recent Epi, programmatic and expenditure data | OH3.2 High use- use of Epi, programmatic and expenditure data; Moderate use – use of some data; Limited use – use of minimal data                                |  |   |
| <b>Component score</b> |       |   |  |  |   |
| T                      | TH1   | Legally binding and actionable Transition plan / Transition elements  | Yes / No qualifiers  | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: TH1.1 indicator is met</li> <li>• Moderate risk: TH1.2 and TH1.3 indicators are met</li> <li>• High risk: only TH1.3 or TH1.2 or none</li> </ul>                     |
|                        | TH1.1 | Legally binding and actionable transition plan exists   |  |  |   |
|                        | TH1.2 | Draft transition plan exists  |  |  |   |
|                        | TH1.3 | Transition elements embedded into the legally empowered national programme/ NSP   |  |  |   |
| T                      | TH2   | Transition plan / Transition elements characteristics:  | Yes / No qualifiers  | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: At least three indicators are met and TH2.3</li> <li>• Moderate risk: at least two indicators are met</li> <li>• High risk: One indicators is met or none</li> </ul> |
|                        | TH2.1 | Clearly identifies time-bound activities to be implemented during transition  |  |  |   |
|                        | TH2.2 | Clearly outlines roles and responsibilities of Transition process management  |  |  |   |
|                        | TH2.3 | Incorporates M&E indicators for   |  |  |   |

|                 |       |  |                       |  |   |
|-----------------|-------|--|-----------------------|--|---|
|                 |       | transition process                         |                       |  |   |
|                 | TH2.4 | Incorporates budget for transition         |                       |  |   |
| T               | TH3   | Transition M&E                             | Yes / No qualifiers   | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: One indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul> |
|                 | TH3.1 | CSO participates in the transition updates | If NA qualify as "No" |  |   |
|                 | TH3.2 | CSO participates in the transition updates |                       |  |   |
| Component score |       |  |                       |  |   |
| Overall score   |       |  |                       |  |   |

Tuberculosis Modular TPA Framework

| Component letter Code       | Disease | Indicators   | Measurement   | Data source   | Risk assessment criteria   |
|-----------------------------|---------|--|---|---|--|
| <b>External Environment</b> |         |  |   |   |  |
| P                           | PG1     | Existence of political will to prioritize health investments   | Trend analysis of the last 5 years<br><br><i>DEFINITIONS</i><br>1.1 High share of government spending on health out of General Government Expenditure. High share if more than a mean for income group countries for the most recent year available. E.g. for 2013:<br><br>For LMIC $\geq 11\%$<br>For UMIC $\geq 12\%$<br>These indicators might not be applicable during economic crises, therefore trend (share) before the crises should be considered when country has gone through a recent economic crisis.<br>Yes / No qualifiers | <a href="http://www.worldbank.org">www.worldbank.org</a>  | <ul style="list-style-type: none"> <li>• Low risk: Both indicator are met</li> <li>• Moderate risk: At least one indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>  |
|                             | PG1.1   | Increasing trend or stable high share of government spending on health out of General Government Expenditure   |   |   |  |
|                             | PG1.2   | Increasing trend of the share of government spending on health out of Total Health Expenditure   |   |   |  |
| P                           | PTB2    | Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for Key Populations and people living with disease. | <i>DEFINITION</i><br>Policies that create barriers to TB prevention and control<br><br>Yes / No qualifiers  | Qualitative (IDI)   | <ul style="list-style-type: none"> <li>• Low risk: No legal barriers and strong rule of law</li> <li>• Moderate risk: Certain legal barriers OR no legal barriers but moderate or weak rule of law</li> <li>• High risk: High restrictive legal environment</li> </ul> |
|                             | PTB3    | Rule of Law  | <i>DEFINITION</i><br><br>Rule of law index for last year available. The Index ranges from -2.5 (weak) to 2.5 (strong). The categories below are based on countries percentile distribution<br>Strong rule of law: from 0.56 to 2.5<br><br>Moderate rule of law: from -0.60 to 0.55  | Worldwide Governance Indicators ( <a href="http://www.govindicators.org/">http://www.govindicators.org/</a> ) |  |

|                             |        |   |   |  |   |
|-----------------------------|--------|---|---|--|---|
|                             |        |   | Weak rule of law: from -2.5 to -0.61  |  |   |
| P                           | PG4    | Government ability to contract with CSOs - Existence of general regulation for CSO contracting in the economy | Yes / No qualifiers   | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: Only PG4 is met</li> <li>• High risk: Neither indicator is met</li> </ul>  |
|                             | PG5    | CSO contracting is being practiced in any sector  |   |  |   |
| Component score             |        |   |   |  |   |
| E                           | EG1    | Favourable economic indicators  | Trend analyses for last 5 years<br>EG1.1 GDP per capita growth (annual %) stable increase over the 5-year period<br>EG1.2 General Government Revenues as % of GDP increasing or stable trend for past 5 years; High share if more than a mean for income group countries for the most recent year available. E.g. For 2012:<br>LIC – 15.7%<br>LMIC – 21.4%<br>UMIC – 28.9%<br>Yes / No qualifiers | <a href="http://www.worldbank.org">www.worldbank.org</a>             | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: At least one indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>                                      |
|                             | EG1.1  | Increasing in GDP per capita  |   |  |   |
|                             | EG1.2  | Increasing or stable high share of General Government Revenues as % of GDP                                    |   |  |   |
| Component score             |        |   |   |  |   |
| <b>Internal Environment</b> |        |   |   |  |   |
| <b>Inputs</b>               |        |   |   |  |   |
| F                           | FTB1   | Budgetary commitment to disease   |   | DR: National budgets; NHA, where available                           | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are met and at least FTB1.2.1</li> <li>• Moderate risk: At least two indicators are met</li> <li>• High risk: Less than two indicators are met</li> </ul> |
|                             | FTB1.1 | Increasing public expenditure on Disease Specific Programmes  | Trend analyses for last 5 years<br>Yes/No qualifiers  |  |   |
|                             | FTB1.2 | Share of public funding in Disease Specific Programme budget  | Share of public funding for last year. (Ref: PEPFAR sustainability index tool modified)<br>1.2.1 ≥ 75%<br>1.2.2 50 – 74%<br>1.2.3 ≤ 49%   |  |   |

|                 |        |  |  |   |  |
|-----------------|--------|--|--|---|--|
|                 | FTB1.3 | Existence of dedicated budget lines for Disease Specific expenditures in MTEF or in national budgets aligned with costed NTP | Yes/No qualifiers  |   |  |
| F               | FTB4   | Treatment / input financing from public sources  | <p><i>DEFINITIONS</i><br/>Case detection / diagnostic include screening and confirmatory tests. Drugs include First Line Drugs (FLD) and Second Line Drugs (SLD)</p> <p>Qualifiers:<br/>Fully funded /Partially funded / Not funded</p> <p>Share of public funding:</p> <ul style="list-style-type: none"> <li>• &gt;=80% - Fully funded</li> <li>• 30-79% - Partially funded</li> <li>• &lt;=29% - Not funded</li> </ul> <p>(ref. PEPFAR sustainability index tool, modified)</p> | <p>DR: National budgets or NHA, where available</p> <p>Qualitative (IDI) validated through document review, where necessary</p> | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are at least partially funded by public sources</li> <li>• Moderate risk: One indicator not funded</li> <li>• High risk: More than one indicator not funded</li> </ul> |
|                 | FTB4.1 | Case detection / diagnostics   |  |   |  |
|                 | FTB4.2 | Drugs procurement  |  |   |  |
|                 | FTB4.3 | Adherence support  |  |   |  |
| Component score |        |  |  |   |  |
| HR              | HRTB1  | Sufficient human resources addressing a specific disease – TB (quantities, geographic distribution and aging)                | <p>Qualifiers:</p> <ul style="list-style-type: none"> <li>• Sufficient</li> <li>• With some limitations</li> <li>• Severe shortage</li> </ul>  | Qualitative (IDI) validated through document review, where necessary  | <ul style="list-style-type: none"> <li>• Low risk: Sufficient</li> <li>• Moderate risk: With some limitations</li> <li>• High risk: Severe shortage</li> </ul>   |
| HR              | HRTB2  | Donor supported trainings for health personnel institutionalized in national education system                                | <p><i>DEFINITIONS</i><br/>Institutionalization: training is part of formal educational curriculum and is financially supported by the government and delivered by the state/non-state institutions charged with such responsibility in a given country.</p> <p>Qualifiers:<br/>Yes / No</p> <ul style="list-style-type: none"> <li>• 100% institutionalization - Yes</li> </ul>  | Qualitative (IDI) validated through document review, where necessary  | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are met</li> <li>• Moderate risk: Two indicators are met</li> <li>• High risk: Less than two indicators</li> </ul>   |

|                        |        |  |  |   |  |
|------------------------|--------|--|--|---|--|
|                        |        |  | <ul style="list-style-type: none"> <li>less than 100% institutionalization - No</li> </ul>   |   | are met  |
|                        | HRTB3  | Existence of policy for production/training of CSO personnel (non medical, social service) | Qualifiers:<br>Yes / No  |   |  |
|                        | HRTB4  | Donor funded HR salaries aligned with national pay-scale                                   | Qualifiers:<br>Yes / No / NA   |   |  |
| <b>Component score</b> |        |  |  |   |  |
| HIS                    | HISTB1 | Routine statistical reporting integrated in the national system                            | <p><i>DEFINITIONS:</i><br/>Components of the Routine statistical reporting: 1) TB New and relapse cases; 2) TB treatment registry; 3) Paediatric treatment; 4) MDR TB reporting; 5) Care and support (incl. pediatric)</p> <p>Qualifiers: Fully integrated / Partially integrated / Not integrated</p> <ul style="list-style-type: none"> <li>Fully Integrated -Complete harmonization of the routine statistical reporting into the national systems.</li> <li>Partially integrated - One component not included in the national system</li> <li>Not integrated - More than one components not included in the national system</li> </ul> | Observe the database; Qualitative (IDI with programme managers) | <ul style="list-style-type: none"> <li>Low risk: Fully integrated</li> <li>Moderate risk: Partially integrated</li> <li>High risk: Not integrated</li> </ul> |
| HIS                    | HISTB2 | Advanced routine statistical reporting   | <p><i>DEFINITIONS:</i><br/>Components of the Routine statistical reporting: 1) TB New and relapse cases; 2) TB treatment registry; 3) Paediatric treatment; 4) MDR TB reporting; 5) Care and support (incl. pediatric)</p> <p>Qualifiers: Fully advanced / Partially advanced / Not advanced</p> <ul style="list-style-type: none"> <li>Advanced- Web based or electronic at</li> </ul>  | Observe the database; Qualitative (IDI with programme managers) | <ul style="list-style-type: none"> <li>Low risk: Advanced</li> <li>Moderate risk: Partially advanced</li> <li>High risk: Not advanced</li> </ul>             |



|                   |          |   |  |  |   |
|-------------------|----------|---|--|--|---|
|                   |          |   | <p>national and sub national levels with disaggregation (age, gender, geography)</p> <ul style="list-style-type: none"> <li>Partially advanced- Electronic &amp; paper based; or Limited disaggregation;</li> <li>Not advanced - Completely paper-based with or without disaggregation.</li> </ul> |  |   |
| Component score   |          |   |  |  |   |
| <b>Governance</b> |          |   |  |  |   |
| Gov               | GovTB1   | Strong political commitment to diseases   |  | Qualitative (IDI)  | <ul style="list-style-type: none"> <li>Low risk: GovTB1.1.and GovTB1.3 indicators are met</li> <li>Moderate risk: GovTB1.2 and GovTB1.3 indicators are met</li> <li>High risk: Neither OR only GovTB1.2 indicator is met If GovTB1.3 NA</li> <li>Low risk: GovTB1.1 indicator is met</li> <li>High risk: GovTB1.2 indicator is met</li> </ul> |
|                   | GovTB1.1 | NTP with legal and enforceable power in a given country context   | <p><i>DEFINITIONS:</i><br/>Current Strategic plan, legally empowered with validity of at least 6 months.</p> <p>Qualifiers:<br/>Yes / No</p>   |  |   |
|                   | GovTB1.2 | NTP in preparation or without legal and enforceable power   | <p><i>DEFINITIONS:</i><br/>If NTP validity is less than 6 months new Strategic Plan preparation should be in process</p> <p>Qualifiers:<br/>Yes / No</p>   |  |   |
|                   | GovTB1.3 | TB as a priority in National Health Strategy document   | <p><i>DEFINITIONS:</i><br/>High level national document such as National Health Strategy or National Development Plan, legally approved in accordance to existing laws of a country, identifies disease as a priority</p> <p>Qualifiers:<br/>Yes / No / NA</p>                                     |  |   |
| Gov               | GovTB2   | Strong leadership   | <p><i>DEFINITIONS:</i><br/>Individual leader or 'champion' – a person who advocates the disease-specific programme (encouraging sustained financing, commitment and transparency) and/or who pushes the programme plans</p>  | Qualitative (IDI)<br>Responses to GovTB2.2<br>Triangulated across diverse group of respondents | <ul style="list-style-type: none"> <li>Low risk: Both or at least GovTB2.1 indicator is met</li> <li>Moderate risk: Only GovTB2.2 indicator is met</li> </ul>   |
|                   | GovTB2.1 | Legally empowered leading organization to effectively manage the functioning of the given disease programme |  |  |   |

|                 |          |   |  |   |   |
|-----------------|----------|---|--|---|---|
|                 | GovTB2.2 | Individual leader(s) advocate for disease specific programme  | forward<br>Yes / No qualifiers<br>If not effective qualify as "No"   |   | <ul style="list-style-type: none"> <li>High risk: Neither indicator is met</li> </ul>   |
| Gov             | GovG3    | Strong coordination mechanisms  | Yes / No qualifiers  | Qualitative (IDI)                                     | <ul style="list-style-type: none"> <li>Low risk: All three indicators are met</li> <li>Moderate risk: Two indicators are met</li> <li>High risk: One indicator is met</li> </ul>                              |
|                 | GovG3.1  | Coordinating body adequately placed within the government hierarchy and legally empowered within the national government structure to assure adequate coordination across the sectors |  |   |   |
|                 | GovG3.2  | CSOs have a legally determined seat in the coordinating body  |  |   |   |
|                 | GovG3.3  | Coordinating body functions effectively   | Effective functioning if: meets regularly, considers issues raised by different stakeholders, makes documented decisions that are considered/acted by the government and other players<br><br>Yes / No qualifiers  |   |   |
| Component score |          |   |  |   |   |
| A               | ATB1     | Programme performance results are available and accessible through public domain  | <i>DEFINITIONS</i><br>Epidemiological data: Prevalence and incidence rates/new cases.,<br>Program performance report may include M&E process indicators according to the Disease specific M&E Plan<br><br>For ATB1.1 new cases - annually<br>For ATB1.2- 1.4 - at least biennial<br>For ATB1.5 - at least every 3 years<br><br>Yes / No qualifiers | Qualitative (IDI) validated through literature review | <ul style="list-style-type: none"> <li>Low risk: At least four indicators are met</li> <li>Moderate risk: At least three indicators are met</li> <li>High risk: Less than three indicators are met</li> </ul> |
|                 | ATB1.1   | Epidemiological data  |  |   |   |
|                 | ATB1.2   | Programmatic performance, monitoring reports  |  |   |   |
|                 | ATB1.3   | Programme expenditure data  |  |   |   |
|                 | ATB1.4   | Programme   |  |   |   |
|                 | ATB1.5   | Evaluation reports NTP and other periodic reviews   |  |   |   |

|                 |        |   |   |  |   |
|-----------------|--------|---|---|--|---|
| A               | AG2    | Enabling Environment for Civil Society engagement | <p><i>METHODS DESCRIPTION:</i></p> <p>The EEI measures conditions that affect the capacity of citizens (whether individually or collectively) to participate and engage in civil society. The EEI not only measures the governance and policy factors that directly affect civil society, it also looks at the socio-economic and socio-cultural conditions. The EEI is made up of 71 secondary statistical data sources. Over 70% of the sources are from the years 2010 and 2011.</p> <p>Qualifiers: Not Enabling / Enabling with Limitations / Enabling</p> <ul style="list-style-type: none"> <li>• Not enabling - EEI 0-0.38 – there are laws and policies that restrict civil society from playing an oversight role</li> <li>• Enabling with limitations - EEI 0.39 – 0.50 – there are no laws and policies that restrict civil society from playing an oversight role, but in practice it is not accepted by the government</li> <li>• Enabling - EEI &gt; 0.51-0.76 there are no laws or policies that restrict civil society from playing an oversight role, and civil society is actively engaged in providing oversight</li> </ul> <p>(Ref: PEPFAR sustainability index tool)</p> | <a href="http://civicus.org/eei/">http://civicus.org/eei/</a>  | <ul style="list-style-type: none"> <li>• Low risk: Enabling</li> <li>• Moderate risk: Enabling with Limitations</li> <li>• High risk: Not Enabling</li> </ul> |
| Component score |        |   |   |  |   |
| Programme       |        |   |   |  |   |
| S               | STB1   | Treatment   | <p>Last 5 years analyses, or at least three data points for the latest years available</p> <p>Qualifiers: Increasing / stable / decreasing</p>  | <p>DR: Clinical data;</p> <p>WHO TB database<br/><a href="http://www.who.int/tb">http://www.who.int/tb</a></p> | <ul style="list-style-type: none"> <li>• Low risk: Both indicators increasing</li> <li>• Moderate risk: At least one</li> </ul>                               |
|                 | STB1.1 | Treatment outcome – success rate for all TB cases |   |  |   |
|                 | STB1.2 | Treatment outcome –                               |   |  |   |

|                        |        |   |   |  |   |
|------------------------|--------|---|---|--|---|
|                        |        | success rate for MDR TB   |   |  | increasing and other stable<br><ul style="list-style-type: none"> <li>High risk: At least one indicator is worsening</li> </ul>   |
| S                      | STB2   | Integrated services   | High level of integration - $\geq 50\%$ of facilities<br>Partial integration - 21 - 49% of facilities<br>Limited to no integration - $\leq 20\%$ of facilities<br>(Ref. PEPFAR sustainability index tool, modified) | DR: Operations Research<br><br>Qualitative (IDI)                     | <ul style="list-style-type: none"> <li>Low risk: At least one partially and one high level</li> <li>Moderate risk: At least one partially and other limited</li> <li>High risk: Both limited OR no integration</li> </ul> |
|                        | STB2.1 | Integrated TB in primary care   |   |  |   |
|                        | STB2.2 | Integrated HIV and TB services  |   |  |   |
| S                      | SG4    | CSOs contracting in health  | Yes / No qualifiers   | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>Low risk: Both indicators are met</li> <li>Moderate risk: SG4.1 indicator is met</li> <li>High risk: Neither indicator is met</li> </ul>   |
|                        | SG4.1  | Existence of detailed rules and procedures for contracting CSOs for health service delivery (includes medical and other health related social services) |   |  |   |
|                        | SG4.2  | Government already contracts CSOs for various health service provision using public funds   |   |  |   |
| <b>Component score</b> |        |   |   |  |   |
| O                      | OTB1   | Strong management of the National Disease Programme Management Entity   | National Disease Programme Management Entity is not assessed if it serves as Principal Recipient (PR)   | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>Low risk: At least three indicators are met</li> <li>Moderate risk: Two indicators are met</li> <li>High risk: Less than two indicators are met</li> </ul>                         |
|                        | OTB1.1 | Existence of National Programme management capacity assessment OR staff performance evaluation practice   | OTB1.1 evaluation practice - at least once in every second year<br>If more than one entity assess separately.<br><br>Yes / No qualifiers  |  |   |
|                        | OTB1.2 | Closely integrated TGF PR and National Programme Management   |   |  |   |

|                 |        |  |  |  |   |
|-----------------|--------|--|--|--|---|
| 0               | OTB2   | PSM  | Yes / No qualifiers<br><br>OTB2.3 Low frequency - not more than one over for last year<br>OTB2.4 Rare - not more than once for last year   | Qualitative (IDI)  | <ul style="list-style-type: none"> <li>• Low risk: At least four indicators are met</li> <li>• Moderate risk: Three indicators are met</li> <li>• High risk: Less than three indicators are met</li> </ul>                |
|                 | OTB2.1 | TGF funded procurement is conducted using national system  |  |  |   |
|                 | OTB2.2 | Supply chain management integrated into the national system  |  |  |   |
|                 | OTB2.3 | Low frequency of emergency procurements for drugs  |  |  |   |
|                 | OTB2.4 | Rare stock outs for drugs  |  |  |   |
|                 | OTB2.5 | If national procurement – paying no more than 5% above the international benchmark price   |  |  |   |
| Component score |        |  |  |  |   |
| 0               | OTB3   | M&E  | <i>DEFINITIONS</i><br><br>OTB3.2 Recent data: Based on a program / strategic plan development cycle for a disease in the country.<br><br>Qualifiers: High / Moderate / Limited or None<br><br>OTB3.2 High use- use of Epi, programmatic and expenditure data; Moderate use – use of some data; Limited use – use of minimal data | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: One indicator at moderate and other high, or both at moderate level</li> <li>• High risk: None OR limited</li> </ul> |
|                 | OTB3.1 | Existence of analytical capacity at MoH/main public health agency reflected in availability of analytical reports that are produced with defined periods |  |  |   |
|                 | OTB3.2 | Information use for evidence-based programme planning and management, e.g. NTP uses recent Epi, programmatic and expenditure data                        |  |  |   |
| Component score |        |  |  |  |   |
| T               | TTB1   | Legally binding and actionable Transition plan / elements  | Yes / No qualifiers  | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: TTB1.1 indicator is met</li> <li>• Moderate risk: TTB1.2 and TTB1.3 indicators are met</li> <li>• High risk: only TTB1.3 or TTB1.2 or</li> </ul>                       |
|                 | TTB1.1 | Legally binding and actionable transition plan exists  |  |  |   |
|                 | TTB1.2 | Draft transition plan  |  |  |   |

|                 |        |   |                     |  |  |                       |
|-----------------|--------|---|---------------------|--|--|-----------------------|
|                 |        | exists  |                     |  | none   |                       |
|                 | TTB1.3 | Transition elements embedded into the legally empowered national programme/ NTP |                     |  |  |                       |
| T               | TTB2   | Transition plan / Transition elements characteristics:                          | Yes / No qualifiers | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: At least three indicators are met and TTB2.3</li> <li>• Moderate risk: at least two indicators are met</li> <li>• High risk: One indicators is met or none</li> </ul> |                       |
|                 | TTB2.1 | Clearly identifies time-bound activities to be implemented during transition    |                     |  |  |                       |
|                 | TTB2.2 | Clearly outlines roles and responsibilities of Transition process management    |                     |  |  |                       |
|                 | TTB2.3 | Incorporates M&E indicators for transition process                              |                     |  |  |                       |
|                 | TTB2.4 | Incorporates budget for transition  |                     |  |  |                       |
| T               | TTB3   | Transition M&   | Yes / No qualifiers | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: One indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>                                      |                       |
|                 | TTB3.1 | M&E is followed   |                     |  |  | If NA qualify as “No” |
|                 | TTB3.2 | CSO participates in the transition updates                                      |                     |  |  |                       |
| Component score |        |   |                     |  |  |                       |
| Overall score   |        |   |                     |  |  |                       |

Malaria Modular TPA Framework (not piloted)

| Component letter Code       | Indicator Code | Indicators  | Measurement   | Data source  | Risk assessment criteria  |
|-----------------------------|----------------|---|---|--|---|
| <b>External Environment</b> |                |   |   |  |   |
| P                           | PG1            | Existence of political will to prioritize health investments  | Trend analysis of the last 5 years<br><i>DEFINITIONS</i><br>1.1 High share of government spending on health out of General Government Expenditure. High share if more than a mean for income group countries for the most recent year available. E.g. for 2013:<br>For LMIC $\geq 11\%$<br>For UMIC $\geq 12\%$<br>These indicators might not be applicable during economic crises, therefore trend (share) before the crises should be considered when country has gone through a recent economic crisis.<br>Yes / No qualifiers | <a href="http://www.worldbank.org">www.worldbank.org</a>             | <ul style="list-style-type: none"> <li>• Low risk: Both indicator are met</li> <li>• Moderate risk: At least one indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul> |
|                             | PG1.1          | Increasing trend or stable high share of government spending on health out of General Government Expenditure  |   |  |   |
|                             | PG1.2          | Increasing trend of the share of government spending on health out of Total Health Expenditure                |   |  |   |
| P                           | PG4            | Government ability to contract with CSOs - Existence of general regulation for CSO contracting in the economy | Yes / No qualifiers   | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: Only PG4 is met</li> <li>• High risk: Neither indicator is met</li> </ul>              |
|                             | PG5            | CSO contracting is being practiced in any sector  |   |  |   |
| <b>Component score</b>      |                |   |   |  |   |
| E                           | EG1            | Favourable economic indicators  | Trend analyses for last 5 years<br>EG1.1 GDP per capita growth (annual %) stable increase over the 5-year period  | <a href="http://www.worldbank.org">www.worldbank.org</a>             | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> </ul>   |

|                      |       |   |   |  |  |
|----------------------|-------|---|---|--|--|
|                      | EG1.1 | Increasing in GDP per capita  | EG1.2 General Government Revenues as % of GDP increasing or stable trend for past 5 years; High share if more than a mean for income group countries for the most recent year available. E.g. For 2012:<br>LIC – 15.7%<br>LMIC – 21.4%<br>UMIC – 28.9%<br>Yes / No qualifiers |  | <ul style="list-style-type: none"> <li>• Moderate risk: At least one indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>  |
|                      | EG1.2 | Increasing or stable high share of General Government Revenues as % of GDP  |   |  |  |
| Component score      |       |   |   |  |  |
| Internal Environment |       |   |   |  |  |
| Inputs               |       |   |   |  |  |
| F                    | FM1   | Budgetary commitment to disease   |   | DR: National budgets; NASA or NHA, where available | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are met and at least FM1.2.1</li> <li>• Moderate risk: At least two indicators are met</li> <li>• High risk: Less than two indicators are met</li> </ul> |
|                      | FM1.1 | Increasing public expenditure on Disease Specific Programme   | Trend analyses for last 5 years.<br>Yes / No qualifiers   |  |  |
|                      | FM1.2 | Share of public funding in Disease Specific Programme budget  | Share of public funding for last years in total disease funding/budget. (Ref: PEPFAR sustainability index tool modified)<br>1.2.4 ≥ 75%<br>1.2.5 50 – 74%<br>1.2.6 ≤ 49%  |  |  |
|                      | FM1.3 | Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NMCP | Yes/No qualifiers   |  |  |
|                      | FM2   | Prevention priority<br><b>For areas of high transmission</b>  | <i>DEFINITIONS:</i><br>1. Prevention activities in areas of high transmission include regular distribution of Long lasting insecticide treated Nets (LITNs), indoor residual spraying (IRS), larval source management, chemoprevention to most                                | DR: National budgets; NHA where available          | <b>For areas of high transmission</b> <ul style="list-style-type: none"> <li>• <b>Low risk:</b> Both indicators are met</li> <li>• <b>Moderate risk:</b> At least</li> </ul>   |
|                      | FM2.1 | Increasing or stable total public spending on malaria prevention activities   |   |  |  |



|       |  |   |   |
|-------|--|---|---|
| FM2.2 | Increasing or stable share of public spending in strengthening epidemiological and entomological surveillance activities | <p>vulnerable groups (pregnant women, infants, and seasonal chemoprevention for children under 5 years).</p> <p>2. Prevention activities in areas of low transmission include regular distribution of Long lasting insecticide treated Nets (LITNs) indoor residual spraying (IRS), larval source management, chemoprevention to most vulnerable groups (pregnant women, infants, and seasonal chemoprevention for children under 5 years) and transmission-blocking chemotherapy.</p> <p>3. Prevention activities in areas targeted for elimination include regular distribution of Long lasting insecticide treated Nets (LITNs), indoor residual spraying (IRS)</p> <p><i>DEFINITIONS .</i></p> <p>1. Epidemiological surveillance in areas of high transmission should concentrate efforts to ensure that all admissions for malaria to hospitals and health centers and deaths from malaria therein are confirmed by a parasitological test and reported through a national surveillance system.</p> <p>2. Epidemiological surveillance in areas of low transmission should focus in identifying population groups more susceptible to the disease and be vigilant against potential outbreaks, with intensified reporting (e.g. weekly) of the incidence of infections and the monitoring of major determinants of transmission, such as meteorological data.</p> <p>3. Epidemiological surveillance in areas targeted for elimination should focus in increasing the strength of reporting and surveillance systems (capturing data of private sector and investigating individual cases)</p> <p>Yes/No qualifiers</p> | <p>st one indicator is met</p> <ul style="list-style-type: none"> <li>• High risk: None of indicators are met or data not available</li> </ul> <p><b>For areas of low transmission</b></p> <ul style="list-style-type: none"> <li>• Low risk: all indicators are met</li> <li>• Moderate risk: At least one indicator is met</li> <li>• High risk: None of indicators are met or data not available</li> </ul> <p><b>For areas targeted for elimination</b></p> <ul style="list-style-type: none"> <li>• Low risk: All indicators are met</li> <li>• Moderate risk: At least one indicator is met</li> <li>• High risk: None of indicators are met or data not available</li> </ul> |
| FM2.3 | <b>For areas of low transmission</b><br>Stable total public spending on malaria prevention activities.                   |   |   |
| FM2.4 | Increasing share of public spending in strengthening epidemiological surveillance activities                             |   |   |
| FM2.5 | Stable share in public spending in entomological surveillance system   |   |   |
| FM2.6 | <b>Areas targeted for elimination</b><br>Stable total public spending on malaria prevention activities.                  |   |   |
| FM2.7 | Increasing share of public spending in strengthening epidemiological surveillance activities                             |   |   |
| FM2.8 | Stable share in public spending in entomological surveillance system   |   |   |

|   |       |   |  |  |  |
|---|-------|---|--|--|--|
| F | FM3   | Regular evaluations (operational research) funded from public sources | <p><i>DEFINITIONS</i> Operational research (OR) is defined as “the use of systematic research techniques for program decision-making to achieve a specific outcome. OR provides policy-makers and managers with evidence that they can use to improve program operations”</p> <p>Research should include malaria drug resistance studies, insecticide resistance studies, Population studies for LLITNs use and coverage, IRS coverage. Etc.</p> <p>Qualifiers: Fully funded / Partially funded / Not funded</p> <p>Share of public funding:</p> <ul style="list-style-type: none"> <li>• &gt;=80% - Fully funded</li> <li>• 30-79% - Partially funded</li> <li>• &lt;=29% - Not funded</li> </ul> | DR: National budgets or NHA, where available                         | <ul style="list-style-type: none"> <li>• Low risk: Fully funded</li> <li>• Moderate risk: Partially funded</li> <li>• High risk: Not funded</li> </ul>   |
| F | FM4   | Treatment / input financing from public sources                       | <p><i>DEFINITIONS</i></p> <p>Case detection / Diagnostics from Public funding should include all diagnostic means including Rapid Diagnostic tests (RDT) and microscopic detection</p>   | DR: National budgets or NHA, where available                         | <ul style="list-style-type: none"> <li>• <b>Low risk:</b> Both indicators are funded by public sources at least partially</li> <li>• <b>Moderate risk:</b> One indicator Not funded</li> <li>• <b>High risk:</b> Both indicators Not funded</li> </ul> |
|   | FM4.1 | Diagnostics   | Treatment: All antimalarial drugs schemes according to NMCP including those for chemoprophylaxis. The drug regimens can vary depending of the type of malaria in a specific country /area and the severity of the case (uncomplicated or complicated malaria cases)  | Qualitative (IDI) validated through document review, where necessary |  |
|   | FM4.2 | Treatment (Antimalarial drugs according to NMCP)                      | <p>Qualifiers:<br/>Fully funded /Partially funded / Not funded qualifiers.</p> <p>Share of public funding:</p> <ul style="list-style-type: none"> <li>• &gt;=80% - Fully funded</li> <li>• 30-79% - Partially funded</li> <li>• &lt;=29% - Not funded</li> </ul> <p>(ref. PEPFAR sustainability index tool, modified)<br/>Yes / No qualifiers</p>  |  |  |

|                 |       |   |  |   |   |
|-----------------|-------|---|--|---|---|
| <b>F</b>        | FM5   | Prevention financing from public sources  | <p>Qualifiers:<br/>Fully funded /Partially funded / Not funded.<br/>Share of public funding:</p> <ul style="list-style-type: none"> <li>• &gt;=80% - Fully funded</li> <li>• 30-79% - Partially funded</li> <li>• &lt;=29% - Not funded</li> </ul> | <p>DR: National budgets or NHA, where available</p> <p>Qualitative (IDI) validated through document review, where necessary</p> | <ul style="list-style-type: none"> <li>• Low risk: At least three indicators are funded by public sources at least partially</li> <li>• Moderate risk: Two indicators Not funded</li> <li>• High risk: More than two indicators Not funded</li> </ul> |
|                 | FM5.1 | Funding of LLITN's (Long-Lasting Insecticide-Treated Net) from public sources   |  |   |   |
|                 | FM5.2 | Funding of Chemoprophylaxis ((pregnant women, infants, and seasonal chemoprevention for children under 5 years and transmission-blocking chemotherapy), from public sources |  |   |   |
|                 | FM5.3 | Funding of vector control activities (IRS, materials, larval source management) from public sources   |  |   |   |
|                 | FM5.4 | Community involvement in prevention activities  |  |   |   |
| Component score |       |   |  |   |   |

|                 |      |   |  |  |  |
|-----------------|------|---|--|--|--|
| HR              | HRM1 | Sufficient human resources in key areas of intervention:<br>Quantities, geographic distribution, type (medical staff, community staff, entomological staff) | <p><i>Qualifiers:</i></p> <p>1.1 – Sufficient<br/>1.2 – With some limitations<br/>1.3 – Severe shortage</p> <p><i>DEFINITIONS</i></p> <p>HR in key areas of intervention:<br/>Diagnosis: Qualified staff to adequately diagnose malaria cases (laboratory staff and community health workers)<br/>- Treatment: Qualified staff that can provide adequate treatment and follow up of patients (medical staff in health centres and community health workers in communities)<br/>- Prevention: Qualified staff that can provide chemoprophylaxis and teams that can undergo vector control activities (LLINs distribution, IRS, larval source management)<br/>- Surveillance: Qualified staff at local and central level that can manage surveillance activities</p> | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Sufficient</li> <li>• Moderate risk: With some limitations</li> <li>• High risk: Severe shortage</li> </ul>                                     |
| HR              | HRM2 | Donor supported trainings for health personnel institutionalized in national education system   | <p><i>DEFINITIONS</i></p> <p>Institutionalization: training is part of formal educational curriculum and is financially supported by the government and delivered by the state/non-state institutions charged with such responsibility in a given country.</p> <p>Qualifiers:<br/>Yes / No</p> <ul style="list-style-type: none"> <li>• 100% institutionalization - Yes</li> <li>• less than 100% institutionalization - No</li> </ul>   | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are met</li> <li>• Moderate risk: Two indicators are met</li> <li>• High risk: Less than two indicators are met</li> </ul> |
|                 | HRM3 | Existence of policy for production/training of CSO personnel (non medical, social service)  | Qualifiers:<br>Yes / No  |  |  |
|                 | HRM4 | Donor funded HR salaries aligned with national pay-scale  | Qualifiers:<br>Yes / No / NA   |  |  |
| Component score |      |   |  |  |  |

|     |       |   |  |   |   |
|-----|-------|---|--|---|---|
| HIS | HISM1 | Routine statistical reporting fully integrated in the national system         | <p><i>DEFINITIONS</i><br/>Components of Routine statistical reporting: 1) Malaria testing; 2) Case notification; 3) Cases that receive parasitological confirmation; 4) API (annual parasitic incidence); 5) Treatment; 6) Death<br/>Qualifiers: Fully integrated / Partially integrated / Not integrated</p> <ul style="list-style-type: none"> <li>▪ Fully Integrated: Complete harmonization of the routine Statistical reporting into the national systems.</li> <li>▪ Partially integrated: At least four components included in the national system</li> <li>▪ Not integrated: More than two components not included in the national system</li> </ul>           | Qualitative (IDI)<br>Observation of the databases | <ul style="list-style-type: none"> <li>• Low risk: Fully integrated</li> <li>• Moderate risk: Partially integrated</li> <li>• High risk: Not integrated</li> </ul>              |
| HIS | HISM2 | Advanced routine statistical reporting  | <p><i>DEFINITIONS</i><br/>Components of Routine statistical reporting: 1) Malaria testing; 2) Case notification; 3) Cases that receive parasitological confirmation; 4) API (annual parasitic incidence); 5) Treatment; 6) Death<br/>Qualifiers: Fully advanced / Partially advanced / Not advanced</p> <ul style="list-style-type: none"> <li>• Advanced: Web based or electronic at national and subnational levels with disaggregation (age, gender, geography, population types)</li> <li>• Partially advanced- Electronic &amp; paper based; or Limited disaggregation</li> <li>• Not advanced: Completely paper-based with or without disaggregation.</li> </ul> | Qualitative (IDI)<br>Observation of the databases | <ul style="list-style-type: none"> <li>• Low risk: Advanced</li> <li>• Moderate risk: Partially advanced</li> <li>• High risk: Not advanced</li> </ul>                          |
| HIS | HISM3 | Malaria Early warning system (MEWS) to detect possible new outbreaks in place | <p><i>DEFINITIONS</i><br/>MEWS want to predict the following:</p> <ul style="list-style-type: none"> <li>- Areas of high transmission: Potential prediction of seasonal onset</li> <li>- Areas of low transmission: Prediction of outbreaks</li> <li>- Areas targeted for elimination: Prediction of outbreaks</li> </ul>  | Qualitative (IDI);<br>Observation of the system   | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are met</li> <li>• Moderate risk: Two indicators are met</li> <li>• High risk: Less than two</li> </ul> |

|                   |         |   |   |                   |   |
|-------------------|---------|---|---|-------------------|---|
|                   | HISM3.1 | Functional System   | System integrated to the malaria program, plus weather national office  |                   | indicators are met  |
|                   | HISM3.2 | Routinely using free available remote sensing information to predict malaria epidemics                | MEWS must provide with regular reports (every month at least) in order to have enough information to predict epidemics  |                   |   |
|                   | HISM3.3 | Malaria epidemic-prone districts and their health facilities monitoring malaria case trends regularly | Districts/regions with high risk of malaria should have their own regional MEWS in place. Regular monitoring should be done monthly.  |                   |   |
| HIS               | HISM4   | Operational research for program decision making  | <p><i>DEFINITIONS</i><br/>Operational research (OR) is defined as “the use of systematic research techniques for program decision-making to achieve a specific outcome. OR provides policy-makers and managers with evidence that they can use to improve program operations”</p> <p>Research should include malaria drug resistance studies, insecticide resistance studies, Population studies for LLITNs use and coverage, IRS coverage. Etc.</p> <p>Regular OR is recommended to be at least once a year or according to the NMCP or Strategic Plan</p> <p>Qualifiers: yes / no</p> | Qualitative (IDI) | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: One indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul> |
|                   | HISM4.1 | Regular   |   |                   |   |
|                   | HISM4.2 | Included in the Malaria Strategic Plan  |   |                   |   |
| Component score   |         |   |   |                   |   |
| <b>Governance</b> |         |   |   |                   |   |
| Gov               | GovM1   | Strong political Commitment to diseases   |   | Qualitative (IDI) | <ul style="list-style-type: none"> <li>• Low risk: GovM1.1.and GovM1.3 indicators are met</li> <li>• Moderate risk: GovM1.2 and GovM1.3 indicators</li> </ul>                       |
|                   | GovM1.1 | NSP/NMCP with legal and enforceable power in a given country context                                  | <p><i>DEFINITIONS:</i><br/>Current Strategic plan, legally empowered with validity of at least 6 months.<br/>Qualifiers: Yes / No</p>   |                   |   |

|     |         |   |  |  |   |
|-----|---------|---|--|--|---|
|     | GovM1.2 | NSP/NMCP in preparation or without legal and enforceable power  | <i>DEFINITIONS:</i><br>If NSP/NMCP is less than 6 months new Strategic plan preparation should be in process<br>Qualifiers: Yes / No   |  | are met   |
|     | GovM1.3 | Malaria as a priority in National Health Strategy document  | <i>DEFINITIONS:</i><br>High level national document such as National Health Strategy or National Development Plan, legally approved in accordance to existing laws of a country, identifies disease as a priority<br>Qualifiers: Yes / No / NA   |  | <ul style="list-style-type: none"> <li>• High risk: Neither OR only GM1.2 indicator is met</li> <li>• If GovM1.3 NA</li> <li>• Low risk: GovM1.1 indicator is met</li> <li>• High risk: GovM1.2 indicator is met</li> </ul> |
| Gov | GovM2   | Strong leadership   | <i>DEFINITIONS:</i><br>Individual leader or ‘champion’ – a person who advocates the disease-specific programme (encouraging sustained financing, commitment and transparency) and/or who pushes the programme plans forward<br><br>Yes / No qualifiers<br>If not effective qualify as "No" | Qualitative (IDI)<br>Responses to GovM2.2.<br>Triangulated across diverse group of respondents | <ul style="list-style-type: none"> <li>• Low risk: Both or at least GovM2.1 indicator is met</li> <li>• Moderate risk: Only GovM2.2 indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>              |
|     | GovM2.1 | Legally empowered leading organization to effectively manage the functioning of the given disease programme   |  |  |   |
|     | GovM2.2 | Individual leader(s) advocate for disease specific programme  |  |  |   |
| Gov | GovG3   | Strong coordination mechanisms  | Yes / No qualifiers  | Qualitative (IDI)  | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are</li> <li>• Moderate risk: Two indicators are met</li> <li>• High risk: One indicator is met</li> </ul>  |
|     | GovG3.1 | Coordinating body adequately placed within the government hierarchy and legally empowered within the national government structure to assure adequate coordination across the sectors |  |  |   |
|     | GovG3.2 | CSOs have a legally determined seat in the coordinating body  |  |  |   |

|                 |         |   |   |   |   |
|-----------------|---------|---|---|---|---|
|                 | GovG3.3 | Coordinating body functions effectively   | Effective functioning if: meets regularly, considers issues raised by different stakeholders, makes documented decisions that are considered/acted by the government and other players<br>Yes / No qualifiers   |   |   |
| Component score |         |   |   |   |   |
| A               | AM1     | Programme performance results are available and accessible through public domain: | <p>DEFINITIONS</p> <p>Epidemiological data: new cases, positivity rates, death rates, Percentage of suspected malaria cases that have had a diagnostic test</p> <p>Programmatic performance report: may include M&amp;E process indicators according to the Malaria M&amp;E Plan</p> <p>For AM1.1 new cases - weekly<br/>For AM1.2- 1.4 - at least biennial<br/>For AM1.5 - at least every 3 years</p> <p>Yes / No qualifiers</p> | Qualitative (IDI) validated through literature review | <ul style="list-style-type: none"> <li>• Low risk: At least four indicators are met</li> <li>• Moderate risk: At least three indicators are met</li> <li>• High risk: Less than three indicators are met</li> </ul> |
|                 | AM1.1   | Epidemiological data  |   |   |   |
|                 | AM1.2   | Programmatic performance, monitoring reports                                      |   |   |   |
|                 | AM1.3   | Programme expenditure data  |   |   |   |
|                 | AM1.4   | Programme Evaluation reports  |   |   |   |
|                 | AM1.5   | NSP/NTP/NMCP and other periodic reviews   |   |   |   |



|                 |       |   |   |   |   |
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| A               | AG2   | Enabling Environment for Civil Society engagement           | <p><i>METHODS DESCRIPTION:</i></p> <p>The EEI measures conditions that affect the capacity of citizens (whether individually or collectively) to participate and engage in civil society. The EEI not only measures the governance and policy factors that directly affect civil society, it also looks at the socio-economic and socio-cultural conditions. The EEI is made up of 71 secondary statistical data sources. Over 70% of the sources are from the years 2010 and 2011.</p> <p>Qualifiers: Not enabling / Enabling with limitations / Enabling</p> <ul style="list-style-type: none"> <li>• Not enabling - EEI 0-0.38 – there are laws and policies that restrict civil society from playing an oversight role</li> <li>• Enabling with limitations - EEI 0.39 – 0.50 – there are no laws and policies that restrict civil society from playing an oversight role, but in practice it is not accepted by the government</li> <li>• Enabling - EEI &gt; 0.51-0.76 there are no laws or policies that restrict civil society from playing an oversight role, and civil society is actively engaged in providing oversight</li> </ul> <p>(Ref: PEPFAR sustainability index tool)</p> | <a href="http://civicus.org/eei/">http://civicus.org/eei/</a> | <ul style="list-style-type: none"> <li>• Low risk: Enabling</li> <li>• Moderate risk: Enabling with Limitations</li> <li>• High risk: Not Enabling</li> </ul> |
| Component score |       |   |   |   |   |
| Programme       |       |   |   |   |   |
|                 | SM1   | Diagnosis   | Yearly analysis from the epidemiological information systems  | DR: Clinical data, epidemiological reports                    | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are increasing (or sustained)</li> <li>• Moderate risk: At least</li> </ul>                |
|                 | SM1.1 | Trend of confirmatory diagnosis (through RDT or microscopy) | <p><i>DEFINITION</i></p> <p>The total number of suspected malaria cases tested among the number of people living in areas where malaria transmission occurs.</p>  | WHO Malaria   |   |

|                 |       |   |   |   |   |
|-----------------|-------|---|---|---|---|
|                 | SM1.2 | Trend in Annual blood examination rate  | Higher annual blood examination rates reflect more complete malaria surveillance. In high-transmission settings, the rate is likely to greatly exceed 10% due to passive case detection alone.<br><br>Qualifiers: Increasing (or sustained) / stable /worsening   | database<br><a href="http://www.who.int/malaria/data/en/">http://www.who.int/malaria/data/en/</a><br><br>Qualitative (IDI)          | one indicator is increasing (or sustained) and other stable<br><br>• High risk: At least one indicator is worsening   |
| S               | SM2   | Treatment   | Last 5 years analysis, or at least three data points for the latest years available<br>Yes / No qualifiers  | DR: Clinical data;<br>WHO Malaria Database<br><a href="http://www.who.int/malaria/data/en/">http://www.who.int/malaria/data/en/</a> | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: One indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>   |
|                 | SM2.1 | Availability of antimalarial drug regimes in areas where there is active malaria transmission   |   |   |   |
|                 | SM2.2 | People receiving antimalarial treatment according to the national protocol  |   |   |   |
| S               | SM3   | Population at risk reach with preventive services based on rigorous survey data   | Population at risk as defined by NSP/NMCP. At least three data points<br>Preventive services: LLITNs distribution, chemoprophylaxis for pregnant women, indoor residual spraying<br>Rigorous survey – data based on household surveys or national demographic surveys<br>Qualifiers: Increasing (or sustained) / stable / worsening<br>If data is not based on Rigorous survey data is considered as not valid and qualify as “worsening” | DR: studies<br>Qualitative (IDI)  | <ul style="list-style-type: none"> <li>• Low risk: All three indicators are increasing</li> <li>• Moderate risk: At least one indicator is increasing and others stable</li> <li>• High risk: At least one indicators is worsening</li> </ul> |
|                 | SM3.1 | LLITNs distribution   |   |   |   |
|                 | SM3.2 | Chemoprophylaxis for pregnant women   |   |   |   |
|                 | SM3.3 | Indoor residual spraying  |   |   |   |
| S               | SG4   | CSOs contracting in health  | Yes / No qualifiers   | Qualitative (IDI) validated through document review, where necessary  | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: SG4.1 indicator is met</li> <li>High risk: Neither indicator is met</li> </ul>   |
|                 | SG4.1 | Existence of detailed rules and procedures for contracting CSOs for health service delivery (includes medical and other health related social services) |   |   |   |
|                 | SG4.2 | Government already contracts CSOs for various health service provision using public funds   |   |   |   |
| Component score |       |   |   |   |   |

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|-----------------|-------|--|--|--|--|
| 0               | OM1   | Strong management of the National Disease Programme Management Entity  | National Disease Program Management Entity is not assessed if it serves as Principal Recipient (PR). If more than one entity is assess separately.<br>OM1.1 evaluation practice - at least once in every second year<br><br>Yes / No qualifiers  | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: At least two indicators are met</li> <li>• Moderate risk: One indicator is met</li> <li>• High risk: None of indicators are met</li> </ul>  |
|                 | OM1.1 | Existence of National Programme management capacity assessment OR staff performance evaluation practice  |  |  |  |
|                 | OM1.2 | Closely integrated TGF PR and National Programme Management  |  |  |  |
| 0               | OM2   | PSM  | Yes / No qualifiers<br><br>OM2.3 Low frequency - not more than one over for last year<br>OM2.4 Rare - not more than once for last year   | Qualitative (IDI)  | <ul style="list-style-type: none"> <li>• Low risk: At least four indicators are met</li> <li>• Moderate risk: Three indicators are met</li> <li>• High risk: Less than three indicators are met</li> </ul>   |
|                 | OM2.1 | TGF funded procurement is conducted using national system  |  |  |  |
|                 | OM2.2 | Supply chain management integrated into the national system  |  |  |  |
|                 | OM2.3 | Low frequency of emergency procurements for drugs  |  |  |  |
|                 | OM2.4 | Rare stock outs for drugs  |  |  |  |
|                 | OM2.5 | If national procurement – paying no more than 5% above the international benchmark price   |  |  |  |
| 0               | OM3   | M&E  | <i>DEFINITIONS</i><br>Recent data: Based on a program / strategic plan development cycle for a disease in the country.<br>Qualifiers: High / Moderate / Limited or None<br>OM3.2 High use- use of Epi, programmatic and expenditure data; Moderate use – use of some data; Limited use – use of minimal data | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators at high level</li> <li>• Moderate risk: One indicator at moderate and other high, or both at moderate level</li> <li>• High risk: At least one indicator limited OR None</li> </ul> |
|                 | OM3.1 | Existence of analytical capacity at MoH/main public health agency reflected in availability of analytical reports that are produced with defined periods |  |  |  |
|                 | OM3.2 | Information use for evidence-based programme planning and management, e.g. NSP/NTP, uses recent Epi, programmatic and expenditure data                   |  |  |  |
| Component score |       |  |  |  |  |

|                 |       |   |  |  |   |
|-----------------|-------|---|--|--|---|
| T               | TM1   | Legally binding and actionable Transition plan / Transition elements  | Yes / No qualifiers                              | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: TM1.1 indicator is met</li> <li>• Moderate risk: TM1.2 and TM1.3 indicators are met</li> <li>• High risk: only TM1.3 or TM1.2 or none</li> </ul> |
|                 | TM1.1 | Legally binding and actionable transition plan exists   |  |  |   |
|                 | TM1.2 | Draft transition plan exists  |  |  |   |
|                 | TM1.3 | Transition of programme elements embedded into the national Malaria programme / NSP that is legally binding |  |  |   |
| T               | TM2   | Transition plan / transition elements characteristics:  | Yes / No qualifiers                              | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: TM1.1 indicator is met</li> <li>• Moderate risk: TM1.2 and TM1.3 indicators are met</li> <li>• High risk: only TM1.3 or TM1.2 or none</li> </ul> |
|                 | TM2.1 | Clearly identifies time-bound activities to be implemented during transition                                |  |  |   |
|                 | TM2.2 | Clearly outlines roles and responsibilities of a Transition process management                              |  |  |   |
|                 | TM2.3 | Incorporates M&E indicators for transition process  |  |  |   |
|                 | TM2.4 | Incorporates budget for transition  |  |  |   |
| T               | TM3   | Transition M&E  | Yes / No qualifiers<br><br>If NA qualify as "No" | Qualitative (IDI) validated through document review, where necessary | <ul style="list-style-type: none"> <li>• Low risk: Both indicators are met</li> <li>• Moderate risk: One indicator is met</li> <li>• High risk: Neither indicator is met</li> </ul>                 |
|                 | TM3.1 | M&E is followed   |  |  |   |
|                 | TM3.2 | CSO participates in the transition updates  |  |  |   |
| Component score |       |   |  |  |   |
| Overall score   |       |   |  |  |   |

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