

BURDEN SHARING OR BURDEN SHIFTING?

HOW THE HIV/TB RESPONSE IS BEING DERAILED



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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral(s)
ART	Antiretroviral Therapy
BRICS	Brazil, Russia, India, China, South Africa
CAR	Central African Republic
CHE	Current Health Expenditures
CHW	Community Health Workers
COE	Challenging Operating Environment
COP	Country Operations Plan
CNLS	Comité National du Lutte Contre le Sida – National AIDS Council
Crag	Cryptococcal Antigen
CSO	Civil Society Organisation
DAH	Development Assistance for Health
DRC	Democratic Republic of Congo
DR-TB	Drug-Resistant Tuberculosis
DTG	Dolutegravir
FCAS	Fragile or Conflict Affected States
GDP	Gross Domestic Product
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
MDR-TB	Multi Drug-Resistant Tuberculosis
MoH	Ministry of Health
NCD	Non Communicable Disease
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OOP	Out Of Pocket
PEPFAR	The US President's Emergency Plan for the AIDS Response
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPP	Purchasing Power Parity
RR-TB	Rifampin Resistant Tuberculosis
TB	Tuberculosis
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
WCA	West and Central Africa
WHO	World Health Organization

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1. INTRODUCTION

After over a decade of steady global political investment in response to the health burden of HIV/tuberculosis (TB) and a firm commitment to “ending AIDS and TB by 2030”, recent data indicate that national and global responses to the two deadliest infectious diseases are veering off target. The annual number of deaths due to AIDS has declined only minimally since 2014. Worldwide, TB infection causes one in three deaths linked to AIDS. Each day 30,000 people fall ill with TB, and drug resistant TB continues to fuel a growing public health crisis. Global progress in fighting the dual threat of HIV and TB is regrettably uneven relative to the realities at the national level. Efforts and resources needed to support and treat people with HIV/TB are lagging in several heavy-disease burden countries as well as countries with lower prevalence levels of HIV, such as those in West and Central Africa.

In several countries where Médecins Sans Frontières/Doctors Without Borders (MSF) operates, our staff and other partners are observing persistent and expanding gaps in essential services, posing an increasing risk to the people they serve and the health of the population. A particular concern is the slow decline in mortality. Only five countries have met the 2020 target to reduce HIV related deaths by 75%.¹ Globally the death toll from AIDS has barely dropped over the past few years. There is urgent need to invest in reducing AIDS and TB related mortality, by improving access to optimal treatment and advanced diagnostic tools. However, measures to deal effectively with ‘contemporary’ AIDS and TB, ensuring people’s needs and circumstances at the center, remain glaringly insufficient.

Flatline-funding, driven to a large extent by international political fatigue, is a major limitation contributing to the stagnation in progress. Donor investments in HIV and TB dropped by 9 and 12%

respectively between 2017 and 2018 following a levelling off period of investment. In contrast, domestic funding for HIV has gradually increased over the past decade. However, the combined resources for the HIV in the most affected countries still fall woefully short. Additionally, 2018 marked a drop in funding, from both domestic and international sources, for the first time since fundraising efforts began. The drop approaches a billion dollars in low and middle-income countries.

At a time when continued investments are critical to keeping the HIV/TB response on course, and when investment should increase in line with accumulating challenges including: an increasing number of people on life-long treatment for HIV, drug resistance and shifts to new treatment regimens, the growing disengagement of donors and slow progress in domestic resource mobilisation, are propelling efforts to stem the threat of HIV/TB in reverse. While funding shortfalls are not the only barriers to accelerating progress – legal, cultural and other barriers as well as restrictive policies must also be removed – they risk undermining not only concrete actions but also political ambitions.

MSF works across the globe providing HIV/TB services. This report examines the health and HIV/TB financing situation in nine countries (**Central African Republic, Democratic Republic of Congo, Eswatini, Guinea, Kenya, Malawi, Mozambique, Myanmar, Zimbabwe**) where MSF is present. Focusing on resource availability, this report aims to highlight the current risks and gaps in HIV and TB service delivery in these countries. The collection of information was carried out through literature reviews and semi-structured interviews with key informants at both national and international levels. While MSF provides HIV and TB treatment also in countries not included in the report, the countries selected for the report are among those that bear a higher burden of HIV and TB coinfection.

¹ UNAIDS. *UNAIDS reports mixed progress towards reaching the 2020 target of reducing TB deaths among people living with HIV by 75%*. Press release. [Online]. 2019 Mar 22 [Cited 2019 Jun25]. Available from: http://www.unaids.org/sites/default/files/20190324_PR_TB_en.pdf

"I've been living with HIV for 15 years now. If I'm still in good health today, it's thanks to ARV treatment. But for several months now, there have been no more drugs. I'm depressed because I have been on ARVs since the beginning. I'm having sleepless nights. I don't know how we'll get out of it. One of my neighbours just lost her daughter because she didn't get her treatment. She was unwell and then she just died. As for me, I'm beginning to have health issues that I didn't have before. Before we started our treatment, we were told it was for life. But today, we feel abandoned in the middle of the road. We don't know what to do."

(Laetitia, Central African Republic)

■ Box 1

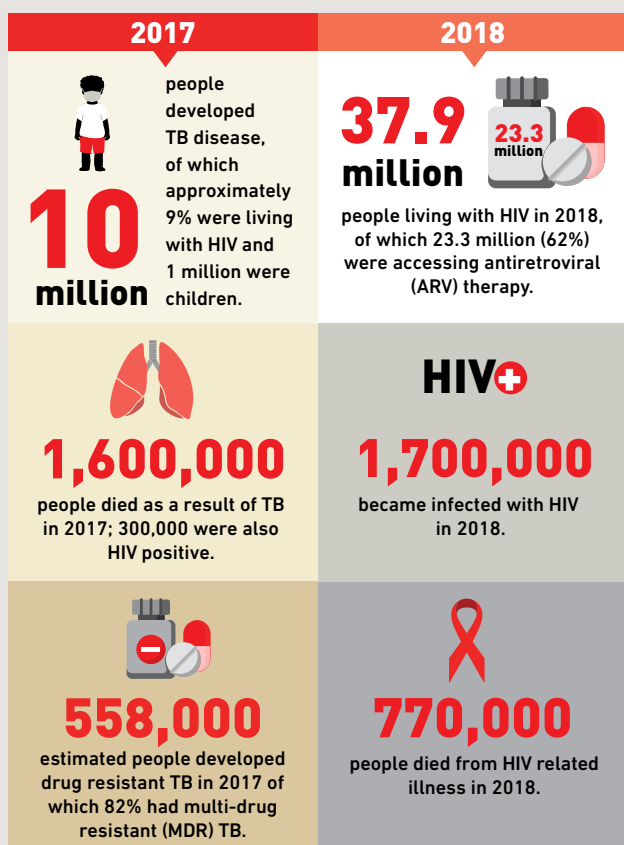
THE CHANGING FACE OF THE HIV EPIDEMIC AND THE RETURN OF AIDS

The close to 38 million people living with HIV and over three quarters of a million HIV related deaths yearly, most in low resource contexts, illustrate the worldwide challenge of HIV. Many countries in Sub-Saharan Africa are facing a high burden, with up to 20% of their population affected, and with HIV/AIDS being the main cause of death. Detecting HIV early and immediately starting ARV treatment is key to limiting illness, death and transmission of the virus. Keeping thousands of people on uninterrupted-lifelong ARV requires resources and adapted strategies for bringing treatment close to People Living with HIV (PLHIVs), and supporting them to remain in care. Resistance to first line ARV is rising, requiring switching to more expensive 2nd and 3rd line ARV regimens. In the coming years a massive shift to the cheaper and more effective Dolutegravir based 1st line treatment is planned.

TB: AN OLD DISEASE, STILL A KILLER TODAY

Each day 30,000 people fall ill with TB. Globally, around 10 million people developed TB disease in 2017, including one million children. Despite being preventable and curable, TB is now the leading cause of death from infectious diseases, accounting for 1.6 million deaths in 2017. Every year, an estimated 4.1 million cases go undetected and untreated and one in three deaths among PLHIV is due to TB. Moreover, drug-resistant TB continues to fuel a growing public health crisis, and the available treatments for multi-drug resistant (MDR-TB) are long, painful, toxic and debilitating for patients. Treatment success remains low at 55% (worldwide average). MDR-TB detection and treatment are very costly for the health system and the patients.

THE GLOBAL BURDEN OF HIV AND TB IN NUMBERS^{2,3}



² UNAIDS Data 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

³ Global TB report 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

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ARVS

2. GLOBAL HIV AND TB FINANCING TRENDS

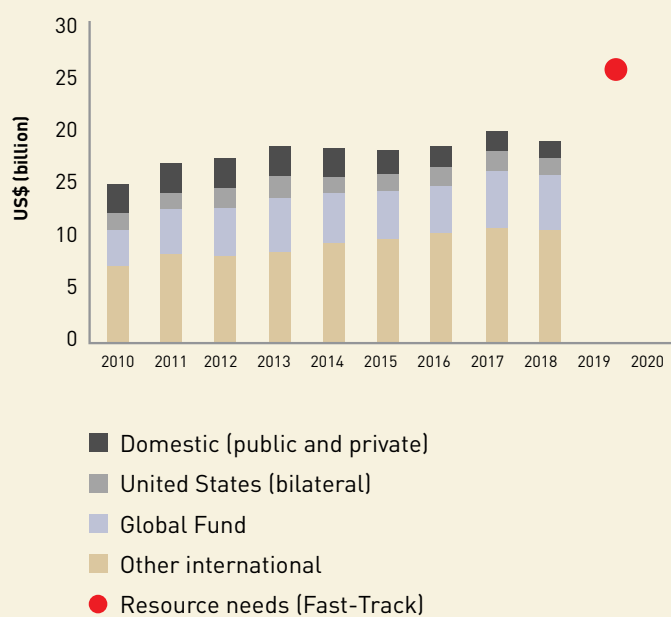
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Over the past year, there has been increasing recognition that the HIV and TB response is being pushed off the mark in relation to the global targets of ending the Tuberculosis and AIDS epidemics by 2030. In making the case for its sixth replenishment for the 2020 to 2022 period, the Global Fund to fight AIDS, TB and Malaria (Global Fund) indicates that merely continuing current levels of treatment and prevention efforts for the three diseases would lead to a rebound in incidence and mortality.⁴

2.1 GLOBAL HIV/AIDS RESOURCE TRENDS

For HIV, the 2016 UN General Assembly High Level Meeting political declaration called for increased annual investments to at least USD 26 billion by 2020 in order to meet the 2030 target.⁵ In 2018, however, only USD 19 billion was made available, marking a decrease of nearly one billion USD in total resources (domestic and international) for HIV globally in comparison to 2017. This decline marks the first time funding decreased since 2000. The decrease in resources occurred across all sources; specifically: 2% in domestic resources, 20% in Global Fund,⁶ 2% for other multilateral platforms, 3% from the bilateral US government programs and 17% among other donor countries' bilateral contributions, as well as 18% and 4% reductions in philanthropic and other international sources, respectively.⁷

Figure 1. HIV resource availability for HIV in low- and middle-income countries, 2010–2018 and 2020 Fast-Track resource needs (in constant 2016 US dollars)⁸



⁴ Global Fund Investment Case Summary Sixth Replenishment, [Available online from] https://www.theglobalfund.org/media/8174/publication_sixthreplenishmentinvestmentcase_summary_en.pdf

⁵ *Communities at the center – Global AIDS Update 2019*, UNAIDS, July 2019. [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf

⁶ The annual reduction in the Global Fund disbursements to countries is explained by fluctuations in its three year grant cycle. *The Global Fund 2018 Annual Report* [Available online from] https://www.theglobalfund.org/media/8470/corporate_2018annualfinancial_report_en.pdf?u=636939343860000000

⁷ *Communities at the center – Global AIDS Update*, UNAIDS, July 2019 Page 173. [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf

⁸ *Communities at the center – Global AIDS Update*, UNAIDS, July 2019, Page 174.



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International assistance for HIV/AIDS

Overall development assistance for health (DAH) has plateaued since 2010.⁹ After a decade of steady increases through 2011, DAH targeted for HIV/AIDS, has declined annually at the rate of 2% per year.¹⁰ Between 2017 and 2018, contributions directed towards HIV/AIDS took an even starker downturn decreasing by 8.8%, to USD 9.7 billion.¹¹

Taking only donor government assistance (i.e. excluding funders such as NGOs and foundations) into consideration as assessed in the Kaiser Family Foundation/UNAIDS July 2019 report, there appears to have been little change in funding between 2017 and 2018 (i.e., from USD 8.1 to USD 8.0 billion). Reductions in funding could be noted from five key bilateral donor countries including the US¹², which continues to be the largest HIV donor to date. Therefore, reductions in US support, reflected either directly in financial contributions, or indirectly in policy changes, demonstrate important implications, as described in chapter 3.3. Overall, HIV-directed funding from donor governments has stagnated and in many cases decreased over the past years, and by 2018 was more than USD 600 million below the peak support seen in 2014.¹³

Domestic resources for HIV/AIDS

Against the backdrop of waning international assistance, the call for increased domestic funding has grown louder to achieve 'sustainable HIV response results in the era of shrinking donor funding'. While focus in the past has been on mobilising both domestic and international resources, the shift to the former has increased dramatically. The message is now focusing on the inevitable and urgent need for domestic resources to replace dwindling international funds. Domestic

⁹ *Financing global health 2018 – countries and programs in transition*, Institute of Health Metrics and Evaluations (IHME), Seattle, WA, IHME, 2019, page 47. [Available online from] http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2019/FGH_2018_full-report.pdf

¹⁰ *Increased out-of-pocket spending threatens universal health coverage in 'missing middle' countries*, Dieleman et al. 25th of April 2019. [Available online from] <http://www.healthdata.org/news-release/increased-out-pocket-spending-threatens-universal-health-coverage-%E2%80%98missing-middle%E2%80%99>

¹¹ *Financing global health 2018 – countries and programs in transition*, Institute of Health Metrics and Evaluations (IHME), Seattle, WA, IHME, 2019, page 80. [Available online from] http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2019/FGH_2018_full-report.pdf

¹² *Donor Government Funding for HIV in Low- and Middle-Income Countries in 2018*, Kaiser family Foundation/UNAIDS, July 2019, page 3. [Available online from] <http://files.kff.org/attachment/Report-Donor-Government-Funding-for-HIV-in-Low-and-Middle-Income-Countries-in-2018>

¹³ Ibid.

resources already accounted for more than half of the overall resources directed toward the HIV response in low and middle-income countries in 2018.¹⁴

Some countries have shown evidence of their increasing ability to provide quality health care for their respective populations as their domestic economies have grown. However, the beneficial circumstances in these countries are not determined by economic growth alone, nor is it replicated across all regions and countries. Take for example the Eastern and Southern Africa Region where UNAIDS reports an average increase of 34% in domestic and 31% international resources, for the HIV responses from 2010 to 2018. These increases are heavily influenced by South Africa, where current domestic contributions make up 78% of total HIV resources, and by increases in domestic resources in Zambia and Zimbabwe by more than 70% over the last eight years.¹⁵ However, excluding South Africa reveals a 10% annual decline in the total resource available to the other countries of the East and Southern Africa region by 2018. In these countries domestic resources decreased by 27%, and international resources by 4%. Still today, these countries jointly finance only 20% of their HIV responses domestically.¹⁶

A recent study published in the *Lancet* tracked spending on HIV/AIDS in 137 low and middle-income countries and estimated the potential for governments to devote additional domestic funds to HIV/AIDS. The study concluded that countries could spend an additional USD 12.1 billion on HIV/AIDS per year. However, over 80% of these resources are estimated to come from 10 countries classified as middle-income.¹⁷ According to the report, many middle and low-income countries (including Kenya and Malawi) were considered unlikely to be able to replace even 10% of the current development assistance contributed toward care and treatment. The struggle for these governments to fill the funding gap, if development assistance declines, would potentially leave about five million PLHIV on

Antiretroviral Therapy (ART) to either self-finance care or discontinue treatment.¹⁸

Bottom line is that neither donors nor countries should allow the principle of “country responsibility” to eclipse the real challenges and constraints of health financing experienced at the country level and the untoward effect that these constraints may have on the health needs of the population at large, especially for those people who are already ill.

2.2 GLOBAL TB RESOURCE TRENDS

Despite TB now being the leading cause of death from infectious diseases, adequate resources needed to address current challenges and the increasing threat of Drug Resistant TB (DR-TB) have not been raised.¹⁹ The Stop TB Partnership’s Global Plan to End TB 2016-2020 estimates the total resource needed for the implementation of TB prevention, diagnostic and treatment worldwide at USD 58 billion, over the 5-year period. Low and middle-income countries would require approximately 90% of that amount, excluding research and development, which translates to a necessary annual increase from USD 8.3 billion in 2016 to (at least) USD 13 billion in 2022, according to updated estimates produced for the UN High Level Meeting on TB in 2018.²⁰ The plan also estimated that Global Fund eligible countries will require USD 29.4 billion in total funding from 2016 to 2020 with USD 16 billion expected to come from domestic sources and the rest (i.e., USD 13 billion, or USD 2.6 billion per year on average) from international donors.²¹

Current funding levels are far from meeting these targets. In 2018, according to WHO, funding for TB prevention, diagnosis and treatment in 119 low and middle-income countries (i.e., countries accounting for 97% of the global number of TB cases notified in 2017), reached only USD 6.9 billion. According to the

14 *Communities at the center -Global AIDS Update*, UNAIDS, July 2019 Page 173. [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf

15 Ibid. *Communities at the center -Global AIDS Update*, UNAIDS, July 2019 Page 198.

16 Ibid. *Communities at the center -Global AIDS Update*, UNAIDS, July 2019 Page 198.

17 Argentina, China, Colombia, India, Indonesia, Mexico, Nigeria, Russia, South Africa and Vietnam.

18 *Potential for additional government spending on HIV/AIDS in 137 low-income and middle-income countries: an economic modeling study*, Haakenstad et al. *The Lancet*, 26 April 2019. [Available online from] <https://www.thelancet.com/action/showPdf?pii=S2352-3018%2819%2930038-4>

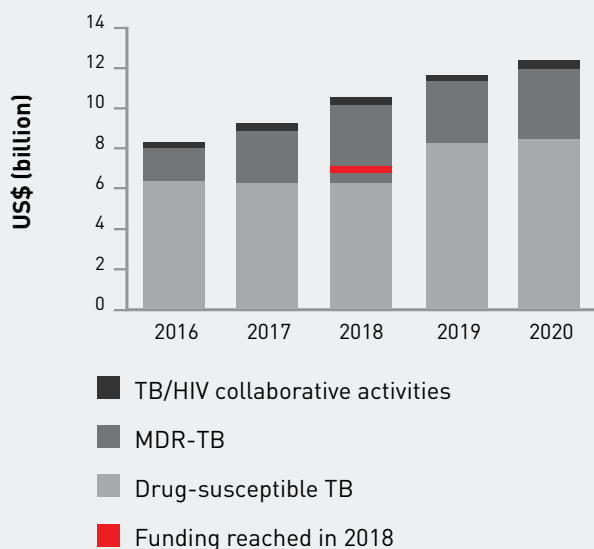
19 *Financing global health 2018 – countries and programs in transition*, Institute of Health Metrics and Evaluations (IHME), Seattle, WA, IHME, 2019. [Available online from] http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2019/FGH_2018_full-report.pdf

20 *Global Tuberculosis Report 2018*, WHO 2019, pages 114-115. [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

21 *Global Tuberculosis Report 2018*, WHO 2019, pages 115, 117. [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

Global Plan estimated USD 10.4 billion was needed for that year.²² The shortfall widened from USD 2.3 billion in 2017 to USD 3.5 billion in 2018, despite an absolute increase in resources.²³

Figure 2.: Estimated funding required in low-and middle-income countries to achieve the Global Plan to End TB 2016-2020²⁴



International assistance for TB

Similar to HIV, the growth rate in development assistance for TB has slowed down substantially since 2010. While DAH for TB increased by 4% in 2017 compared to 2016,²⁵ it decreased by 12.2% in 2018. The USD 1.6 billion disbursed in 2018 is far off the target of USD 2.6 billion put forth in the Global Plan estimates. The US government is the largest contributor overall, followed by the Bill and Melinda Gates Foundation.²⁶ The Global Fund is the main channel, providing 69% of all international financing for tuberculosis (10% of total available resources).²⁷

²² Ibid. *Global Tuberculosis Report 2018*, WHO 2019, pages 115, 117.

²³ Ibid.

²⁴ Ibid. *Global Tuberculosis Report 2018*, WHO 2019, pages 114, 115.

²⁵ *Financing Global Health 2017 Funding Universal Health Coverage and the unfinished HIV/AIDS agenda*, Institute of Health Metrics and Evaluations (IHME), page 50. [Available online from] http://www.healthdata.org/sites/default/files/files/policy_report_FGH/2018/IHME_FGH_2017_fullreport_online.pdf

²⁶ *Financing global health 2018 – countries and programs in transition*, Institute of Health Metrics and Evaluations (IHME), Seattle, WA, IHME, 2019, page 85. [Available online from] http://www.healthdata.org/sites/default/files/files/policy_report_FGH/2019/FGH_2018_full-report.pdf

²⁷ *The Global Fund Results Report 2019*, p 24 [Available online from] https://www.theglobalfund.org/media/8752/corporate_2019results-report_report_en.pdf?u=637044316700000000

Domestic resources for TB

Domestic sources provide most of the funding for TB programs. In 2018, they provided 86% of the USD 6.9 billion available. The contributions from domestic resources vary significantly across countries with BRICS countries accounting for more than half of the total funding for TB in 2018 (international and domestic) — 96% of the total funding in BRICS countries came from domestic sources.²⁸ India quadrupled its budget for TB between 2016 and 2018. In Africa, domestic resources make up only 60% of TB funding and international donors provided the majority (57%) of funding to low income countries in 2018.²⁹ While the significant increases in domestic resources for TB in selective countries show positive steps toward country ownership and more resources towards an effective response, the double burden of disease from HIV and TB however continues to plague many nations where vulnerable and marginalized groups are most at risk. This struggle is evident in several countries in this report. According to WHO, domestic funding for TB is only 14% in CAR, 2% in DRC, 33% in Kenya, 5% in Mozambique and 4% in Myanmar.³⁰

2.3 LEVERAGING TRENDS IN HIV AND TB INVESTMENTS

In the Global Fund investment case for its sixth replenishment, the estimated amount of total resources needed for HIV, TB and malaria for implementation during the period 2021-2023 is USD 101 billion. According to replenishment targets, the Global Fund would contribute USD 14 billion, domestic funds would provide USD 45.8 billion and other external funders would contribute USD 23.3 billion. These contributions would, however, only cover 82% of the needs, leaving a shortfall of: USD 10 billion for TB, USD 4.4 billion for HIV (and USD 3.4 billion for malaria). Of the three, TB faces the largest funding gap at 37% while HIV will be 8% off target.³¹ These projections are based on the assumption of an

²⁸ Ibid. *Global Tuberculosis Report 2018*, WHO 2019, page 119

²⁹ *Global Tuberculosis Report 2018*, WHO 2019, page 119 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

³⁰ *Global Tuberculosis Report 2018*, WHO 2019, Country sheets <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

³¹ *Step up the fight – investment case, Sixth Replenishment*, the Global Fund, 2019 page 4 [Available online from] <http://www.stoptb.org/assets/documents/about/cb/meetings/31/31-06%20POST-UNHLM%20-%20Global%20Fund%20&%20Find.Treat.All%20initiative/31-6.4%20GF%20Investment%20Case.pdf>

increase in domestic resources by 48% during the upcoming period.³² However, the feasibility of such an increase remains uncertain for many countries, considering that this calculation is largely based on co-financing commitments made by governments in the 2018 to 2020 grant implementation period. These commitments currently remain yet to be disbursed and the calculation does not take into account the most recent economic developments in some countries.

Domestic resource mobilisation and co-financing

In an attempt to reinforce its role in leveraging increased domestic resources in countries, the Global Fund recently adopted its Sustainability, Transition and Co-financing policy. The policy includes ambitious expectations and requirements for all countries to increase their contributions and expects all countries, including those with low-income to progressively increase, not only their general health investments, but also co-financing of disease program costs, such as purchasing medicines and diagnostics and the uptake of human resource costs.³³

In view of increasing treatment costs and flatlining donor resources, other donors such as The United States President's Emergency Plan for AIDS Relief (PEPFAR), have also increased their pressure on countries to take up additional recurrent program costs. Furthermore, in several countries, transitions away from international funding are taking place simultaneously across health programs (such as GAVI for vaccination). In principle, this shift is intended to lead to greater country ownership and financial independence, rendering countries less vulnerable to international donor volatility.

However, transference of responsibility from global to local should not occur at the expense of ensuring timely and quality patient care. A shift without the rigorous assessment of risk and readiness, in terms of financial and technical capacity, can lead to disruptions in services, and leave the quality and availability of services vulnerable to a decline.

The Universal Health Coverage (UHC) agenda

In 2017, the WHO estimated that achieving the Sustainable Development Goal's health targets for Universal Health Coverage (UHC) would require new investments of USD 371 billion or USD 58 per person, annually, by 2030. The analysis suggests that 85% of the costs could be met with domestic resources. However, even with such an ambitious scenario, 32 of the world's poorest countries would face an annual gap of USD 54 billion and continue to need external assistance.³⁴ Donors such as the Global Fund aim to align with the UHC agenda's promotion of more integrated programming and health financing and seeking efficiencies.³⁵

The UHC agenda both shares synergies and poses risks to existing efforts to end the HIV and TB epidemics.³⁶ Approaches defined within UHC would ideally provide opportunities to better meet the multiple health needs of PLHIV and TB, such as when HIV care is systematically included in packages of essential health benefits.³⁷ Ambitions to increase coverage of health services while reducing financial hardship, however will require continual and, in most cases, increased overall investments by both domestic and donor resources. The effects of competing priorities and managing expenses within a stagnating-resource envelope, however, are cause for concern in efforts to combat HIV and TB, as the drive to achieve UHC takes centre stage in the international policy arena.

32 *Step up the fight – investment case, Sixth Replenishment*, the Global Fund, 2019 page 4 [Available online from] https://www.theglobalfund.org/media/8279/publication_sixthreplenishmentinvestmentcase_report_en.pdf?u=636898877700000000

33 *The Global Fund Sustainability, Transition and Co-financing policy*, April 2016 [Available online from] https://www.theglobalfund.org/media/4221/bm35_04-sustainability-transitionandcofinancing_policy_en.pdf

34 "WHO estimates cost of reaching global health targets by 2030", WHO 17 July 2017 [Available online from] <https://www.who.int/news-room/detail/17-07-2017-who-estimates-cost-of-reaching-global-health-targets-by-2030>

35 *Step up the fight – investment case, Sixth Replenishment*, the Global Fund, 2019 page 4 https://www.theglobalfund.org/media/8279/publication_sixthreplenishmentinvestmentcase_report_en.pdf?u=636898877700000000

36 Ibid. *Communities at the center -Global AIDS Update 2019*, UNAIDS, July 2019, page 170.

37 Ibid. *Communities at the center -Global AIDS Update 2019*, UNAIDS, July 2019, page 170.

3. NATIONAL HIV/TB AND HEALTH FINANCING TRENDS

3.1 TACKLING THE BURDEN OF HIV AND TB IN THE CONTEXT OF SOCIO-ECONOMIC CHALLENGES

This report focuses on nine countries³⁸ out of 74 where MSF is present today. MSF is implementing HIV and TB activities in these nine countries and all are facing various challenges related to a significant humanitarian emergency, or geopolitical and economic concern. For instance, ongoing conflict, regular displacement and consequential protracted crisis situations plague CAR and DRC with over two million people, in each country in need of humanitarian assistance. Several of the countries are especially prone to a disaster or outbreak. These include Zimbabwe and Mozambique recently affected by cyclones and Ebola outbreaks in DRC and Guinea. Both Kenya and Myanmar face significant challenges of displacement, either due to an influx of refugees from neighboring countries, displaced within, or sub-populations crossing borders to flee from persecutions, human rights violations and conflict. Five of the nine countries are mentioned in the World Bank list of Fragile or Conflict Affected States (FCAS)³⁹; and the Global Fund classified three countries as Challenging Operational Environments (COE).⁴⁰

In addition, these nine countries remain relatively poor. CAR, DRC, Guinea, Malawi and Mozambique are considered low-income countries according to the World Bank classification, and Eswatini, Kenya, Myanmar and Zimbabwe are considered middle-income countries. Poor governance and ongoing corruption continue to plague many of these countries. Countries included in the survey are also confronted with economic challenges that range from decreasing revenues due to a drop in agricultural production (e.g., following droughts and floods), or plummeting world market prices for minerals and oil, currency depreciation, macro-economic instability, misappropriation of loans and funds, excessive government interference and mismanagement or political power struggles.

Beyond the countries' economic volatility, limited fiscal space restricts public budgets, including for health and health staff.⁴¹ Allocation inequity, disbursement and management issues further complicate optimal use of available domestic revenue for priority health interventions. For many countries these challenges, compounded by vast public health needs, make a rapid transition to domestic financing without creating additional service gaps, a pipe dream.

38 CAR, DRC, Eswatini, Guinea, Kenya, Malawi, Mozambique, Myanmar and Zimbabwe

39 CAR, DRC, Mozambique, Myanmar, Zimbabwe (2019). <http://pubdocs.worldbank.org/en/892921532529834051/FCSList-FY19-Final.pdf>

40 Guinea, DRC and CAR (2017). http://www.aidspace.org/gfo_article/six-african-countries-classified-challenging-operating-environments-craft-tailored

41 Rowden R. (2019) *Advocates of the SDGs have a monetarism problem*. Sheffield Political Economy Research Institute. <http://speri.dept.shef.ac.uk/2019/09/09/advocates-of-the-sdgs-have-a-monetarism-problem/>

Table 1. General Economic information⁴²

	CAR	DRC	Eswatini	Guinea	Kenya	Malawi	Mozambique	Myanmar	Zimbabwe
Population size (million)	4.7	84.68	1.13	12.4	51.39	18.14	29.49	53.70	14.44
GDP (billion USD)	2.38	47.23	4.7	10.99	87.91	7.06	14.45	71.21	31
GNI/capita (PPP)	870	900	10.680	2.480	3.430	1.310	1.300	6.480	3.010
World Bank income classification	LIC	LIC	MIC	LIC	MIC	LIC	LIC	MIC	MIC
Extreme poverty: Poverty headcount ratio at 1.9\$/day (2011 PPP) (% of population)	66.3%	76.6%	42%	35.3%	36.8%	70.3%	62.4%	32%	21.4%

3.2 NATIONAL HEALTH FINANCING TRENDS

In the contexts described in the previous section, health and humanitarian needs are understandably high with notable gaps in the ability to meet those needs, either technically or financially. The nine countries in this study are highly dependent on international assistance, including for health. While substantial, that aid still falls far below the actual estimated need; for example, the 2018 Humanitarian Response Plan in the DRC met only 48% of funding requests and only 12% of the health needs.

Currently, only one country reviewed, Eswatini, was by 2016 meeting the government budget target allocation of 15% for health as recommended in the 2001 Abuja Declaration, with Zimbabwe coming very close. Domestic government health expenditures as a proportion of GDP also remain low (See Table 2). Unfortunately, where increases have occurred in public health financing, they have not necessarily translated into reducing Out-Of-Pocket (OOP) health expenditures. For example, the proportion of OOP health expenditure by households in Myanmar is 74%, thereby emphasizing that it remains the dominant source of financing for health services in the country. In Guinea, OOP represents 49.8% of health expenditure and in DRC households bear 37.4% of total health expenditures. In many countries, the expense of OOP entails financial barriers to patients accessing healthcare, with catastrophic and impoverishing spending linked to care for many households. Such trends, coupled with waning donor support, place public health gains at risk and impair a country’s capacity to achieve UHC.



“My husband died in 2004 and my daughter died at the end of 2012. When my husband died, I was receiving treatment from a private hospital. Although I was told that “your blood is not good”, I didn’t understand what my disease was. A doctor from the private clinic came and saw me at my home and gave me medicines and injections. I had to sell all my things because the treatment was so expensive. My daughter was only two years old at the time. One of my friends was working at the hospital and said she would help me. I took a blood test again and found out that I am HIV positive. I began receiving treatment from MSF. Now I work as a peer counsellor. I share my own experiences with our patients, and I tell them how I overcame the suffering of HIV.”

Daw Aye Aye New (Myanmar)

⁴² WHO data, accessed from Word Bank database online <https://data.worldbank.org/>

OUT-OF-POCKET PAYMENTS

The negative effects of patients paying out-of-pocket (OOP) are well established⁴³ and user fees requested at a health facility can constitute a significant financial barrier to a patient accessing adequate and timely health care as needed.⁴⁴ Based on the WHO's and other technical advice, HIV and TB treatment has mostly been provided free of charge to patients in public health structures, but other service fees or informal fees are still common. Even where the remaining costs for the patients are often perceived as relatively small by health workers, patients are deterred from timely use of care. For both HIV and TB, patient fees also hinder retention in care. The

dynamics of obtaining revenues from patient fees also induces several perverse effects on quality of care, with patients receiving substandard, incomplete or, sometimes, unnecessary treatments. Additionally, people and households are pushed (further) into poverty due to health expenses competing with other essential household expenses, thereby forcing people to sell goods and take out loans. As documented in several countries, including those in West and Central Africa, the presence of user fees has contributed to blocking progress in scaling up access to HIV and TB care and retention in treatment.⁴⁵

Table 2. Health financing Information⁴⁶

	CAR	DRC	Eswatini	Guinea	Kenya	Malawi	Mozambique	Myanmar	Zimbabwe
Current Health Expenditures (CHE) per capita (USD)	16.4	20.5	220.6	37.5	66.2	29.6	19.2	62	93.9
Domestic General Government Health Expenditures (as % of GDP)	0.6	0.5	5.3	0.7	1.6	2.8	2.7	1.0	4.4
OOP (as % of CHE)	43.1%	37.4%	9.9%	49.8%	27.7%	11.4%	7.7%	74.0%	21.2%
External resources (as % of CHE)	40.9%	43.4%	13.8%	27.2%	19.5%	53.8%	38.1%	5.9%	25.4%
Domestic General Government Health Expenditures (as % of CHE)	14.9%	12.3%	69.3%	12.3%	36.2%	28.0%	53%	20.1%	46.5%
Domestic General Government Health Expenditure (as % of General Government Expenditures)	5.1%	3.7%	15.2%	4.1%	6.1%	9.8%	8.3%	4.8%	14.5%

⁴³ Qin VM, Hone T, Millett C, et al. *The impact of user charges on health outcomes in low-income and middle-income countries: a systematic review*, BMJ Global Health 2019;3:e001087

⁴⁴ *Taxing the ill – How user fees are blocking Universal Health Coverage*, MSF December 2017 [Available online from] <https://www.msf.org/sites/msf.org/files/msf-userfeesbriefingpaper-finaluk-2017.pdf>

⁴⁵ *Out of Focus – How millions of people in West and Central Africa are being left out of the global HIV response*, MSF 2016, [Available online from] https://www.msf.org/sites/msf.org/files/2016_04_hiv_report_eng.pdf

⁴⁶ Figures in million constant USD (2016) Retrieved from WHO Global Health Expenditure Database [Accessed on 170919] [Available online from] <https://apps.who.int/nha/database/ViewData/Indicators/en>



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Tin Lay, 42, from Myanmar is in the preparation stage for TB treatment at MSF's Insein clinic, Yangon, Myanmar.

3.3 NATIONAL HIV/TB FUNDING TRENDS – SHIFTS IN DONOR FUNDING AND POLICIES

While obtaining a complete mapping of contributions and expenditures dedicated to the HIV/TB response remains a challenge for each country, the large proportion of total HIV and TB financing provided through external support places programs at risk as donors start to withdraw aid and alternative resources cannot be mobilised in time. Global Fund and PEPFAR are the two largest contributors to HIV and TB programs in these settings. The Global Fund for example provides over 70-80% of donor funding for HIV and TB in Guinea and Myanmar and is the main funder in CAR, while PEPFAR dominates in Eswatini. Both organisations are contributing significantly to HIV and TB financing in DRC, Kenya, Malawi, Mozambique and Zimbabwe.

Only one country reviewed (Malawi) saw a notable increase in funding in past years. Waning donor contributions are seen in the Global Fund's HIV and TB grants to several countries. For example, the

Global Fund's grant amounts for HIV and TB signed with DRC dropped by approximately 20% for the 2018 – 2020 period in comparison to the previous period.⁴⁷ In Guinea, the 2018 – 2020 signed grants for HIV and TB were reduced by approximately 17% relative to the prior three-year period.⁴⁸

Declines in PEPFAR funding took place in Eswatini, specifically, USD 58 million for 2019 compared to USD 61 million for 2018. PEPFAR's Country Operation Plan (COP) for Kenya was USD 375 million in 2019 compared to USD 505 million in 2018 and that is a 25% decline from COP18. In Mozambique, PEPFAR's COP dropped by 16% between 2018 to and 2019⁴⁹, and translated into a shift in priorities. We note a recent increase in PEPFAR funding for the DRC where its grant increased from USD 66 million to 78 million between 2018 and 2019 due to good results of the program (recent roll out of full continuum of care program).

⁴⁷ Global Fund Prospective Country Evaluation, 2019 Annual Report PATH, IHME, January 2019, page 5-6 [Available online from] http://www.healthdata.org/sites/default/files/files/Projects/Global_Fund_PCE/Prospective_Country_Evaluation_DRC_annual_report_2019.pdf

⁴⁸ Calculation based on annual average signed amounts for the Jan 2015- Dec 2017 period compared to Jan 2018- Dec 2020 period Global Fund Dataset [Available online from] <https://data-service.theglobalfund.org/downloads>

⁴⁹ PEPFAR country SDS, Reports and Approval memos



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Decreases or flatlining in support are not limited to the Global Fund or PEPFAR. The Bill and Melinda Gates Foundation, United Populations Fund (for key populations) and others have also begun to cut back as evidenced by the reductions in funding noted in Zimbabwe and Kenya. In most countries the World Bank funding dedicated to HIV ended many years ago, and the Global Financing Facility (GFF), with its objectives to reduce the burden of ill health among mothers and children, does not appear to be stepping in to fill critical gaps in the HIV or TB response. In several countries, such as Malawi, Mozambique and CAR, needs are rapidly outpacing resources available and unfunded needs (as registered on the Global Fund's register of Unfunded Quality Demand, UQD) clearly demonstrate the need for additional funders to contribute. Unfortunately very few donors have come forward so far.

Coupled to the funding challenges are shifts or restrictions in donor policies and priorities that have had implications on the actual implementation of healthcare services. In Mozambique some actors have closed their programs due to a loss of funding and shift in support towards a selection of essential services. According to the new PEPFAR sustainability strategy, countries are required to transition their PEPFAR funding to local partners currently at 40% in COP19 and expected to reach 70% by 2020.⁵⁰ Countries like Mozambique already plan to meet this requirement, with 40% of PEPFAR funds already being re-directed to local organisations. Aiming to achieve the desired sustainable results, these transition plans require careful planning and implementation to ensure sufficient capacity and quality of care. Additionally, the consequences of the US' Mexico City Policy (also called the Global Gag Rule) have restricted the global implementation capacity in sexual and reproductive health, with some organisations ending health interventions.

The Global Fund's co-financing requirements (i.e., progressive increase of domestic investments in health and disease programs) have become more ambitious and apply to all countries, including low-income countries and (with flexibilities) contexts classified as COE. If governments do not comply,

⁵⁰ "PEPFAR chief wants 70 percent 'indigenous' funding in 30 months", Devex 16 July 2018
<https://www.devex.com/news/pepfar-chief-wants-70-percent-indigenous-funding-in-30-months-93118>

this may lead to reductions in their forthcoming allocations. Nevertheless, several countries are likely to struggle to meet or account for their current obligations, including CAR, DRC and Mozambique. In Guinea, in accordance with the policy and when faced with limited external funding, the government agreed to provide co-financing for ARV supply and to cover the needs for 23% of its ART target population and 11% of the TB targets by 2020. There is however doubt this obligation can be met on time, as unfulfilled commitments were believed to have exacerbated the consequences of ARV shortages experienced during 2018.

3.4 MORE FUNDING SHORTFALLS ON THE HORIZON

As already alluded to, the countries reviewed are already facing significant gaps in their HIV and TB responses, and future prospects are looking increasingly bleak. Funding gaps are expected to rise sharply in the near future. In Eswatini, conservative estimates (with only a flattening in support) indicate its HIV funding gap will grow to USD 24.9 million for 2020 and the TB funding gap will rise to USD 10.9 million by 2021.⁵¹ A further 50% reduction in PEPFAR support would increase the HIV funding gap to USD 253 million at 30 million per year between 2018 and 2022.⁵² A similar situation is noted in Zimbabwe, with an estimated HIV funding gap of USD 76 million in 2015 rising to USD 188 million at the start of 2019.⁵³ Other examples include Myanmar and its projected gap in HIV funding at USD 150 million for the 2016 – 2020 period, and Mozambique with approximately USD 65-70 million missing by 2020 to cover funding needs for ARV according to updated treatment targets.⁵⁴

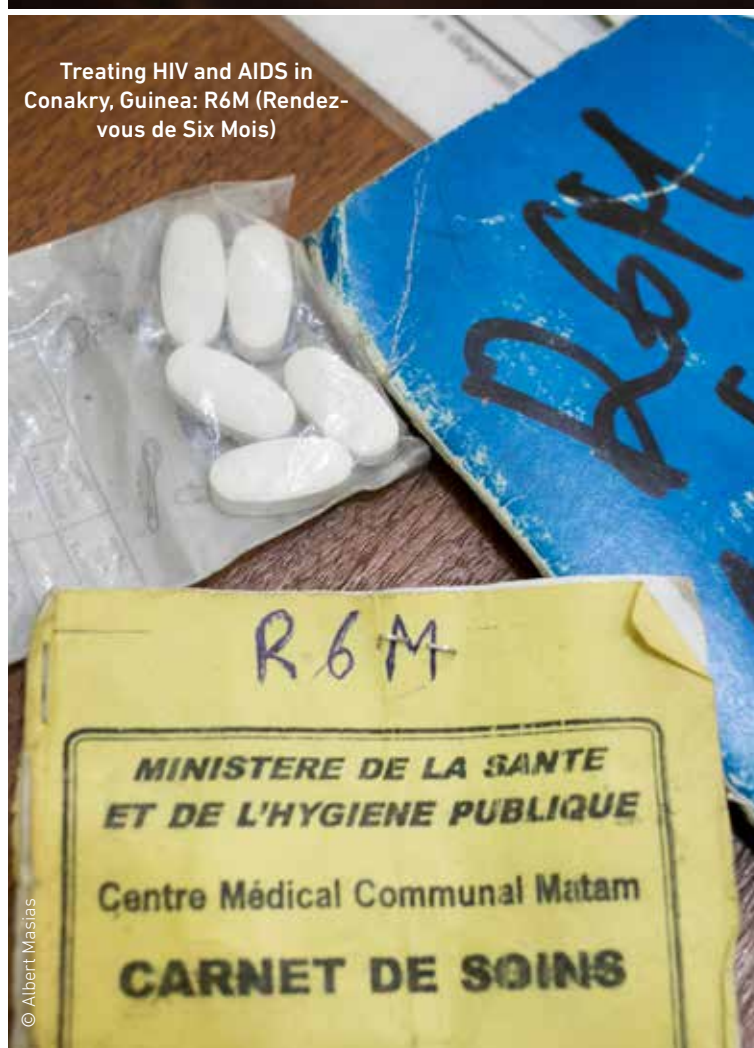
The bottom line is that current financing gaps and trends will only worsen with the withdrawal or flatlining of donor support at this stage. While commitment and the political will to increase domestic funding for health may exist, the translation of intention to practice currently remains far from

reality. International donor support must remain to ensure that gains in health today do not fall victim to seemingly unrealistic expectations regarding domestic resource mobilisation.



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MSF HIV Clinics in Kinshasa, DRC



© Albert Masias

Treating HIV and AIDS in Conakry, Guinea: R6M (Rendez-vous de Six Mois)

⁵¹ The Global Fund Funding Request HIV/TB, Eswatini, 2017, p. 37, [Available online from] <https://data.theglobalfund.org/documents>

⁵² The Government of the Kingdom of Eswatini, The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018 – 2023, p. 67, [Available online from] https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/06/Eswatini_NSF-2018-2023_final.pdf

⁵³ MoHCC, Consolidated Resource Mapping Presentation, 2019

⁵⁴ Global Fund Register of Unfunded Quality Demand (UQD), 31 July 2019 [Available online from] https://www.theglobalfund.org/media/6578/core_2017-2019registerunfundedqualitydemand_tool_en.xlsx?u=637044314900000000

4. CRITICAL GAPS RISK UNDERMINING PAST ACHIEVEMENTS, INNOVATION AND QUALITY OF CARE



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As presented in the previous chapter, the countries reviewed all face socio-economic challenges, and current budget constraints that lead to substantial funding gaps. These gaps have an impact on critical program activities and lead to rationing and competition between key service areas. Beyond the foreseen gaps, additional gaps and shortfalls are likely to appear because increased domestic investment commitments made by many countries are at risk of not materializing.

“Each delay in reducing the incidence and the mortality caused by HIV and TB means more infections, more deaths, more human, health and economic costs in the medium and long term.”

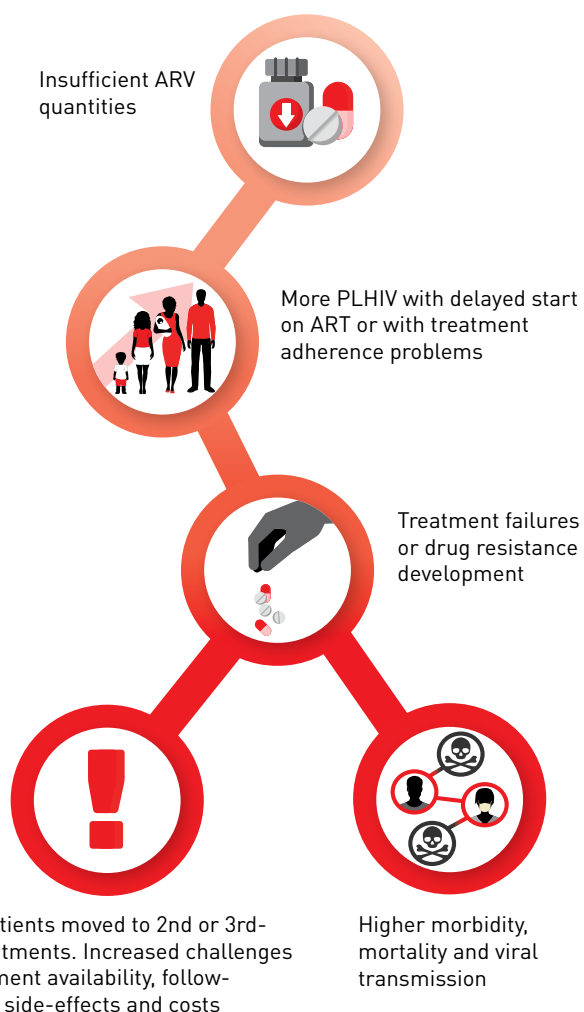
Existing and potential constraints hinder progress made through the necessary scale up of effective interventions and the adoption of innovative approaches to increase positive results and outcomes. Additionally, some countries are facing serious risks of undermining past achievements and backsliding in their HIV and TB responses.

The impact on the HIV and TB epidemics will be determined by what actions will be taken today, both by the effectiveness of the chosen strategies and the timeliness of curbing these epidemics. Each delay in reducing the incidence and the mortality caused by HIV and TB means more infections, more deaths, more human, health and economic costs in the medium and long term.

This chapter takes a closer look at the findings from the country reviews conducted for this report and highlights key areas at risk of being negatively impacted now and in the future by the current shortfall in funds.

4.1 ACCESS TO QUALITY LIFESAVING HIV AND TB TREATMENT IN JEOPARDY

The reviews identified several examples that highlight the consequences of existing or foreseen gaps in treatment provision in the countries studied. Insufficient quantities of ARVs lead to increased numbers of PLHIV that are not timely in starting ART or able to adhere to their treatment as needed. The consequence is patients disengaging from health care, facing treatment failure or developing drug resistance. This, in turn increases the risk of more patients having to move to second- or third-line treatment and additional challenges in follow up care, side-effects, availability and increased costs. Increases in the number of people with treatment failure lead to higher morbidity and mortality, as well as increased transmission. Moreover, poorly prepared shifts to national purchasing of ARV and TB drugs raises concerns about the assured quality of medicines and diagnostics, with the risk of undermining quality of care and potentially inducing resistance (see box 3 on page 21).



Funding gaps impacting treatment coverage, continuity of care and early initiation

Low income countries, such as CAR, DRC and Mozambique remain critically dependent on donors for the provision of essential HIV and TB commodities. Against the backdrop of funding shortages, current and planned treatment enrolments exceed available funding from the Global Fund and PEPFAR and place a greater strain on already fragile health systems and supply chains.

- While having the highest prevalence rate in the West and Central African region (3.6%), treatment coverage in CAR remains extremely low (36% at the end of 2018⁵⁵), with the Global Fund as the single donor providing ARV treatment. Despite significant implementation challenges, the concerted efforts by various stakeholders have led to an important but not yet sufficient increase in ART coverage. The original Global Fund 2018 - 2020 allocation only allowed for a flat treatment target of 32,000 patients per year. The target was rapidly exceeded and the Global Fund made supplementary funds available in 2019 to enable enrolment of 7,500 additional people per year until the end of 2020. However, the additional 8,003 people enrolled on ART in 2018, provide a clear indication that the current capacity and the urgent need for further scale up continue to exceed available resources. The funding limitations for ARVs and delays in the procurement process eventually depleted the country's buffer stock, leaving patients exposed to further delays and fluctuations in supply. By mid-2019, CAR experienced severe ARV drug shortages and stockouts. The lack of resources for necessary scale up is currently holding back the delivery of urgently needed care to the population.
- In the DRC health zones supported by the Global Fund, a significant portion of treatment costs for additional people with TB and HIV could not be covered within available grant funds and was therefore listed as Unfunded Quality Demand (UQD). This means that although this activity is

55 UNAIDS data 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

deemed relevant, necessary and technically sound, it was placed on hold to be funded in the event additional funds could be raised or identified through savings. The USD amounts to nearly USD 43 million for HIV and TB, which includes USD 8.8 million for the diagnosis and treatment of an additional 65,297 TB cases and USD 19.9 million for the provision of ARVs to an additional 24,399 people, including 1,078 children.⁵⁶ An analysis of active treatment cohorts is currently underway to better assess the extent and urgency of gaps in ARV procurement for the supported health zones.

- In Mozambique, following ambitious scale up of ART coverage (reaching 56% by end of 2018)⁵⁷, PEPFAR, the largest donor in the country, revised its strategic direction to focus more on retention and less on testing. A slow-down in new inclusions is foreseen and an estimated gap of USD 70 million for purchasing of ARVs projected for 2020. Given the very limited fiscal space in Mozambique to mobilise domestic resources for health, the gap will need to be urgently addressed by donors (primarily the Global Fund and PEPFAR).
- Malawi is confronted with a shortfall in ARV supply, including USD 7.1 million needed to effectively implement a rapid switch to Dolutegravir (DTG). An additional USD 3.9 million is needed to enable a planned scale up of point of care viral-load testing. The gap for case detection and treatment of people with MDR-TB is estimated at USD 1.5 million and in order to apply TB preventative therapy as required, the current gap of USD 6.1 million needs to be addressed.⁵⁸

Risk of exacerbated treatment gaps and supply interruptions

Other countries such as Guinea, Myanmar, Zimbabwe, Kenya and Eswatini face similar funding constraints and/or funding reductions for the 2018 - 2020 period. Additionally, overly optimistic expectations for rapid transitions to domestically funded treatment may lead to widening the gaps and negatively impact quality and continuity of programs.

In these situations, currently known gaps might be an underestimation, as overall funding projections include significantly increased domestic contributions that may not be fully realized due to economic and fiscal challenges at the national level. The Global Fund and PEPFAR co-financing and sustainability requirements now also encourage countries to start or increase their financing of essential health products such as ARVs and TB drugs. This shift from donor to government funded and managed procurement also raises particular concerns for the continued supply and availability of ARVs and other medical commodities at affordable prices and the necessary quality. *See box 3 for further explanations.*

- Guinea, a low-income country, is also considered a COE.⁵⁹ The Global Fund is the primary source of financial assistance to the HIV and TB responses in the country. As the financial and health systems recover from an Ebola outbreak that took place from the 2014 - 2016, various factors, such as a lack of sufficient buffer stock and delays in orders, have contributed to gaps and shortfalls. In 2018, these factors culminated into an interruption in the supply of ARV drugs. Apart from reductions in annual Global Fund allocations, another variable was the Global Fund's expectations on Guinea's capacity to co-finance ARV treatment. This overwhelmed the national financial and purchasing systems at the time and the issue has still not been resolved.

⁵⁶ Global Fund register of Unfunded Quality Demand, updated 31 July 2019 [Available online from] https://www.theglobalfund.org/media/6578/core_2017-2019registerunfundedqualitydemand_tool_en.xlsx?u=637006143980000000

⁵⁷ UNAIDS Data 2019 [Available online from], https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

⁵⁸ Global Fund register of Unfunded Quality Demand, updated 31 July 2019 [Available online from] https://www.theglobalfund.org/media/6578/core_2017-2019registerunfundedqualitydemand_tool_en.xlsx?u=637044314900000000

⁵⁹ COEs are countries or sub-regions of countries that the Global Fund characterizes as having weak governance, poor access to health services, manmade crises (such as conflict) or natural crises (such as famine). The Global Fund Challenging Operating Environments Policy, April 2016 [Available online from] https://www.theglobalfund.org/media/4220/bm35_03-challengingoperatingenvironments_policy_en.pdf

- Myanmar has also been encouraged to start taking up the cost of ARVs, while Zimbabwe, Kenya and Eswatini are all encouraged to increase their co-financing of ARVs and/or TB drugs. However, the reviews identified critical risks raising the question of whether these countries will have stable resources to ensure continuous supply of life-saving treatment. Because of its “AIDS levy”, which involves earmarked funds for ARV purchasing, Zimbabwe has been considered a front runner in domestic resource mobilisation for treatment costs, but the country is actually facing severe challenges to meeting its current commitments. Economic problems are shrinking the country’s tax base. Following devaluation of local currency and abolishing the use of the US dollars, a deepened currency crisis makes the purchasing of commodities from abroad, for example medicines, a major challenge.

■ Box 3

ENSURING ACCESS TO QUALITY MEDICINES AS COUNTRIES SHIFT FROM DONOR SUPPORT TO NATIONAL SYSTEMS

The risks of shifting too swiftly to domestically financed and managed procurement of ARV and TB drugs are often related to the capacity and the maturity of the country’s procurement and supply and financing systems. Through Global Fund support, countries have been able to access pre-negotiated, volume-based, lower-priced drugs that are procured with adequate drug quality standards. As countries revert to national procurement for HIV and TB, other legal frameworks and incentives apply, along with the major risk that countries may end up paying higher drug prices. In turn, countries may become inclined to prioritize lower price over quality and unable to sustain an uninterrupted supply of lifesaving drugs.⁶⁰ The prospect of continuing to use pooled procurement mechanisms, such as that of the Global Fund for ARVs or the Global Drug Facility for TB drugs, may alleviate some of these issues. These mechanisms do not remove legal barriers at the country level to quality procurement, nor do they safeguard against fluctuating national budgets. Uncertainty about the quality of HIV and TB health products also raises serious concerns about inducing treatment failure and resistance.

⁶⁰ Torreele, E., Tatay, M., *Ensuring access to life-saving medicines as countries shift from Global Fund support*, *Bulletin of the World Health Organization* 2019;97:311-311A. [Available online from] <https://www.who.int/bulletin/volumes/97/5/19-234468/en/>



Limiting treatment access for vulnerable groups and people with advanced disease

Funding shortages affecting drug supply and treatment strategies will also have a detrimental impact on vulnerable groups, such as people with advanced HIV or key populations including migrants that are already marginalized in the treatment response.

- In DRC, financial constraints in PEPFAR-supported areas prevent sufficient availability of third-line ARVs and block expanding the offer of care for patients with advanced HIV. The need for this care is demonstrated in the MSF-run Kabinda Hospital (a 41-bed hospital always at more than 100% capacity). Patients arrive often very late, and from very far away, either because other general hospitals are: unable to identify the signs that would prompt them to refer patients earlier, unable to provide treatment, or keeping patients for too long in order to recoup user fees.
- In Mozambique, due to funding limitations, a foreseen gap in CD4 testing, which is essential for advanced HIV, has resulted in a decision to rationalize its use. Additional diagnostic and treatment capacity, including Cryptococcal Antigen Tests (Crag), Ampho B liposomal for Cryptococcal meningitis and third-line ARVs are also part of the HIV advanced disease package of care,⁶¹ which is currently only funded and supplied by MSF within its projects. Funds for other diagnostic tools such as TBLam (a rapid test for TB) and Syphilis are also insufficient. In the current context of resource constraints in Mozambique, plans to expand services remain uncertain.

■ Box 4

ADVANCED HIV DISEASE

WHO defines Advanced HIV Disease (AHD) as patients with a CD4 cell count below 200 cells/mm³ or a WHO clinical stage 3 or 4 or all children under the age of 5 years at the presentation of care.⁶² Today at least 33% of people worldwide, who are starting ARV treatment, do so with a CD4 below 200. The low count is an indicator of serious immune failure and grave risk of dying. The majority of people presenting with AIDS already know their HIV positive status, and are already on ART. In MSF supported hospitals providing care for AIDS patients, the percentage of patients in 2017 already on treatment were: Kinshasa (DRC) 71%, Conakry (Guinea) 62%, Homa Bay (Kenya) 60% and Nsanje (Malawi) 67% of patients.

The challenges of treatment fatigue, coupled with weak health systems struggling to support PLHIV result in barriers to timely diagnosis, treatment and switching patients to 2nd and 3rd line ARV treatment. People experience 'treatment failure' when they stop treatment or their treatment stops working for them. A significant proportion of these patients develop resistance to existing treatment. The biggest challenge remains people not tested and initiated on treatment early enough to prevent opportunistic Infections. The lack of diagnostic equipment renders it impossible to diagnose and treat TB and Cryptococcal Meningitis. Many health workers and patients remain unaware of Advanced HIV. Stigma is also a barrier to patients seeking care. Additionally, user fees and other costs in some places prevent people from seeking care earlier.

⁶¹ MSF Mozambique has an estimation of costs based on laboratory and drugs needs, but does not include other costs as human resources

⁶² Guidelines for managing advanced HIV disease and rapid initiation of Antiretroviral Therapy, WHO, July 2017 [Available online from] <https://apps.who.int/iris/bitstream/handle/10665/255884/9789241550062-eng.pdf>

- In Myanmar, gaps in treatment are notable for vulnerable populations. As it is, there is an important gap in HIV/TB service for key populations in some states of Myanmar, especially in the northern regions of the country, e.g. Kachin and Shan. The gaps further drive the epidemic, considering the concentrated nature of the HIV epidemic in the country. In addition, migrant TB cases are underreported in the provincial statistics along the Thailand/Myanmar border due to jurisdictional interpretations and resource barriers. Results from a study suggest that TB/HIV and MDR-TB treatment options are limited for migrants, noting that services are very much concentrated in urban settings, namely Yangon;⁶³ this could worsen if donor funding for migrant TB services decreases as there is reluctance to allocate government resources to migrant services.

4.2 UNDERFUNDING OF CASE FINDING AND DIAGNOSIS ACTIVITIES

In order to roll out effective HIV and TB treatment, it is essential to identify cases early and refer them to health services to start treatment as soon as possible. Without early diagnosis, treatment delays occur and valuable time, needed to avoid the degradation of a person's health status, is lost. Untreated HIV and TB cases also enable transmission to continue longer.

Funding gaps for HIV tests and laboratory services were reported in several countries, with challenges posed to early treatment initiation and ensuring optimal course of treatment. Similarly, with TB being the most frequent opportunistic infection for HIV patients, screening and early identification of TB in HIV patients determines treatment success and mortality reduction.

- The shift of focus in the PEPFAR COP19 for Mozambique towards retention in care would mean less investment in testing activities, and consequently, fewer new cases identified and included in treatment programs. This defies ongoing efforts in scaling up Test & Start and can push Mozambique off the current course to reaching its targets. It has been reported that implementing partners are reluctant



Nurse Fanuel Sifeku prepares an HIV test, Zimbabwe.

to start new treatments, given they are instructed to prioritize retention in care with the available resources. Combined with the foreseen ARV gaps mentioned above, this can have a significant impact on the retention in care of already untrusting patients.

- Guinea is seeing some investments in testing services for Key Populations, but due to the lack of funds, tests are no longer made available at testing centres. Plans to organize testing campaigns in the community in 2018 had also been cancelled because health commodities were lacking. Actors interviewed in Guinea also raised issues related to TB prevention and early case detection. While some indicators are improving, the notification rate is still low compared to the number of estimated cases. The lack of funds will prevent TB actors from making better investments in proactive case detection (including in children).

⁶³ Treating the invisible: Gaps and opportunities for enhanced TB control along the Thailand-Myanmar border. [Available online from] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5237139/>



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Marie sensitises HIV patients about viral loads in Kinshasa, DRC.

- TB is a leading cause of death in CAR.⁶⁴ However, very few stakeholders are present to support the national program and resources remain limited, and as a result, services are not available to the extent needed. Treatment coverage remains low at 49%,⁶⁵ and access to diagnostics was pointed out as one of the biggest challenges for all forms of TB in CAR.
- Zimbabwe is at 70% treatment coverage for TB, but more investment is needed to find the remaining 30%. Activities, such as active community case-finding and improved coverage through mobile screening, have been identified by in-country partners as necessary to address this need.

4.3 PROGRESS UNDERMINED BY INSUFFICIENT PREVENTION ACTIVITIES AND HEALTH PROMOTION

In most countries, funding gaps for HIV and/or TB prevention services were also highlighted

in the reviews. Prevention interventions have been considered the poor parent for several years.⁶⁶ As overall funding decreases, services for prevention have not received the required levels of prioritization and resources. The vital importance of the continuous provision of ART in the context of flatlining or declining resources forces countries to make impossible choices that have had a detrimental impact on critical elements, such as community-based support and prevention activities. In contexts and population groups where incidence rates are not decreasing rapidly enough or even increasing, this is particularly worrying. Moreover, in the light of decreasing international funding, prevention and promotion measures within specific key population groups – including education for youngsters in school – are rarely prioritized by governments. Such activities are often implemented through Civil Society Organisations (CSO), peer or community approaches.

- As meeting the more ambitious 95-95-95 targets require huge investments in prevention activities to stop new infections, many stakeholders in Zimbabwe and Kenya

⁶⁴ Institute for Health Metrics and Evaluation (IHME), Global Burden of disease, 2017 [Available online from]: <http://www.healthdata.org/central-african-republic>

⁶⁵ WHO Global Tuberculosis report, 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

⁶⁶ Dehne et al. "HIV Prevention 2020: a framework for delivery and a call for action" *Lancet HIV*. 2016 Jul;3(7):e323-32. doi: 10.1016/S2352-3018(16)30035-2. [Available online from] <https://www.ncbi.nlm.nih.gov/pubmed/27365207>

express concern that further funding will be pulled back from interventions that are already underfunded, such as condom programming. Zimbabwe is at a critical juncture, because while funding from external donors has flatlined, the number of people requiring treatment has grown. Its commitment to ensuring treatment for all is unwavering, but the financial burden of ensuring life-long treatment for PLHIV is beyond the country's current financial capacity. Prevention programs continue to lag behind, with resource allocation for condom programming, male circumcision and other prevention activities across districts being unequal and insufficient in HIV hotspots. While USAID is supplying condoms for distribution through the Ministry of Health, there is no money for promoting their use. According to COP2019, there will be a further 40% reduction in funding for condoms.

- In Guinea where overall resources are constrained, the financial support for PMTCT by the Global Fund was reduced in the 2018-2020 period and a very limited budget has been made available for prevention activities. Efforts made in advancing awareness and recognition of HIV and TB at the country level are set to backslide due to these low funding streams. The lack of knowledge about HIV, prevention and transmission among the general population in Guinea is striking, including in the capital Conakry, and stigma associated with HIV will likely worsen.
- In Eswatini, the strategic plan strongly focuses on increasing prevention efforts in order to reduce incidence, which continues to be very high particularly among young women and girls. However, prevention is highlighted by several stakeholders as one of the main areas at risk in view of reduced funding from both donor and government sources.

4.4 DEFICITS IN COMMUNITY PROGRAMS AND PSYCHOSOCIAL SUPPORT

"At the beginning of my treatment, things weren't going well. There were constant stockouts [of drugs] and my health didn't improve. I weighed just 32 kg. Through the association of people living with HIV, I was recommended to a clinic where this wouldn't happen. I was treated, my viral load quickly improved and I gained weight. I'm lucky to be in Conakry. Elsewhere, patients die. A friend's husband comes here for treatment from Kankan, more than 600 km away, because there is nothing there."

Odia (Guinea)

In recent years, the value of reinforcing community-led and community-based HIV and TB interventions (to address socioeconomic challenges and achieve outcomes through more people-centered prevention, diagnosis, treatment and care) has received global recognition and commitments to supporting these interventions.⁶⁷ Community and peer approaches make a significant difference toward reaching effective results in the scale up of HIV and TB programs. In many countries, Civil Service Organisation (CSO) interventions enable better coverage in testing and treatment, linkage to health facilities, retention in care, patient autonomy, and treatment literacy. Additionally, they are key to developing and implementing effective preventive strategies – both among general and key population groups. These commitments stand in contrast to the recent global decline in the funding of community-based service delivery and advocacy. A 2018 UNAIDS survey showed that global investment in AIDS activities managed by CSOs began declining slightly by 2016 since peaking between 2012-2013.⁶⁸ Indications that this trend is continuing were found in several of the countries studied, where gains, made thus far in this area, are put at risk.

⁶⁷ Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, 2016 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf and Political declaration on the fight against Tuberculosis, 2018 [Available online from] <https://www.un.org/pga/72/wp-content/uploads/sites/51/2018/09/Co-facilitators-Revised-text-Political-Declaration-on-the-Fight-against-Tuberculosis.pdf>

⁶⁸ *Best practices on effective funding of community-led HIV responses*, UNAIDS Geneva, Coordinating Board Issue date: 20 November 2018 [Available online from] https://www.unaids.org/sites/default/files/media_asset/20181203_UNAIDS_PCB43_Item%208_Financing_Community-led_Responses_EN.pdf



In the review for both HIV and TB, this critical area was highlighted as experiencing gaps in several countries. Insufficient funding was reported for community-led programs in service delivery and advocacy, provision of psychosocial support, as well as in structural programs that address: social drivers (critical for uptake, use and retention in HIV prevention, care and treatment) and human rights, gender equality, stigma and discrimination.

- In countries such as CAR, Guinea, DRC and Myanmar, the community and civil society networks involved in the HIV and TB responses have historically been relatively limited compared to those in higher prevalence contexts such as those in Kenya, Eswatini, Zimbabwe and Malawi. However, across all the countries reviewed, funding for community-led and delivered services is flagged as insufficient and, in several cases, in decline, and showing a significant negative impact on programs.
- Funding for community interventions are on a downward trajectory in Kenya. Sub-optimal funding and poor implementation of community activities continue to affect CSO's advocacy and peer support interventions, which are needed to complement the biomedical prevention and treatment programs.
- In Zimbabwe, financial support for community systems and community-based organisations has decreased, even with the government recognizing the importance of community structures as an interface between the health system and the community. Activities, such as demand creation,

identification of presumptive TB cases and helping to implement differentiated models of care and support (including for key populations) are now at risk of being undermined.

- In Guinea, funding for psychosocial support aimed at improving quality of care and patient adherence has been insufficient to support the whole country. With the shortfall in Global Fund grant allocations, there will be piecemeal coverage, targeting only certain regions.
- A similar lack of psychosocial support for PLHIV was noted in DRC by key informants, highlighting a resultant gap in measures for retention and adherence of patients.
- In CAR, where support activities, such as counselling, are not rolled out in many places, the national AIDS council (CNLS) is currently running a differentiated model pilot, including support groups for adolescents. However, given the funding shortfall, resources risk being insufficient to implement the initiative. The country is also experiencing a shortfall of "community health workers" (CHW). This is despite the recognition by the Ministry of Health that CHWs are key to defending a patient right to access care in practice. They guide patients to and within the hospital and help patients to avoid having to pay admissions fees that should not be paid.

4.5 SHORTFALLS IN HUMAN RESOURCES AND SUPPLY CHAIN MANAGEMENT

Each of the countries included in this study face significant challenges to ensuring timely access to quality HIV and TB services in their health systems. Reaching the HIV and TB targets will require tackling health system weaknesses to address inefficiency and inequity. Availability of sufficient and motivated health staff, as well as an uninterrupted supply of quality health commodities (that includes poorer or rural areas) are key pillars of a well-functioning health system. With announced ambitions to achieve UHC, there is a renewed motivation in countries (and among donors) to invest in strengthening health systems. However, many of the country reviews highlight how funding shortfalls in support for health staff and supply chain are already hampering



progress in the HIV and TB responses. The additional resources needed to progress toward UHC are currently lacking. Moreover, longstanding issues around recruitment, remuneration and retention of health workers are unlikely to be solved in the short term, as they require fundamental improvements in fiscal space, and removing recruitment freezes and wage bill restrictions.

When frontline health staff are missing or unmotivated, the availability and quality of services suffer. Without sufficient remuneration, absenteeism and corruption prevail. Some health workers make ends meet by forcing patients to pay out-of-pocket or by embezzling funds or drugs. Treatment might be incomplete or inadequate, and patients might be

refused care or referred to private services that are more expensive.

- The health workforce is perhaps the biggest challenge facing the HIV and TB programs in Myanmar. The training, recruitment and retention of health staff are problematic, and so are decentralization and remuneration. Strengthening the community health workforce is urgently needed for rural areas.
- In CAR, the health worker gap for both HIV and TB services is severe. Despite the current lack of qualified staff and although the health workforce is considered a

priority in the so-called “catch up plan” for HIV, strategies such as task shifting⁶⁹ have not been implemented and the necessary funding has yet to be identified.

- In Malawi, severe staffing shortages and inadequate management affect health services. National vacancy rates are at around 51% on average, and five times higher in rural and poor areas. Current levels of training for health workers (nurses/midwives) are not keeping up with the needs. Moreover, due to recruitment caps, only half of the trained staff had been absorbed on the pay roll in 2016. Estimates indicate that by 2022 Malawi will need to spend at least USD 775 million per year to maintain the status quo in line with population growth,⁷⁰ the number is far more than the 2017 - 2018 allocated budget of approximately USD 177 million.
- Frequent stockouts are likely to affect existing infrastructure and could negatively derail a system’s progress. For example, a fire at the central pharmacy in Guinea in June 2017, coupled with constrained funding, caused the loss of ARV buffer stocks. These events led to persistent drug shortages and stockouts through 2018 and 2019, as the process for ordering (i.e., quantification exercise, validation of orders, placement of orders) was not only sub-optimal but also prone to significant delays.

⁶⁹ Task shifting can be defined as the transfer of a task normally performed by a more highly trained health care worker to another with a different, usually lower level of education and training. This strategy has been recommended by the WHO for low and middle income countries, due to the low HCW to patient ratio Taskshifting, Global Recommendations and Guidelines WHO, UNAIDS, PEPFAR [Available online from] https://www.unaids.org/sites/default/files/media_asset/ttr_taskshifting_en_0.pdf

⁷⁰ *Mind the funding gap: who is paying for the health workers? Achieving an adequate, fair funding level for a strong health workforce in Malawi*, Wemos, November 2018 [Available online from] https://www.wemos.nl/wp-content/uploads/2018/11/Wemos_Country-report-Malawi-2018.pdf



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5. REFLECTIONS ON THE DILEMMA OF COMPETING PRIORITIES AND THE IMPACT ON EQUITABLE ACCESS AND PATIENT-CENTRED HEALTH CARE



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Displaced responsibility and impossible choices

With limited means, whether real, perceived or otherwise, choices always have to be made. But in making ambitions and strategies fit with existing resources, effectiveness and efficiencies in the response to HIV and TB may be lost. Withdrawing resource inputs before viable alternatives have been verified can be especially disruptive in keeping up with the challenges we are facing in sustaining any progress made over the last decade in the HIV and TB response. Anticipation of shortfalls dampens ambitions

in programming and paralyze innovation. The decisions made at the global level to withdraw funding often place the burden on programs, health providers, patients and the people living with these diseases.

For any epidemic, time and coverage are essential factors to controlling the expansion of cases and costs. Costs in the medium-to long-term may rise because of cutbacks in the short-term. Decision-making led by short-term political and economic considerations leaves little room for effectively setting appropriate

health priorities and considering the most urgent needs of the patient and population. Health is made to fit within economic constraints rather than being allowed to define funding needs. As a consequence, **the onerous task of managing competing priorities, challenging dilemmas and tensions are deferred to the health delivery level, where different health issues and strategies are pitted against each other and making already hard choices impossible to make.**

“Decision-making led by short-term political and economic considerations leaves little room for effectively setting appropriate health priorities and considering the most urgent needs of the patient and population.”

PLHIV on ARV today are not only threatened with the risk of having their treatments discontinued or denied access to second and third line options, they are also placed in competition with those who are not yet on treatment. **On the other side of the consultation desk, healthcare providers are also affected by the resource constraints.** Without treatments or the capacity to carry out their duties, healthcare workers are undermined in their efforts to perform their work effectively. Their inability to be effective erodes the trust of their patients, and eventually that of the community in the health system.

It has also been exemplified in this review that **a lack of resources exacerbates existing tensions between prevention and treatment.** There is no doubt that each play a critical role in stemming the spread of disease and that they mutually reinforce each other. Without the effective scaling up of prevention, higher incidence rates will add more stress on national treatment programs and overwhelm health services. Gaps in funding for treatment scale up will undermine any benefits of prevention and the credibility of the health system. This cycle is also having a negative impact at the community level, where

similar cuts have been noticed, such as in key mobilisation and awareness efforts. Once more, the tension becomes misplaced, this time between health systems and communities, short-changing the individual patient and public health.

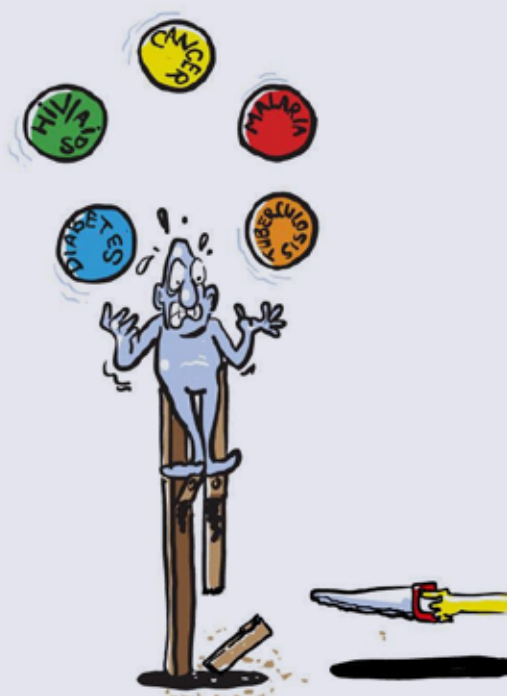
On the policy level, disease programs are often wrongly perceived as competing with health system strengthening and universal coverage. Approaches defined within UHC would ideally provide opportunities to better meet the multiple health needs of PLHIV and other key populations, especially if HIV and TB care is systematically included in packages of essential health benefits. **An optimal mix of health system and community approaches can provide people the best, adapted choice within a range of options of treatment and prevention.** However, as expressed by some interlocutors in the review, the concern lies in the risk of having already limited funds for HIV and TB being siphoned away for systems management.

While in global health discussions, integration of HIV and TB within existing services is promoted as a means to achieve more efficiency and cost savings, the main objective should be improved patient outcomes through services adapted to patient needs and reduce missed opportunities and costs for people seeking care. However, reaching the minimal conditions to make integrated care a success while protecting patient outcomes and programmatic results is a major challenge. Enthusiasm around service integration and UHC still needs to translate into concrete measures to tackle the existing resource gap, in order for all people to benefit from more accessible health care, without leaving anyone behind.

False assumptions and elusive goals: the need for a reality check

Many countries are reviewing their health finance strategies today, and that includes assessing the options for increased domestic resource mobilisation. **Nowadays, the widespread assumption is that achieving HIV and TB targets and progress towards UHC will have to be financed mainly by domestic resources.** For many countries, such as those included

Drawnalism®



in this review, there are often not many viable options, certainly not in the short or medium-term. **Countries with economies under strain, a limited tax base and restricted fiscal space are facing significant shortfalls in resources and cannot reach the projected government health expenditures.** Additional revenues from loans, so-called innovative financing streams and/or the private sector are not yet available and without external financial support, disease targets and UHC goals for 2020 and 2030 may remain elusive for many countries.

As indicated by the case studies for this report, the goal of ending HIV and TB as global health threats is still far from being achieved. Reports on progress measured by global averages are hiding the reality in countries that still experience unacceptably high levels of illness and death.

While several high burden countries included in this report experience impossible dilemmas of prioritizing services in the face of an approaching breaking point, many low prevalence and poor countries in the West and Central African region remain unfortunate examples of a prevailing crisis. It is well observed as per UNAIDS that where funding has been made available, results are more robust. This is the case for several countries in Eastern and Southern Africa, where

expenditures per PLHIV in general have reached the resource-need estimates, and where HIV infections and deaths are reduced to levels closing in on the 2020 targets. Sadly this is not the case in the West and Central African region, where the resources available will be only 48% of what is needed by 2020 and where in many countries, results are far off the 2020 targets.⁷¹ The point is that regardless of whether people live in high burden or low burden countries, access to essential services must be made available to all.

Despite notable shortfalls today, donor countries seem to harbour great optimism in the short term for low and middle-income countries to raise the necessary revenue domestically — not only to expand financing to cover more ambitious health objectives but also replace international funding. Resources, domestic or otherwise, that can be raised without placing the burden on patients and be equitably distributed towards health needs should always be encouraged. However, **there is a palpable risk that a poorly planned and premature withdrawal of international funding will lead to key areas in the fight against HIV and TB being sacrificed, and fundamentally alter the world's ability to rise to the challenges ahead.** Attention increasingly tends to shift solutions that in practice mean “robbing Peter to pay Paul” essentially just redistributing the gaps, instead of providing care in an equitable way, according to people's needs.

These expectations and calculations require an urgent reality check, going beyond broad macro-economic factors and political pressure, and assessing how this “transition” is translating in the lives of people, health workers and authorities. Without the proper review of real issues underlying the lag in, or lack of, resource mobilisation, this could lead to wasteful investment of precious resources and efforts placed on building a road to nowhere. We cannot rely on fostering false hopes that with political will alone, the course will correct. **Healthcare ideally should be everyone's concern and ultimately the responsibility of governments combined with robust international support to provide health care equitably, fairly and justly.**

⁷¹ Communities at the center -Global AIDS Update, UNAIDS, July 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf

6. CONCLUSION AND RECOMMENDATIONS – THE RESPONSE IS MISSING THE MARK, WHAT NEXT?

With a little more than a year remaining before several 2020 global targets in the fight against HIV and TB should be met, such as the three 90s and reducing TB related death, including among PLHIV by 75%,⁷² many countries still remain far off target.⁷³ **As global institutions, such as Stop TB Partnership and UNAIDS will lead the process to develop new targets and milestones beyond 2020, a closer look at existing gaps, capacities and needs will be critical.**

Ensuring that all people affected by HIV and TB can access effective prevention and treatment services requires consistent political commitment, innovative strategic approaches and continual financial investment over the following crucial years. Financial investments must become more ambitious, and considerate of what is feasible and equitable. International donors oftentimes call for sobriety when considering what resources can realistically be mobilised within their own countries, but is the same request for realism applied to countries most affected by HIV and TB?

The Global Fund has built its investment case for its 2019 replenishment on an assumption of a 48% increase in domestic funding resources by 2022, based on percentage increases in commitments in previous years. The most

recent trends in both domestic and international resource mobilisation for HIV in 2018, however, tell another story, of declines and uncertainty. **Historically, the Global Fund has been instrumental** in enabling governments, health agencies and civil society groups to implement innovative HIV and TB strategies, provide affordable quality medicines and support health workers. **The value of its continued support to countries and people is undisputable and its unprecedented role over the past decades in mobilising international resources is as crucial as it has ever been.** The intent to leverage domestic resources should not distract the Fund from the ultimate goal of attracting and allocating additional resources towards ending the epidemics as global health threats, while saving lives and providing equitable access to care.

The international drive to reduce the global HIV and TB burden, which allowed the unparalleled progress in reduced mortality, morbidity and transmission to date, seems to be stalling and is at risk of derailing the fight against HIV and TB. **Focus must remain on global burden sharing and on what needs to be done** instead of premature exit tactics and an international discourse that appears to underplay the impact of the funding shortfall.

72 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, 2016 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf
Political declaration on the fight against Tuberculosis, 2018 <https://www.un.org/pga/72/wp-content/uploads/sites/51/2018/09/Co-facilitators-Revised-text-Political-Declaration-on-the-Fight-against-Tuberculosis.pdf>

73 https://www.unaids.org/sites/default/files/media_asset/tuberculosis-and-hiv-progress-towards-the-2020-target_en.pdf

Recommendations

As the HIV and AIDS community is faced with the consequences of constrained global health financing, we need to take stock of what is at risk of being sacrificed. The gradual move in funding for TB and HIV, from international to domestic public investments, is in principle a very positive step, but it risks putting undue pressure on countries to transition away from international funding in order to comply, when many are neither ready nor able, even if they may be willing. Ambitions for domestic resource mobilisation are currently dominating many global health conversations, at the risk of side tracking the primary goals set to end the epidemics. The HIV/TB response is at a critical juncture and it is a truly shared responsibility to ensure that it gets back on track, while ‘leaving no one behind’.

The following is therefore recommended:

- 1** Governments, international agencies, donors and partner organisations must **step up efforts to keep HIV and TB responses high on their agenda and increase investments to reduce transmission, morbidity and mortality related to HIV and TB**. Preventing, detecting and treating TB and advanced HIV and AIDS requires specific and enhanced attention, including but is not limited to:
 - Increased funding to ensure increased coverage of testing and continuation of TB treatment and ART enrolment at the current pace as a minimum
 - Allocation of additional resources toward retention and mortality reduction, specifically to prevent, detect and manage advanced HIV and drug resistant forms of HIV and TB
 - Provision of “emergency funding” to countries experiencing critical shortfalls in ARV, TB drugs and testing provision to prevent treatment interruption and rationing of ARV and TB treatment initiation
 - Increased investments in community-based and community-led programs and patient-centred care proven to be key in reducing mortality, incidence and social costs of HIV and TB.
- 2** Global leaders, agencies and in-country stakeholders should **firmly restate the key challenges in bringing the HIV and TB response back on track, based on proactive and realistic assessment** of the state of the epidemic, resource availability and needs, as well as current and future programmatic gaps and funding shifts, along with the necessary mitigation measures. Such assessments should be a key component of the elaboration of global plans for HIV and TB that will set targets for the 2020-2025 period.
- 3** International agencies and donors must **reverse the recent decline in funding for HIV and TB and increase funding** to support comprehensive programs for HIV and TB prevention, treatment and care services. This includes:
 - Meeting the Global Fund’s replenishment target of raising *at least* USD 14 billion for the 2020-2022 period.
 - Continued strong engagement in comprehensive HIV and TB services by the US government.

- Re-engagement of other bilateral donors that have gradually disengaged over the past years.
- World Bank and other development agencies to provide additional concessional funding for the HIV and TB response and support an enabling fiscal environment for critical investments in health.

4

Countries facing major funding gaps in the next few years should (with support of UNAIDS and Stop TB Partnership) call for a multi-stakeholder meeting to gauge the consequences and risks for their HIV and TB response and to explore mitigating strategies and financing options including potential additional international efforts to bridge the critical period.

5

International donors and agencies such as the Global Fund and PEPFAR should encourage and support **robust assessments of a country's ability (and willingness) to increase government health resources**. Such analysis should inform **risk and readiness assessments** for countries preparing for transition or expected to increase their co-financing of key program costs such as procurement of essential health products or human resources. Impact, quality and coverage indicators that could be negatively affected by the transition to national systems should be carefully monitored and reported on. Support and mitigation measures should be put in place, with the flexibility to delay the process of gradual transition where people and programs are at risk of harm.

6

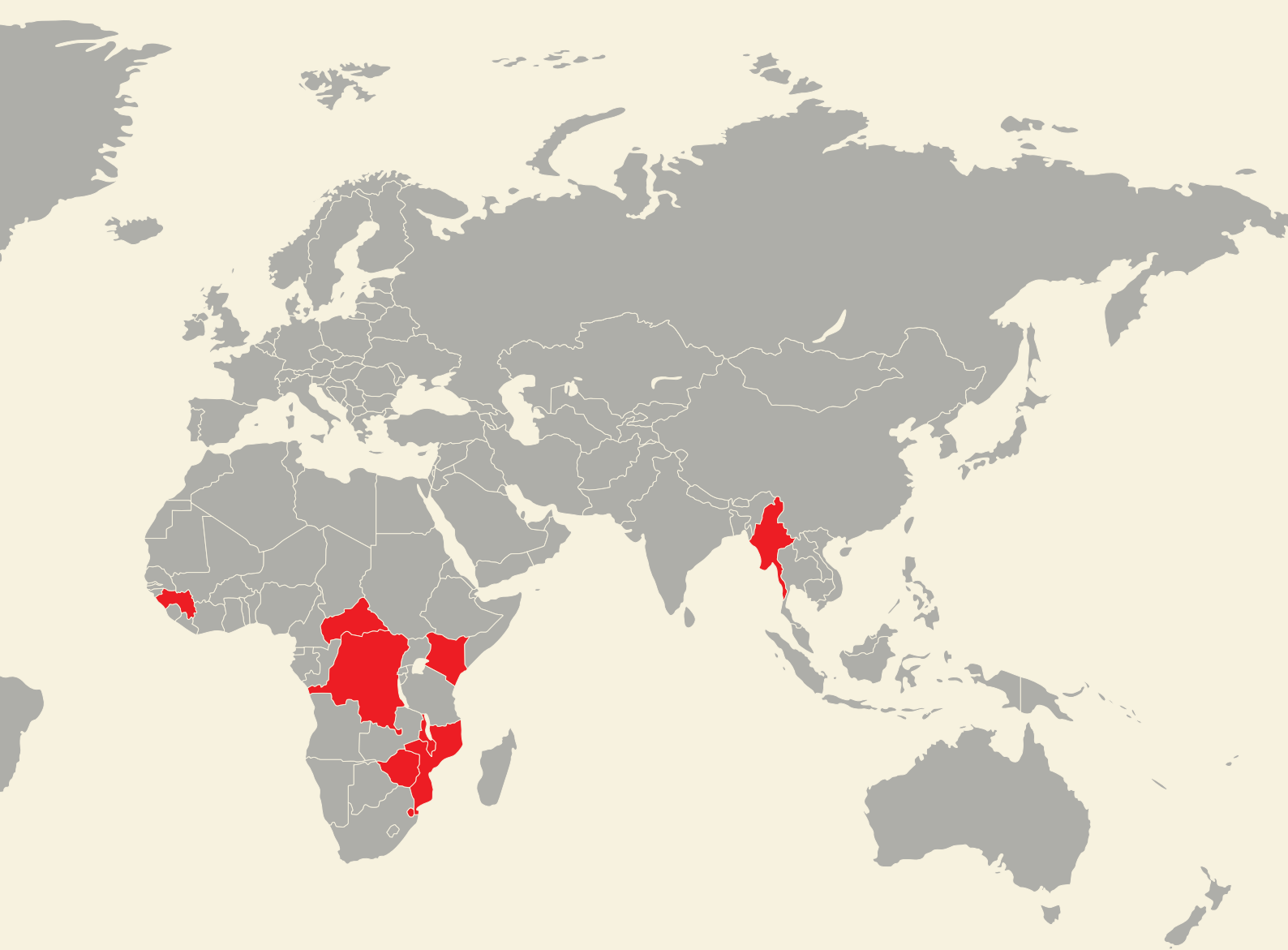
Governments and ministries of health should ensure efficient and effective use of resources and, based on assessment of risk and sources for sustained health financing, increase public domestic funding of HIV and TB services, avoiding service gaps or burdening people living with these diseases. Priority funding should be allocated to protect patient and community-centred support, and effective and innovative approaches.

7

National strategies to increase overall health revenues and achieve UHC should promote equitable access to patient-centred and community-oriented services that include the specific vulnerabilities and needs of people living with HIV and/or TB.



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COUNTRY CASE STUDIES

CENTRAL AFRICAN REPUBLIC

DEMOCRATIC REPUBLIC OF CONGO

ESWATINI

GUINEA

KENYA

MALAWI

MOZAMBIQUE

MYANMAR

ZIMBABWE

MSF OPERATIONS IN THE NINE COUNTRIES

CENTRAL AFRICAN REPUBLIC (CAR)

1. OVERVIEW OF SOCIO-ECONOMIC INDICATORS AND STATE OF THE EPIDEMICS

CAR is one of the least developed countries in the world (ranked 188 out of 189 according to the 2018 UNDP Human Development Index) and the country has been embroiled in armed conflict for over a decade. An increase in violence, during 2017 displaced over 600,000 people. Estimates indicate more than half of the population (about 4.75 million) is in need of urgent humanitarian assistance.

HIV prevalence in CAR is around 3.6% (the highest in the region). An estimated 110,000 people are living with HIV in the country. Access to ARVs has improved (from 14% in 2013 to 36% in 2018)ⁱ but remains one of the lowest in the world. While TB deaths decreased by 31% between 2010 and 2016ⁱⁱ, the number of deaths from TB remained high in 2017ⁱⁱⁱ, marking an increase of 18% over the previous year. TB is a leading cause of death (all ages) in CAR followed by HIV in third place after diarrheal disease.^{iv} Despite major challenges, the country is making some progress. Between 2010 and 2018, HIV-related deaths decreased by 43%, and new infections decreased by 40%.^v These improvements are closely linked to recent investment by the Global Fund and the efforts of implementing actors.

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

The government's budget for health represents 8% of the total government budget, (i.e. below the 15% recommended in the Abuja declaration).^{vi} The households' out-of-pocket or OOP spending is high (43%) and exposing the population to a high risk of catastrophic health expenditures.

ⁱ UNAIDS 2014 Gap Report [Available online from] http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf and UNAIDS Data 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

ⁱⁱ Global Fund WCA Advisory [Available online from] https://www.theglobalfund.org/media/8493/oig_gf-oig-19-013_report_en.pdf

ⁱⁱⁱ Central African Republic Dashboard, [Available online from] http://www.stoptb.org/resources/cd/CAF_Dashboard.html

^{iv} Global Burden of disease, 2017 [Available online from] <http://www.healthdata.org/central-african-republic>

^v UNAIDS Data 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

^{vi} WHO Global Health Expenditure database (2016 figures) [Available online from] <https://apps.who.int/nha/database/Select/Indicators/en>

The health care system in CAR is heavily dependent on foreign financing with 95% of financing for health between 2017 and 2019 coming from external funders.^{vii}

For both TB and HIV, the national plans are far from fully financed and the Global Fund is the main donor for diagnosis and treatment of the two diseases with a commitment that has remained relatively static over the past six years. Domestic resources are mainly covering salaries for health care staff. However, there are recent commitments to start financing ARV treatment.

3. KEY GAPS

The limited ART coverage is one of the main concerns for the country's HIV/AIDS response. The constrained Global Fund allocation for HIV in CAR was only covering 32,000 patients per year (i.e., no new inclusions in 2019 and 2020). As enrollments exceeded targets in 2018, an additional USD 10.5 million was allocated by the Global Fund to cover the 38,569 patients on treatment by the end of 2018, as well as 7,500 additional patients per year through to the end of 2020. While this will support ongoing enrolments, it cannot be considered scale-up at the pace needed to meet the needs of the population. As a result of funding limitations, delays in procurement and supply processes, as well as other factors, a critical ARV shortage and national stockouts of key ARVs materialized in July 2019, causing treatment interruption for thousands of patients.

Moreover, significant funding constraints are also noted for testing services. The Global Fund grant only targets PMTCT, key populations and co-infected patients. Other gaps include the lack of funding for operationalizing the country's prevention strategy and developing targeted programs for key populations. In this context, these constraints make it difficult to ensure access to testing and to care for HIV patients.

TB is often described as an 'orphan' in the health response of CAR. The TB response is lagging behind on many levels with actors in CAR emphasizing access to diagnosis as the biggest challenge (whether for DS-TB or MDR-TB). Out of 1009 primary health care structures in the country, only 84 are providing diagnosis and treatment. The lack of access to services is even greater outside urban areas.

^{vii} Dossier d'investissement, page 47

4. CONCLUSION AND RECOMMENDATIONS

CAR is clearly facing very challenging times when it comes to responding to health needs in general and to the HIV and TB epidemics, in particular.

The national AIDS response is constrained by human resource shortages and weak supply systems within the health system. The volatile security situation continues to prevent the government from systematically accessing all health structures. And, despite these serious barriers, progress has been achieved through the joint efforts of actors at the national level drawing primarily on Global Fund support.

However, the funding shortfalls of the Global Fund and the continued disengagement by various actors in CAR now risk imposing important consequences on those not yet diagnosed and those on treatment, as well as increasing the risk of people becoming infected,

Another worrying trend is how several bilateral and multilateral health actors are simultaneously pushing for the government to take on a bigger share of the health expenses towards numerous areas, with a risk that these efforts will fall short and the patients will in the end bear the financial burden. The Global Fund has previously waived their co-financing requirements in view of the country's constraints, and such flexibility should continue to be considered.

There is national political will to improve the situation but one limiting factor is the lack of donors and actors mobilizing to support the response, despite the huge contribution of HIV and TB to the high national morbidity and mortality rates.

RECOMMENDATIONS:

To national and international health actors and donors:

- More actors and donors need to engage in the responses to these diseases to improve access to diagnosis and treatment. The Global Fund cannot address all expectations.

- Ensure the new decree of free health care for specific groups (*gratuité ciblée*) includes people affected by HIV and TB, is applied in all health facilities and that the mechanisms to guarantee free care are clarified. Whenever the existence of user fees or other costs are affecting access to health care for vulnerable people, this barrier must be removed. HIV and TB care should always be free of charge at the point of care.
- A "maintenance only" strategy for HIV and TB care in CAR is not ambitious enough. Even a flatlining of funding would lead to a regression in any progress made in curtailing HIV and TB incidence and mortality.
- Fully implement the principles of flexibility, partnerships and innovation in the Global Fund COE policy in order to "*enhance responsiveness and timeliness of Global Fund investments*".^{viii}
- TB diagnosis and care access should be improved with adequate funding reflected in the very modest amount allocated in the current Global Fund grant.

HIV/AIDS data, 2018 (UNAIDS)^{ix}

Prevalence (15-49 years)	3.6%
Number of PLHIV (all ages)	110,000
New infections (all ages)	5,570
Number of deaths (all ages)	4,800
Treatment coverage (all ages)	36%

TB data (WHO)^x

	2017
Incidence rate (per 100,00 per year, incl. HIV)	423
Incidence (number of new cases)	20,000
Notified cases	9,819
Number of TB HIV positive cases	6,200
Treatment coverage (all)	49%
Number of deaths (incl. HIV positive)	5,900
Incidence MDR/RR-TB (number of cases)	150

viii Global Fund COE policy [Available online from] https://www.theglobalfund.org/media/4220/bm35_03-challengingoperatingenvironments_policy_en.pdf

ix UNAIDS Data 2019 [Available online from] <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

x WHO Global Tuberculosis report, 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

DEMOCRATIC REPUBLIC OF CONGO (DRC)

1. OVERVIEW OF SOCIOECONOMIC INDICATORS, STATE OF EPIDEMICS

The DRC is a Low Income Country with a GNI per capita of 870 USD and a poverty rate at 76.6% (2012).ⁱ The population of the country is about 85 million.

The fight against HIV and TB in the DRC is an enormous undertaking. The country is vast, with large regions that are virtually unreachable during the rainy season, making service provision challenging under the best of circumstances. Added to this is an extremely weak public health system that is chronically and dramatically underfunded; therefore, the DRC is almost completely dependent on external donors to fund and manage the HIV/TB response.

The prevalence of HIV is 0.8% and the treatment coverage was at 57% by the end of 2018, according to UNAIDS. A data review of people on treatment is underway and depending on the results may indicate a higher coverage rate but also an increased risk of a shortage in ART funding.

In 2017, 151,832 cases of all forms of TB were detected. Those numbers make the DRC one of the 11 countries that bear 80% of the global burden of TB. The number of deaths due to TB (excluding HIV positive individuals) is estimated at 60/100,000 (49,000 in 2017).ⁱⁱ According to the Global Fund advisory report on West and Central Africa (WCA), number of deaths increased by 22% between 2010 and 2016 in DRC, compared to a 5% increase in the WCA region and 8% reduction in the rest of Africa. In 2016, estimated missing cases for the WCA region reached 243,000. Among those, 123,000 were in the DRC.ⁱⁱⁱ

2. FUNDING FLOWS (DOMESTIC & INTERNATIONAL)

In DRC, domestic private expenditure bear 44% of current health expenditures, 86.7% of which comes from out-of-pocket (OOP) expenditures.^{iv} According to the National Strategic Plan for HIV (NSP 2018-2020), these OOP expenditures have reduced the use of curative services to one medical visit every 20 months per person. External health expenditures is in the second position at 39.5% of the Current Health Expenditures (CHE) while domestic general government health expenditures represent only 16.5% of the CHE.^v

While globally, major donors are adapting policies and using new mechanisms to encourage governments to take on a greater financial responsibility in addressing HIV and TB, there seems to be broad recognition that the DRC is not yet in a place where the government can immediately take on a larger role. However, the Global Fund and PEPFAR, the two largest donors in the DRC HIV/TB response are urging the government to meet its current co-financing commitments and invest meaningfully in the health system. PEPFAR increased its budget by 10% for COP19 considering the country's good results. However, the Global Fund decreased its funding for HIV and TB by 19.7%, in signed grant amounts compared to the previous grant cycle.^{vi}

Funding support from external donors does not meet the ambitions of the National HIV and TB programs, which are seeking to meet the global 90-90-90 cascade targets. The main argument is that the country does not have the capacity to scale up programming, despite the progress achieved in recent years. The funding requirements for the new NSP for HIV are dramatically higher than in previous years, because the targets are also greater.

ⁱ Source world Bank database [Available online from] <https://data.worldbank.org/indicator/SI.POV.DDAY>

ⁱⁱ Democratic Republic of Congo [Available online from] https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=CD&outtype=html

ⁱⁱⁱ Grant implementation in Western and Central Africa (WCA) [Available online from] https://www.theglobalfund.org/media/8493/oig_gf-oig-19-013_report_en.pdf

^{iv} DRC Factsheet of Health Statistics 2018, African Health Observatory, WHO

^v DRC Factsheet of Health Statistics 2018, African Health Observatory, WHO

^{vi} Global Fund Prospective Country Evaluation, 2019 Annual Report PATH, IHME, January 2019, page 5-6 http://www.healthdata.org/sites/default/files/files/Projects/Global_Fund_PCE/Prospective_Country_Evaluation_DRC_annual_report_2019.pdf

3. KEY GAPS

Given its position as a low-income country and Challenging Operating Environment (COE),^{vii} the prospects of increasing domestic resources must be realistically assessed. With a decrease in the Global Fund's allocations and grant amounts compared to the previous period, and despite a relative increase in PEPFAR funding for the coming year, there is a growing funding gap between the programming planned in the NSP for HIV and TB, and the funds that are available.

Further gaps may lead to increasing barriers for people living with HIV and TB or both, such as having to pay user fees, or facing medication interruption due to stockouts, and those with advanced or particularly complicated forms of HIV or TB will struggle to find quality care free of charge.

4. CONCLUSIONS AND RECOMMENDATIONS

The DRC finds itself in a Catch-22. Donors are hesitant to increase financing in an operating environment where the Ministry of Health (MoH) capacity is low, and where important challenges to program implementation (such as conflict and instability, logistical challenges, disease outbreaks) exist. While both PEPFAR and the Global Fund emphasize the importance of strengthening the health system, it remains to be seen if this will translate into much needed investments into infrastructure and supply chain systems, and a MoH workforce that is frequently unpaid and unmotivated. Without investment also in training and management, the situation will not improve.

RECOMMENDATIONS FOR DONORS AND THE MOH:

- Measures to prevent barriers to care must be taken. We welcome PEPFAR's willingness to try to address the issue of user fees for HIV patients and suggest the design of practical solutions that would ensure care that is free at point of delivery, such as a voucher system for patients.

^{vii} COEs are countries or sub-regions of countries that the Global Fund characterizes as having weak governance, poor access to health services, manmade crises (such as conflict) or natural crises (such as famine). https://www.theglobalfund.org/media/4220/bm35_03-challengingoperatingenvironments_policy_en.pdf

- In terms of disease prevention, more funds should be directed at education and prevention activities, particularly targeting the youth.
- The HIV path is not linear for every patient (from test to viral suppression), because people drop out and come back when they are sick. Therefore, specific investment for advanced disease care is needed as well as investment for psychosocial support, in order to improve adherence and retention.
- Considering the status of the DRC as a COE and Low Income Country, the Global Fund and PEPFAR should carefully assess the government's ability to invest its co-financing requirements.^{viii}
- Ensure that targets correspond to the actual needs and allow space for new inclusions. If financial gaps are confirmed, additional and alternative sources of funding need to be identified.

HIV/AIDS data, 2018 (UNAIDS) ^{ix}	
Prevalence (15-49 years)	0.8%
Number of PLHIV (all ages)	450,000
New infections (all ages)	19,000
Number of deaths (all ages)	13,000
Treatment coverage (all ages)	57,7%

TB data (WHO) ^x	
Incidence rate (per 100,00 per year)	323
Incidence (number of new cases)	262,000
Notified cases	151,832
Number of TB cases (HIV+ cases)	20,000
Treatment coverage (all)	57%
Incidence MDR/RR-TB (number of new cases)	7,100

^{viii} An eventual gradual shift to government for purchase of commodities for HIV and TB should be well prepared in order to ensure the timely delivery of high quality drugs (pre-qualified WHO) at reasonable prices.

^{ix} UNAIDS Data 2019 [Available online from] <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

^x Global Tuberculosis Report [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

ESWATINI

1. OVERVIEW OF SOCIOECONOMIC INDICATORS AND STATE OF THE EPIDEMICS

Eswatini (formerly Swaziland), located in Southern Africa, has a population of 1.2 million. With a Gross Domestic Product per capita at USD 4,250, the country is classified as a lower-middle income country.ⁱ However, the World Bank estimated that 41% of population lived below the extreme poverty line of USD 1.9 in 2015.ⁱⁱ

The country has the highest HIV prevalence in the world, with an estimated 210,000 or 27.3% of adults living with HIV.ⁱⁱⁱ The early impact of HIV saw high mortality rates and rising numbers of AIDS orphaned and vulnerable children as well as other devastating social and economic impacts. Nevertheless, HIV prevalence has stabilized and the number of new infections among adults has nearly halved since 2011.

In general, women have a higher prevalence than men (35% and 21.3%, respectively). HIV prevalence increases with age for both males and females, peaking at 48.8% among men aged 45 to 49 and 54.2% among women aged 35 to 39. Disparity in prevalence by sex is more pronounced among young people aged 15 to 24 years.

Eswatini has been rapidly expanding HIV/TB care since 2008, leading to a decrease of incident TB and HIV cases by half. Nevertheless, Eswatini has one of the highest burdens of TB worldwide, which is closely linked to the high prevalence of HIV/AIDS. Of people who contract TB, 70% are HIV positive. The TB incidence rate occurring annually is 308 per 100,000 persons in 2017. In addition, 4.2% of people with TB have MDR-TB.^{iv} The TB treatment success rate for people co-infected with TB and HIV is 83%.^v Furthermore, the introduction of the new TB drugs (Bedaquiline/Delamanid) and the shorter 9-month MDR-TB regimen, coupled with further decentralized DR-TB treatment services, have shown a marked decline of DR-TB cases from 495 in 2014 to 318 in 2017 and a significant increase in the DR-TB treatment success rate from 53% in 2013 to 71% for 2017.^{vi}

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

Although in recent years the overall amount of external assistance to the health sector has declined, it continues to receive the highest proportion of Eswatini's external aid (USD 71.1 million - 31.7% in 2017/18). A large portion of this funding goes to supporting the national response to HIV/AIDS and TB in the areas of prevention, treatment and mitigation of the impact of these epidemics. Followed by Taiwan and European Union to the health sector, the US was the largest provider of direct external assistance to Eswatini in 2017/18.^{vii} The Global Fund (GF) and the European Union gave the third and fourth highest amounts respectively in 2017/18. These four partners accounted for more than half (55.5%) of the country's external assistance last year. During the 2017/18 budget allocation, the Ministry of Health (MoH) received in Eswatini Lilangeni E1.85 billion (USD 129 million), or 9.1% of the total health budget. Government spending on HIV represents 39.2% of the total MoH budget from which antiretroviral drugs form the major line item.

3. KEY GAPS

The main funding for the HIV/AIDS response in 2018 comes through domestic and international sources primarily from three partners: the government, PEPFAR, and Global Fund. For HIV, external partners account for approximately 57% of total funding, and the government's contribution has been increasing over the years to an estimated 48% in 2016.

The funding gaps for HIV and TB will remain significant for upcoming years however. For HIV, the funding gap is estimated to peak in 2020 at USD 24.9 million. For TB, the gap will grow to USD 10.9 million by 2021. While the assumption is that HIV funding will only flat line, the reality is less optimistic. As it is, additional resources are already required to address the existing funding gaps in the National Strategy Framework. Assuming that PEPFAR funding is reduced by 50% from 2019/2020, the funding deficit increases to USD 253 million over the 5-year period.^{viii}

ⁱ <https://knoema.com/atlas/Eswatini/GDP-per-capita>

ⁱⁱ World Bank 2018

ⁱⁱⁱ UNAIDS Data 2019, page 42-43 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

^{iv} World Health Organization Global TB report 2017

^v Annual TB Report 2017

^{vi} Annual TB Report 2017

^{vii} External Assistance to Eswatini 2017/2018, The government of Eswatini, Ministry of Economic Planning and development July 2018, produced by The Aid Coordination and Management Section - hardcopy.

^{viii} The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018 - 2023 https://hivpreventioncoalition.unaids.org/wp-content/uploads/2019/06/Eswatini_NSF-2018-2023_final.pdf

Given the fiscal constraints facing the government, there is also likelihood that government funding for HIV may reduce. In that scenario with both entities reducing funding, the gap would increase even more.

4. CONCLUSIONS AND RECOMMENDATIONS

The country is largely dependent on external funding, and PEPFAR and the Global Fund play a vital role. Eswatini is a PEPFAR priority country, and that means as long as PEPFAR maintains an overall stable budget, investments will likely continue in Eswatini. Nevertheless, funding gaps will increase if future funding (after 2021) by PEPFAR or Global Fund decreases; thereby jeopardizing many of the gains made in Eswatini.

While the government of Eswatini is funding basic HIV and TB treatment services (e.g. ARVs), it is assumed that prevention interventions as well as capital investments would be hit the hardest. It would be unlikely that new interventions would be implemented and/or maintained with appropriate quality, compromising the goal of achieving and sustaining epidemic control in HIV and TB. The anticipated decline in government revenues and the devaluation of the local currency compared to USD will negatively impact Eswatini's purchasing power for international commodities, such as drugs and lab consumables.

An additional threat is the decreasing investment of NGOs and other organisations in Eswatini, which have served as catalyzers for change by helping identify priorities and setting new efficient models of care.

Some mitigation interventions for counteracting the funding shortfalls and declining investments may have been identified, but uncertainty remains on just how they will be implemented and how effective they will be.^{ix}

RECOMMENDATIONS

- Avoidance of further decrease in funding and disengagement of external partners is critical to mitigate backtracking of gains made and encourage retention of service innovations and quality of care.
- Increase in domestic funding is crucial, but its limitation needs to be acknowledged given current economic developments and alternatives should be sought.
- There should be serious recognition that donor policies (e.g. US Gag rule) can have significant adverse effects and threaten transversal integration of services, such as in Sexual Reproductive Health, which ultimately impacts negatively the wellbeing of vulnerable groups.
- With the potential decrease in funding, even more attention will be needed in the areas of advanced HIV disease, DR-TB treatment and procurement/ supply of basic HIV drugs and lab commodities.
- Upfront investments are essential for research and innovation in diagnostics, treatment and simplification models because they will play an even more important role in the future of HIV and TB prevention and care.

HIV/AIDS data, 2018 (UNAIDS)^x

Prevalence (15-49 years)	27.3%
Number of PLHIV (all ages)	210,000
New infections (all ages)	7,800
Number of deaths (all ages)	2,400
Treatment coverage (all ages)	86%

TB data (WHO)^{xi}

	2017
Incidence rate (per 100,00 per year)	308
Incidence (number of new cases)	4,200
Notified cases	3,544
Number of TB cases (HIV+ cases)	3,367
Treatment coverage (all)	80%
Incidence MDR/RR-TB (number of new cases)	340

^{ix} The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018 – 2023, Ibid.

^x UNAIDS Data 2019, page 42-43 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

^{xi} WHO TB Report, 2018 [Available online from] https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=SZ&outtype=pdf

GUINEA

1. OVERVIEW OF SOCIOECONOMIC INDICATORS AND STATE OF THE EPIDEMICS

Guinea is considered a low-income country with a GNI per capita of USD 2,130 and 55.2% of the population living under the poverty line. In the country, the prevalence of HIV is 1.5% and treatment coverage is low (35%). The incidence of TB is 176/100,000 and the treatment coverage rate is around 63%.

The state of the HIV and TB responses in Guinea lags far behind most countries in the rest of Africa, and other countries in the West and Central Africa (WCA) region. Between 2010 and 2016, the incidence of HIV in Guinea decreased by 5% while incidence in the WCA region and other African sub-regions decreased by 12% and 26%, respectively. During that same period, deaths linked to HIV increased by 7% in Guinea while decreasing by 27% and 37% in WCA and other sub-regions.ⁱ

The TB death rate in Guinea increased by 4% last year (while it decreased by 8% in sub-regions outside WCA), but there were no changes in the incidence (22,000 cases/year).

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

In this particularly challenging context, efforts and investments should be reinforced to fight HIV and TB. However, the support provided by the Global Fund, the main external donor for HIV and TB in the country, has decreased for HIV and TB by approximately 17% for 2018-2020 signed grants compared to 2015-2017 period.ⁱⁱ The decrease and near flatlining of support has had a negative impact on the ambition and actions regarding prevention, testing and coverage of treatments.

In Guinea, 54.5% of overall health expenditures are from out-of-pocket spending. External health donor organisations provide 25% and the government domestic health expenditure is 17.1%.

Even though the share of health in the National Budget grew from 1.75% in 2013 to 7.52% in 2019ⁱⁱⁱ, domestic health expenditures are far lower than the share supported directly by households and the Abuja target.

3. KEY GAPS

The reduction of funding for HIV and TB means choices have to be made between competing priorities. In TB, actors specifically cited uncovered needs in prevention and early case detection. Even though some indicators improved in recent years (i.e. HIV/TB, success rate, etc.), the notification rate is still low compared to the number of estimated cases. On top of that, the lack of integration of TB and HIV services constitutes a real obstacle for patients in Guinea who are followed-up by different consultants (even in same health center). The lack of funds prevents TB actors from making investments in proactive case detection (including in children), sensitization of the population and better integrating services.

On the side of HIV, the main gaps are being seen in the areas of PMTCT, Viral Load, psychosocial support and health commodities. The PMTCT budget is so small that the Global Fund Sub-Recipient (SR) is concentrating most of its efforts towards less than 10% of the PMTCT sites in the country. For essential associated services such as monitoring viral load and early infant diagnosis, no money was foreseen for building up transportation of samples until the recent reprogramming exercise of Global Fund financed activities. Other challenges include provision of psychosocial support and health commodities for all HIV sites. No buffer stock has been available in the country since June 2017.^{iv} Issues with managing the supply chain contribute to delays in international order placements leading to stockouts or shortfalls. A national stockout of ARVs took place during the summer 2018 and there are currently issues with the viral load test reagents and pediatric ARVs.

Moreover, there is a great deal of pressure on Guinean authorities to assume part of the purchase of the commodities for HIV (23% by 2020) and TB (+/- 11%) despite its low income and status as a Challenging

ⁱ Global Fund WCA Advisory, May 2019 [Available online from] https://www.theglobalfund.org/media/8493/oig_gf-oig-19-013_report_en.pdf?u=637044317920000000

ⁱⁱ Calculation based on annual average signed amounts for the Jan 2015- Dec 2017 period compared to Jan 2018- Dec 2020 period Global Fund Dataset [Available online from] <https://data-service.theglobalfund.org/downloads>

ⁱⁱⁱ With a budget execution rate estimated at around 40% in 2018

^{iv} Due to budget limitations, the buffer stock has not been replenished since a fire broke out in the Central Pharmacy in June 2017. The Global Fund has more recently indicated that a six months buffer stock should be included in the 2019 budget reprogramming.

Operating Environment (COE).^v As a risk mitigation measure, the Global Fund has requested that the government submits the list of products ordered by the country twice a year. However, a more robust evaluation of risks and optimal areas of domestic funding investments in Guinea is needed, as well as targeted Health System Strengthening (HSS) support. Moreover, the Global Fund COE policy has not yet been fully operationalized in Guinea, which should ensure a more flexible approach to grant implementation.

4. CONCLUSIONS AND RECOMMENDATIONS

The number of external actors involved in HIV is low, and this number is even lower for TB. One of the particularities of Guinea is that most of the actors involved in the response are highly dependent on support from the Global Fund. Additional funding provided in the past by other donors, like French NGOs or the UN system, has ended. Other large funders such as PEPFAR are not present in the country.

Therefore, the dominant role of funding for HIV and TB by the Global Fund is becoming a constraint as those funds are stagnating. The increase of domestic resource expenditure for health by the government is not enough to cover the HIV/TB response needs.

The shortage of funds is not the only issue Guinea faces in its HIV and TB response. Others include issues regarding governance, weakness in the supply chain, and Monitoring and Evaluation (M&E), as well as a lack of Human Resources capacities. All of these challenges will worsen without proper investment in the response and will put Guinea at risk of being further left behind to face the re-emergence of AIDS.

RECOMMENDATIONS:

To the government, donors and other health actors:

- Use the meetings of technical and financing partners to share health sector analyses (issues, gaps, etc.) that include HIV and TB, and to define a common agenda for the discussion and definition of priorities with the Government.

- Consider HIV and TB activities in any new integrated health project developed.
- Ensure robust risk assessment and preparation before any transition of responsibility regarding health expenses, taking into account the whole picture of the national budget and the wider context.

To the Global Fund:

- Considering Guinea's status as a low-income country and COE, review the pressure on the government to purchase HIV and TB commodities until continuity and quality can be ensured.
- Regarding the issue of weaknesses in the supply chain, provide technical support to the country and invest adequately in the development and implementation of M&E tools to be able to follow the national cohort and drug consumption at every level (local, regional and national).
- Review grant management practices and rules to facilitate the disbursement process.
- Maintain ambitions regarding testing and coverage targets and ensure that funding gap analyses are publicly shared with civil society organisations and that advocacy efforts are being targeted towards other donors.

HIV/AIDS data, 2018 (UNAIDS)^{vi}

Prevalence (15-49 years)	1.5%
Number of PLHIV (all ages)	120,000
New infections (all ages)	6,600
Number of deaths (all ages)	4,400
Treatment coverage (all ages)	40%

TB data (WHO)^{vii}

	2017
Incidence rate (per 100,00 per year, incl. HIV)	176
Incidence (number of new cases, incl. HIV)	22,000
Notified cases	13,972
Incidence (number of TB+HIV cases only)	5,600
Treatment coverage (all)	61%
Incidence MDR/RR-TB (number of new cases)	670

^v COEs are countries or sub-regions of countries that the Global Fund characterizes as having weak governance, poor access to health services, manmade crises (such as conflict) or natural crises (such as famine). Global Fund COE policy, April 2016 [Available online from] https://www.theglobalfund.org/media/4220/bm35_03-challengingoperatingenvironments_policy_en.pdf

^{vi} UNAIDS Data 2019 [Available online from] <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

^{vii} WHO Global Tuberculosis report, 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

KENYA

1. OVERVIEW OF SOCIOECONOMIC INDICATORS AND STATE OF THE EPIDEMICS

Kenya is classified as a lower middle-income countryⁱ with a population of 44.2 million and a GNI per capita of USD 1,620 in 2018 and 36.1% of the population living under the poverty line in 2015.

The country's HIV epidemic is classified as high prevalence with a generalized epidemic. There are 1.6 million people living with HIV in the country and treatment coverage was 75% in 2017 and 68% in 2018. Within the country, 65% of people are living with HIV and 60% with HIV/TB co-infections are concentrated in 11 of the 47 counties in Kenya namely Nairobi, Homabay, Kisumu, Siaya, Kiambu, Mombasa, Kakamega, Nakuru, Busia, and Kisii.^{ii iii}

Health services are devolved and Kenya is implementing the UHC program targeting achievement of universal health by 2022. Kenya has made significant gains in HIV prevention, treatment and viral suppression. HIV prevalence declined rapidly from 10.5% in 1996 to 4.8% in 2018. Approximately 1.4 million people living with HIV are on ART and 89% of are virally suppressed. The same year, AIDS mortality and new HIV infections both decreased to 25,000 and 46,000, respectively.^{iv v} The TB prevalence is 558 per 100,000, and the treatment coverage remains low at 53%^{vi vii}

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

The Kenyan Government's Health Expenditure as a proportion of Total Government Expenditure increased from 7.6% in 2016/17 to 9.2% in 2018/19.^{viii} County Governments increased the proportion of their total budgets allocated to health from 13.9% in 2013/14 to

27.2% in 2018/19. However out-of-pocket spending still accounts for 32.8% of total health spending in 2015/16.^{ix} While national contributions to HIV/AIDS (as a share of total resources) increased from 25.5% in 2015/16 to 28% in 2016/17 fiscal years, donors remain the predominant source of HIV financing, contributing 63% of HIV expenditures in 2015/16. In 2016/17 the national HIV response funding gap was reported as USD 173 million.

Kenya's lower middle-income status has resulted in reduction in donor support for HIV and TB programming as well as other health interventions.^x The proportion of total health expenditure attributed to donors declined from 35% in 2009/10 to about 23% in 2015/16.

The largest external funders to Kenya's HIV/TB response is PEPFAR and Global Fund. While the Global Fund TB and HIV annual average allocations indicated an increase between the 2014-2017 and the 2018-2020 implementation periods, the equivalent in signed grant amounts indicate an estimated 8% decrease.^{xi} The current grant for HIV/TB allocates 60% to the purchase of ARV's. PEPFAR funding has been on a reducing trend over the past few years decreasing gradually every year from USD 517.9 million in 2011 to USD 505.4 million in 2018 and USD 375 million allocated in 2019.^{xii} Planned spending of PEPFAR funding for Kenya reduced by 25% leading to cuts in funding of certain programs in the 2020 implementation plan.

3. KEY GAPS

Declining donor funds pose a risk to the HIV/TB response. Shifts in donor focus are also evident. For example, in 2019, PEPFAR will focus on 'Rationalizing sites' (transition low volume testing and ART sites to be fully supported by county governments). Kenya's Global Fund funding application in 2017 estimated that

ⁱ <https://www.forbes.com/sites/faraigundan/2014/10/01/kenya-joins-africas-top-10-economies-after-rebasing-of-its-gross-domestic-product/#7b55da32ab80>

ⁱⁱ MOH 2017; County HIV estimates

ⁱⁱⁱ <https://www.unaids.org/en/regionscountries/countries/kenya>

^{iv} UNAIDS Data 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

^v MOH, Kenya epidemic estimates 2019

^{vi} Global Fund Kenya OIG report 2018 [Available online from] https://www.theglobalfund.org/media/8062/oig_gf-oig-18-021_report_en.pdf?u=637044317780000000

^{vii} WHO, TB Global report, 2018

^{viii} PEPFAR Kenya SDS COP19

^{ix} MOH National and County national budget analysis (2016/17)

^x <http://www.health.go.ke/wp-content/uploads/2019/01/Healthcare-financing-Policy-Brief.pdf>

^{xi} Global Fund Dataset [Available online from] <https://data-service.theglobalfund.org/>

^{xii} PEPFAR country SDS, Reports and Approval memos

funding from all sources (domestic, external and Global Fund) would cover 79% (1,198,829) of people living with HIV on treatment by 2020. The current rapid switch to Dolutegravir (DTG) based regimen particularly for all PEPFAR supported counties is more likely to require more funds for ARVs in the short term.^{xiii}

Other gaps in the response include poor implementation of HIV/TB policies, low numbers of TB case identification; Kenya has not met TB case notification targets for the last three years.

The availability of some diagnostic, prevention and treatment commodities are constantly inconsistent. HIV test kits, sexually transmitted infection treatments, lubricants and TB preventative masks are often missing at service delivery points. Additionally, treatment disruptions have been reported for second line and pediatric ARVs. Poor quantification and management of expired drugs have led to losses and in some cases dispensing of expired drugs.^{xiv}

Suboptimal implementation of community interventions continues to affect prevention and treatment coverage. Civil Society Organisation's advocacy and peer support interventions are needed to compliment the biomedical prevention and treatment interventions.

4. CONCLUSIONS AND RECOMMENDATIONS

Due to Kenya's lower middle income country status and the current state of the national epidemic response projected to be near achievement of 90-90-90 UNAIDS targets^{xv}, a trend of reducing funding for the HIV/TB response can be foreseen. This trend is also visible in the entire health sector as already other bilateral funders are pulling out. However, despite demonstrated intent by the government and countries to increase domestic funds for health and HIV/TB, significant gaps remain and gains made are still fragile.

RECOMMENDATIONS:

To Government of Kenya and Ministry of Health:

- The Kenyan Government would benefit from innovations leveraging on the opportunities presented by the country's economic growth to invest in health.

^{xiii} Kenya Global Fund funding Request 2017 [Available online from] http://docs.theglobalfund.org/program-documents/GF_PD_001_9844e7d2-d4c7-4903-a3c4-3bbde64b0338.zip

^{xiv} <https://www.nation.co.ke/news/Kemsa-bosses-to-explain-expiry-of-Sh1-2bn-drugs/1056-5005768-phf251z/index.html>

^{xv} PEPFAR COP19 guidance

- Include HIV and TB in the government plans/implementation of UHC.
- Address the procurement and logistical gaps in the supply of HIV and TB treatment and commodities.

To PEPFAR, Global Fund and other bilateral partners:

- Undertake transition risk assessments that are multi-stakeholder inclusive to enable clarity on securing and sustaining the gains made on the investment of the HIV/TB response so far.
- Ensure sufficient funding for essential program costs, including structural and behavioral interventions that are required to maintain effective HIV/TB programming.
- Increase funding allocation towards health systems strengthening including supply chain management.

Civil society organisations:

- Reinvigorate advocacy for increased financing for health care including ensuring HIV and TB are included in the national UHC program plans and adequately resourced by national and international funding.

HIV/AIDS data, 2018 (UNAIDS) ^{xvi}	
Prevalence (15-49 years)	4.7%
Number of PLHIV (all ages)	1,600,000
New infections (all ages)	46,000
Number of deaths (all ages)	25,000
Treatment coverage (all ages)	68%

TB data (WHO) ^{xvii}		2017
Incidence rate (per 100,00 per year, incl. HIV)		319
Incidence (number of new cases, incl. HIV)		158,000
Notified cases		85,188
Incidence (number of TB+HIV cases only)		45,000
Treatment coverage (all)		53%
Number of deaths (incl. HIV positive)		45,000
Incidence MDR/RR-TB (number of cases)		2,800

^{xvi} UNAIDS Data 2019 [Available online from] <https://www.unaids.org/en/regionscountries/countries/kenya>

^{xvii} WHO Global Tuberculosis report, 2018 <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

MALAWI

1. OVERVIEW OF SOCIOECONOMIC INDICATORS AND STATE OF THE EPIDEMICS

Malawi is one of the poorest countries in the world with a GNI per capita of USD 360 in 2018. The population is 17.5 million with 50.7% living below the poverty line and 25% living in extreme poverty.ⁱ The country's HIV epidemic is classified as high prevalence (9.2% in 2018). For the one million PLHIV, a 78% treatment coverage was achieved in 2018.ⁱⁱ

Malawi continues to progress towards achieving the 90-90-90 targets for HIV prevention, treatment and viral suppression. Of the approximately 810,000 PLHIV on ART, 69% were virally suppressed in 2018. That year marked 13,000 deaths due to AIDS and 38,000 new HIV infections.ⁱⁱⁱ

Mortality is extremely high among patients with advanced HIV. Early detection and treatment of opportunistic infections such as TB and Cryptococcal Meningitis is hampered by the inadequacy of diagnostic and therapeutic packages of care.^{iv}

From 2010 to 2017, TB incidence declined from 332 to 131/100,000 and decreased even more sharply, among PLHIV from 270 to 65/100,000. The HIV prevalence is 49% among TB patients. TB treatment coverage is approximately 68%.

In addition, the health system experiences serious challenges due to inadequate human resource availability, management and supervision at all levels.

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

Health sector allocations have increased only modestly since 2012/13. Malawi's 2018/2019 overall health allocation is 38% of the USD 521 million required. The Government allocation for health is 10% of Total Government Expenditure, (i.e. below the Abuja target).

External resources are a principal source of funding contributing 54% in 2016 with Out-Of-Pocket expenditures accounting for 11%.^{v vi}

The Global Fund and PEPFAR are the largest external funders to Malawi's HIV/TB response. The Global Fund HIV/TB allocation for the 2014-2017 period was USD 487.6 million (which in 3-year equivalent was USD 365.7 million). In addition, Malawi also received USD 37.2 million in incentive funding. The signed amount for the current three-year grant 2018-2020 amounted to USD 398.6 million.^{vii viii} PEPFAR funding has been increasing gradually every year from USD 95 million in COP 2016 USD 159 million allocated for COP19. Most PEPFAR interventions focus on eleven districts. However, a substantial series of interventions deemed relevant and of quality could remain unfunded.

3. KEY GAPS

Despite recent increases in funding, the gap in the country's resources for HIV increased from 5% in 2017 to 22% in 2019 and is expected to widen to 43% in 2021. Similarly for TB, substantial gaps are estimated to increase from 42% in 2018 to 63% in 2021.

Malawi's Global Fund 2018-2020 implementation period had by end of July 2019 a registered Unfunded Quality Demand (UQD) of USD 111 million. The shortfall in ARV supply includes USD 7.1 million needed to effectively implement rapid switching to Dolutagravir (DTG) and a gap of USD 3.9 million for point of care viral load testing as per current WHO treatment guidelines.^{ix}

Malawi's health system faces severe staffing shortages and inadequate human resource management. With significant variation among districts, in all district and central hospitals there is an average of 5.3 clinical and nursing professionals per 10,000 population -compared to the 44.5 recommended by WHO to meet SDG goals.^x Currently Global Fund and PEPFAR provide critical funding for human resources for health. PEPFAR

ⁱ The World Bank in Malawi [Available online from] <https://www.worldbank.org/en/country/malawi/overview>

ⁱⁱ UNAIDS Malawi [Available online from] <https://www.unaids.org/en/regionscountries/countries/malawi>

ⁱⁱⁱ UNAIDS 2019

^{iv} Global Fund, 2018. Malawi TB/HIV funding Request 2018-2020, at 5.

^v UNICEF Budget Brief 2018/19, at 5.

^{vi} Health Sector strategic Plan (HSSP II)

^{vii} Global Fund Allocations 2014-2016 [Available online from] https://www.theglobalfund.org/media/1376/fundingmodel_allocations2014-2016_table_en.pdf?u=637044315870000000

^{viii} Global Fund Data Explorer [Available online from] <https://data.theglobalfund.org/grants/MWI/HIV,TB%7CHIV,Tuberculosis/-/Active>

^{ix} Global Fund Register of Unfunded Quality Demand, 31 July 2019 [Available online from] https://www.theglobalfund.org/media/6578/core_20172019registerunfundedqualitydemand_tool_en.xlsx?u=637006143980000000

^x MoHP, Malawi Human Resources for Health Strategic Plan, 2018-2022, at 34-35.

supports 13,066 staff and within COP19 an additional 550 health workers will be supported in 2019/20.

Key population-focused interventions supported by PEPFAR and Global Fund, underestimate the size of some key populations and have resulted in the insufficient resourcing of related programs. For example, access to a comprehensive package of care (HIV, TB, family planning, STIs, sexual violence) is not fully covered for sex workers.

There is a reduced focus on implementation of community interventions and the ability of Civil Society Organisations (CSO) to play their role in treatment literacy, monitoring and advocacy is affected. Existing CSOs are being redirected away from HIV/AIDS and TB or closing shop.

4. CONCLUSIONS AND RECOMMENDATIONS

International donors have primarily funded the impressive results seen in Malawi's HIV and TB response. Due to budgetary and fiscal constraints at national level, that funding cannot be replaced by domestic resources in the short term without creating additional gaps or penalizing patients.^{xi} Without increased external funding to cover gaps, there is a risk of many being unable to access much needed health care.^{xii} The shortfall also jeopardizes implementation of its 90-90-90 strategy as well as new innovations needed to achieve global development goals.

RECOMMENDATIONS:

On the basis of the analysis undertaken in this study, the following recommendations are made:

For Government:

- Focus on enhancing value for money by improving efficiency and accountability in the use of available resources, including by strengthening financial management capacity.
- Seek additional funding options to bridge the existing funding gaps from international sources beyond the current Global Fund and PEPFAR allocations, such as bilateral donors in country.

- Prioritize recruitment of additional key district health personnel, including community health workers, strengthen HR management at all levels and provide adequate remuneration and retention support.

For Donors:

- Increase and sustain support toward HIV/AIDS, TB and the overall health sector in order to sustain gains made so far and guarantee progress towards national and global health targets. Current efforts to optimize Global Fund and PEPFAR allocations and obtain additional funding should be continued.
- Include resources to fill the existing gap for people with advanced HIV disease in order to mitigate HIV and TB mortality and morbidity.

For civil society:

- Strengthen advocacy targeting both government and donors for increased financing for HIV/AIDS and TB to meet the targets within the National Strategic Plan.

HIV/AIDS data, 2018 (UNAIDS^{xiii})

Prevalence (15-49 years)	9.2%
Number of PLHIV (all ages)	1,000,000
New infections (all ages)	38,000
Number of deaths (all ages)	13,000
Treatment coverage (all ages)	78%

TB data (WHO)^{xiv}

	2017
Incidence rate (per 100,00 per year, incl. HIV)	133
Incidence (number of new cases)	25,000
Notified cases	16,853
Incidence (number of TB HIV positive cases)	12,000
Treatment coverage (all)	68%
Number of deaths (incl. HIV positive)	5,700
Incidence MDR/RR-TB (number of cases)	330

^{xi} *Potential for additional government spending on HIV/AIDS in 137 low-income and middle-income countries: an economic modelling study* [Available online from] [https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018\(19\)30038-4/fulltext?dgcid=raven_jbs_etoc_email#seccetitle10](https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(19)30038-4/fulltext?dgcid=raven_jbs_etoc_email#seccetitle10)

^{xii} Malawi 2018/19 Health Budget Brief – Unicef [Available online from] <https://www.unicef.org/esa/sites/unicef.org.esa/files/2019-04/UNICEF-Malawi-2018-Health-Budget-Brief.pdf>

^{xiii} UNAIDS Data 2019 [Available online from] <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

^{xiv} WHO Global Tuberculosis report, 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf> and <https://www.who.int/tb/country/data/profiles/en/>

MOZAMBIQUE

1. OVERVIEW OF SOCIOECONOMIC INDICATORS, STATE OF THE EPIDEMICS

Mozambique is considered a low-income country with a GNI per capita of 1,220 USD and 62.9% of the population living under the poverty line. The high prevalence of HIV (12.6%) in the country is met with low coverage for treatment (50%). The incidence of TB is 551/100.000 and the treatment coverage rate is around 52%.

Mozambique still battles with an extensive HIV epidemic. Along with South Africa and Tanzania, Mozambique accounted for more than half of new HIV infections and deaths in 2017 in the region. Despite a 27.5% decrease in mortality due to HIV, over the last 10 years, HIV remains the major cause of death in the country and the second leading cause of disabilityⁱ. An estimated 2.2 million people with HIV live in Mozambique, and over 173,000 are children; 411 new infections occur each day of which 28.7% are within key populations.ⁱⁱ The country also counts one of the highest transmission rates from mother to children at 18%.ⁱⁱⁱ

Mozambique is also among the 30 countries with the highest burden of TB and fifth in terms of the HIV/TB co-infection rate which was 40% in 2017.^{iv} Despite implementing the short regimen with Bedaquiline and Delamanid for treating TB in 2018^v, the program still struggles with funding management, quantity and quality of human resources and low TB literacy in the population.

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

The Mozambique health sector is heavily subsidized by external donors - over 57%^{vi} in 2019 - through different mechanisms. Domestically, the health sector was

allocated USD 438 million in 2018, representing 8.7% of the total State Budget.^{vii}

Out-of-pocket payments are still a reality in Mozambique. It can be divided in three main categories: fees at primary health care, 'bypass' fees and fees at specialized private wards within public hospitals. The fees are currently under revision due to the development of the Health Financing Strategy policy.

PEPFAR and the Global Fund together represent around 90% of HIV funding in the country, while the government expenditure accounts for about 2.5%. Similarly, the TB programme is 95% externally funded with its main donors being Global Fund, World Bank and USAID. Government expenditure is allocated for infrastructure and human resources.

3. KEY GAPS

Among the main gaps of the current HIV and TB programmes, is a foreseeable ARV gap of around USD 70 million expected for 2020. The Global Fund is exploring the possibility of covering this gap (partly or in full) through providing additional funding, which is still pending decision. The strategy to cover the gap also includes an expectation that the government will contribute with at least USD 5 million. Gaps in laboratorial commodities amounting to at least USD 49.3million (until the end of 2020) are also worrisome. These gaps are calculated using the lower targets proposed by the government; when considering the new higher targets agreed with PEPFAR these gaps increase.

Another relevant gap is the upcoming deficits in diagnosing advanced HIV, specifically regarding CD4 tests. The funds provided in the Global Fund three-year grant are insufficient.^{viii} PEPFAR supported specific funds in 2017 and 2018 but there is no funding foreseen in the 2019 plan, which carries through to 2020.

ⁱ Institute for Health Metrics and Evaluation Database, Mozambique [Available online from] <http://www.healthdata.org/mozambique>

ⁱⁱ Plano Estratégico Nacional 2015-2019

ⁱⁱⁱ Relatório Anual HIV 2018, MISAU

^{iv} Global TB Report 2018, WHO [Available online from] https://www.who.int/tb/publications/global_report/en/

^v National guidelines set a phased implementation through the country.

^{vi} Considering the health sector budget (i.e. resources that are on-budget) 14% are externally sourced. Therefore the total amount of external resources is over 57%.

^{vii} COP 19

^{viii} GFATM Grant 2018-2020

To mitigate the impact of the decrease in financing, MoH started to rationalize the use of CD4 tests. Unfortunately, even with limiting the CD4 analyses to new people on treatment and, to care for people with symptoms of advanced HIV, it still represents more than 300,000 analyses per year the MoH cannot afford. Moreover, MSF already gap fill in the health centers it supports.

Further gaps encompass funds that enable implementation of national strategies, such as for the supply chain and the health workforce.

4. CONCLUSIONS AND RECOMMENDATIONS

The country is completely dependent on external finance from Global Fund and PEPFAR for its HIV response and, primarily, the Global Fund for TB. This concentration of funding is becoming a significant risk in light of reductions in donor funding. The decrease is already showing an impact with the reduction of partner presence at health facilities, besides the gaps in laboratory reagents and risk of ARV gaps. Beyond this, the Government domestic resources relative to health expenditure is stagnating. Moreover, it seems there is currently no interest from other donors to support the HIV/TB response in Mozambique.

Currently, the shift of the PEPFAR 2019 budget to retention in care means less investment on testing activities and consequentially less identification of new cases. This means fewer inclusions to treatment despite efforts to scale up Test & Start. Implementing partners already report reluctance to start new treatments because their resources must be all allocated to retention in care. The foreseen ARV gaps, if not covered, will potentially have a significant impact on the retention in care of already untrusting patients.

The amount of money is not the only issue the country faces in the HIV and TB responses. Other challenges, already acknowledged by MoH and donors, include issues of supply chain delays due to burdensome bureaucracy, weakness of monitoring and evaluation tools, quality of care and governance. However, all those will be worsened without proper investment in the response in a country that has one of the highest HIV prevalence rates in the world.

RECOMMENDATIONS:

- It is crucial that government and donors together enable a proper response including the provision of ARVs and other commodities in order to mitigate foreseen gaps for 2019/2020.
- The HIV/TB response should be supported by more diverse financing mechanisms. This is needed due to its high level of dependency, to avoid dangerous volatility influencing its capacity to handle the epidemic.
- The increase of domestic funds announced by the government, namely the USD 10 million allocated for the HIV program, should not be seen as a start for transitioning to domestic funding. A continuous commitment from donors is essential – especially PEPFAR and Global Fund – in supporting Mozambique to respond to HIV/TB epidemics.
- Donors' shift in focus to retention in care cannot be at the expense of testing and initiation activities that are essential to reach 90-90-90 targets, especially activities related to key populations.
- Point Of Care testing, including CD4 counts, is imperative to properly detect advanced HIV and tackle the high rates of HIV and TB mortality in the country.

HIV/AIDS data, 2018 (UNAIDS)^{ix}

Prevalence (15-49 years)	12.6% ^x
Number of PLHIV (all ages)	2,200,000
New infections (all ages)	150,000
Number of deaths (all ages)	54,000
Treatment coverage (all ages)	56%

TB data (WHO)^{xi}

	2017
Incidence rate (per 100,00 per year, incl. HIV)	551
Incidence (number of new cases, incl. HIV)	163,000
Notified cases	86,515
Incidence (number of TB+HIV cases only)	66,000
Treatment coverage (all)	52%
Number of deaths (incl. HIV positive)	49,000
Incidence MDR/RR-TB (number of cases)	8,800

^{ix} UNAIDS Data 2019 [Available online from] <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

^x According to the Imasida survey from 2015, prevalence was estimated at 13.2%

^{xi} WHO Global Tuberculosis report, 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

MYANMAR

1. OVERVIEW OF SOCIOECONOMIC INDICATORS AND STATE OF THE EPIDEMICS

Myanmar is classified as a lower middle-income country with GDP per capita at \$1,489 in 2017.ⁱ However, the World Bank estimated that 32% of people lived below the extreme poverty line of \$1.9 in 2015 when the population was 52.4 million.ⁱⁱ

With one of the highest HIV prevalence in the region, UNAIDS has listed Myanmar as a fast-track country with a severe epidemic.ⁱⁱⁱ The general HIV prevalence in adults aged 15 to 49 stabilized in the last 5 to 10 years between 0.6 to 0.9% (0.7%^{iv} or 0.8%^v). However, a high incidence of HIV cases continues. The group most affected by HIV is the people who inject drugs, largely due to drugs farmed, manufactured and distributed in the north of the country.^{vi}

Myanmar is double ranked as among the 30 highest TB and MDR-TB burden countries.^{vii} TB prevalence is twice the regional average and three times the global average, at an estimated 191,000 people (361 cases/100,000 people) with TB in 2016, approximately 25,000 (47/100,000) died from the disease (not including HIV patients), an MDR-TB incidence of 5.1% among new cases and 27% among retreatment cases. A recent prevalence survey presented in April 2019 reveals a disturbing shift in the TB epidemic to the elderly and a worrying high prevalence in Yangon.^{viii}

Also notable is the rising trend in Hepatitis C transmission with an estimated seroprevalence of 2.7% in the population, or 1.3 million infected patients, according to a 2015 survey.^{ix}

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

Total health expenditure in Myanmar (2.3% of GDP per capita)^x is among the lowest in Southeast Asia and Western Pacific. Out-of-pocket payments by households still make up 80% of total health spending.

Myanmar received far less aid per capita in recent years compared to other Least Developed Countries. Nevertheless, Myanmar relies heavily on external resources to finance its HIV response (85% of total funding). Of this, the Global Fund provides 50%, followed by MSF-Holland, which provided 17% of financing in 2015.^{xi} The Access to Health Fund (AtH) committed USD 215 million for 2019-2023, provided through a pooled funding mechanism managed by the United Nations Office for Project Services.^{xii}

Channelled through the budget of the National AIDS Programme and health systems, public sector spending increased from USD 3.6 million in 2014 (5% of total HIV spending) to USD 15 million in 2016 (17% of total HIV spending). The bulk of domestic funding goes to ARV procurement at around USD 15 million, with another USD 2 million, shifting support from DRTB to DSTB drugs.

3. KEY GAPS

Historically, the private not-for-profit sector, through international and local NGOs, has played a key role in service delivery. Focused on the development of sustainable partnerships, the National Strategic Plan (NSP III 2016-2020) calls on the public and private sector, and communities to jointly design, deliver, monitor and evaluate services. Resources needed are estimated at USD 460 million.

The projected HIV funding gap is USD 150 million.^{xiii} Non-Global Fund resources available in 2017-2020 (~USD 98.6 million) and new Global Fund contributions (~USD 200 million)^{xiv} are clearly insufficient to meet the projected funding needs of the NSP.^{xv} The estimated

ⁱ <https://www.worldometers.info/gdp/myanmar-gdp/>

ⁱⁱ <http://documents.worldbank.org/curated/en/829581512375610375/pdf/121822-REVISED-PovertyReportPartEng.pdf>, p. 4.

ⁱⁱⁱ <http://www.unaids.org/en/regionscountries/countries/myanmar>

^{iv} <http://www.unaids.org/en/regionscountries/countries/myanmar>

^v <http://apps.who.int/gho/data/node.country.country-MMR>

^{vi} <https://www.avert.org/professionals/hiv-around-world/asia-pacific/myanmar>

^{vii} <http://www.endtb.org/myanmar>

^{viii} Results of Nationwide TB Prevalence Survey Myanmar, Dr. Si Thu Aung, Director (Disease Control), Department of Public Health, October 2017-September 2018.

^{ix} Myanmar Oxford Clinical Research Unit. Hepatitis C Treatment Study in Myanmar, updated June, 2018. Link.

^x <https://www.who.int/countries/mmr/en/>

^{xi} National Strategic Plan on HIV and AIDS, Myanmar, 2016-2020 (NSP III), p. 22

^{xii} https://www.3mdg.org/sites/3mdg.org/files/publication_docs/20180704_a2f_cfp_presentation.pdf

^{xiii} NSP III, Ibid., p. 116

^{xiv} NSP III, Ibid., p. 117

^{xv} Global Fund Myanmar TB and HIV Concept Note, June 2016 p.31, [Available online from] <https://www.theglobalfund.org/en/portfolio/country/?loc=MMR&k=b3d59122-9d71-4df9-ae0e-9e4b1b315de8>

amount represents a 33% funding gap, significantly higher than the 10% for the previous period.

Total budget requirement for the TB response, as costed in the NSP III, is nearly USD 308 million. The estimated funding gap is USD 100.5 million, considering Global Fund input and the expected flatlining/reductions of other international donor contributions.^{xvi}

While multiple gaps plague the system, as underreporting of vulnerable populations due to TB cases among migrants, human rights barriers and gender inequalities, a main challenge facing the HIV/TB programs is human resource. Strengthening the community-based health work force is crucial for ensuring equity and access to basic health care.^{xvii} Insufficiency exists in all cadres and available resources are concentrated in urban settings, making decentralization difficult to implement.^{xviii} Low salaries and lack of incentives in the public sector make it especially challenging to recruit staff for remote locations much less to retain them.

The Myanmar government recognizes its role and responsibility in ensuring quality health services are made accessible to all without imposing financial hardship. The National Health Plan (NHP) is the expression of the government's strong commitment to accelerating progress towards Universal Health Coverage (UHC).

4. CONCLUSIONS AND RECOMMENDATIONS

The great ambitions in the NHP for the public sector to take over all HIV patients should translate into tangible outcomes. Major donors must acknowledge that by withdrawing funding too rapidly, the risk is in losing the great achievements already made and limit further progress needed to reach the HIV and TB targets.

RECOMMENDATIONS:

For international donors:

- To take a phased and prudent approach in the transition to domestic financing, to mitigate the risk of backtracking on public health gains achieved in the last decade and on not achieving UHC by 2030. To support the Health Ministry's efforts to negotiate within their own government for increased contribution of the GDP to health.

^{xvi} Global Fund, June 2016, Ibid., p.37

^{xvii} Global Fund, June 2016, Ibid., p.14

^{xviii} Programme of Health Reforms: A Roadmap towards Universal Health Care in Myanmar (2016-2030), version 1.0, p. 18

- To share and expand on NGO's comparative advantages as technical and agile partners.

For the Ministry of Health and Sports:

- To continue the drive to improve the health system and increase funding commitment, as investing more in human resource.
- To trust in evidence-based data and adapt new and innovative models of care.
- To continue investing in local actors, as Ethnic Health Organisations (EHO), and strengthening the community-based health work force, crucial for ensuring equity and access to basic health care services at the grass-root level.
- To help address critical public health emergencies, as in key populations (considered a high-level HIV epidemic^{xix}) or the urban TB/DRTB epidemic, especially with already identified pre-XDRTB and XRDTB cases.

HIV/AIDS data, 2018 (UNAIDS) ^{xx}	
Prevalence (15-49 years)	0.8%
Number of PLHIV (all ages)	240,000
New infections (all ages)	11,000
Number of deaths (all ages)	7,800
Treatment coverage (all ages)	71%

TB data (WHO) ^{xxi}	
	2017
Incidence rate (per 100,00 per year)	358
Incidence (number of new cases, incl. HIV)	191,000
Notified cases	132,025
Incidence ((number of HIV+TB cases only)	17,000
Treatment coverage (all)	68%
Incidence MDR/RR-TB (number of new cases)	14,000

^{xix} Public health threshold for the high-level HIV epidemic is considered as HIV prevalence =>1% among general population.

^{xx} UNAIDS Data 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf, p 184

^{xxi} WHO Global Tuberculosis report, 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>, p 194
**NB: A recent TB prevalence survey, carried out from 2017 to 2018 reveals a significant reduction in TB prevalence in States, although TB burden remains high. In attendance of the official publication of results, the 2017 WHO data has been used for this report. Results of Nationwide TB Prevalence Survey Myanmar, Dr. Si Thu Aung, Director (Disease Control), Department of Public Health, October 2017-September 2018.*

ZIMBABWE

1. OVERVIEW OF SOCIOECONOMIC INDICATORS, AND STATE OF THE EPIDEMICS

Zimbabwe is ranked 156 out of 189 countries in the Human Development Index. With a GNI per capita of USD 1,790, Zimbabwe is, as of July 2019, reclassified by the World Bank as a lower middle-income country.ⁱ However, the current financial decline, fuelled by a currency crisis, means the country's economic reality is rapidly changing. In 2018, Zimbabwe recorded a government budget deficit equal to 11.1% of the country's GDP.ⁱⁱ

Zimbabwe was one of the countries hardest hit by HIV/AIDS in the 1980/90s. Prevalence rates peaked at 25%,ⁱⁱⁱ and are now reduced to 12.7%.^{iv} HIV still remains the biggest health challenge and the top cause of death.^v Zimbabwe is often referred to as a success story in its HIV response, acknowledged as one of the most progressive early-adopters of innovative health delivery models. Zimbabwe's aims to eliminate AIDS by 2030 and is on track to achieve the UNAIDS 90-90-90 targets while also seeking to reach 95-95-95 by 2020.

In the country, 1.3 million people are living with HIV/AIDS and 88% are on treatment. Despite these achievements, issues of quality and retention in care persist. Young women aged 20-24 have HIV prevalence rates 2.78 times greater than their male peers. HIV represents the first cause of mortality among adolescents, with high rates of late presentation to care, higher ART attrition and lower viral suppression.^{vi} HIV sub-epidemics amongst key populations include female sex workers (prevalence is 57.1%) and men who have sex with men (prevalence is 23%).^{vii}

Zimbabwe has made considerable progress in its TB response with incidence and mortality rates dropping by nearly 60 and 50 % respectively over the last ten years^{viii} in large part, due to increased investment in TB diagnosis and treatment, TB/HIV collaboration and

scale up of ART. Even so, TB incidence is still high at 221/100,000^{ix}, the rate of DR-TB cases detected is increasing,^x and Zimbabwe remains among the world's top 30 TB burden countries, making intensified TB case finding a top priority. Additionally, the country is facing a double burden of disease. Non-Communicable Diseases (NCDs), many of which are associated with HIV, are emerging as a major cause of morbidity and mortality (estimated to account for 31% of total deaths in the country).^{xi}

2. FUNDING FLOWS (DOMESTIC AND INTERNATIONAL)

Zimbabwe remains highly donor-dependent, particularly for HIV and TB, with 80% of its HIV funding coming from external donors. Global Fund and PEPFAR provide the majority (97%) of the external HIV funding. This leaves the national HIV response extremely vulnerable to changes in key donors' priorities and contributions. Recently the two main donors reduced their combined allocations for 2017 to 2019 from USD 247 million to USD 217 million.^{xii} In 2019, 61% of HIV funding was earmarked for drugs and medical supplies (9% increase from the year before). Only 15% is allocated for prevention and 11% for health systems strengthening. The overall HIV-funding gap for 2019 is estimated at USD 188 million.^{xiii}

TB funding has also been decreasing over the last 3 years —from a total of USD 22 million in 2017, to USD 15 million in both 2018 and 2019. Most TB costs are allocated toward drugs, supply chain management and infrastructure/equipment. The TB funding gap for 2018 is estimated at USD 23 million.

The overall health system in Zimbabwe is suffering from the impact of critical funding gaps, estimated at USD 318 million in 2019. While the government acknowledges the need to develop sustainable, health-financing models, the main plank of its vision, a National Health Insurance Scheme, appears more

ⁱ <https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2019-2020>

ⁱⁱ Page 4, NHS, 2016-2020

ⁱⁱⁱ Zimstat 2013

^{iv} UNAIDS Data 2019 [Available online from] https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

^v Institute for Health Metrics and Evaluation (IHME). Zimbabwe profile, 2018. [Available online from] <http://www.healthdata.org/Zimbabwe>

^{vi} MSF Zimbabwe Country Policy Paper, 2018

^{vii} Global Fund HIV/TB Funding Request 2017

^{viii} Global Fund 2017 funding request

^{ix} WHO Global Tuberculosis report, 2018 [Available online from] <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

^x Stop TB Partnership Country dashboard [Available online from] http://www.stoptb.org/resources/cd/ZWE_Dashboard.html

^{xi} World Development Indicators 2012, cited in NHS, page 23

^{xii} Health Sector Resource Mapping Report, MoHCC, 2018

^{xiii} Resource mapping Round 4 and National Health Strategy gap analysis, MoHCC, 2019

like a long-term concept than an immediate solution for the country's constrained fiscal situation.

3. KEY GAPS

The HIV funding gaps are numerous, with implications ranging from too little investment in prevention to inadequate clinical support for patients with treatment failure and those with advanced HIV. Out of pocket payments for PLHIV exacerbate loss to follow up and poor adherence rates. Other gaps identified include the availability of ARVs and essential commodities like condoms, laboratory support, viral load monitoring systems and support for community-based organisations that play a critical role in offering treatment preparedness, peer support and linkages between the facility and the community. Out of the just over 1 million on treatment, Global Fund provides ARVs for 710,000 people, PEPFAR for 225,000 and 100,000 are supported under the national "AIDS Levy", leaving an estimated gap in 2019 of 53,000 people. The devaluation of the local currency introduced is affecting the country's ability to procure ARVs from international drug manufacturers, and thus its ability to bear its share of the ARV procurement agreement.

The major gaps for TB relate to drugs and medical supplies. WHO also identifies TB prevention gaps including infection prevention control in facilities. The scaling up of preventative TB therapy is still required because coverage still very low for children under-five and PLHIV. While Zimbabwe is at 70% treatment coverage for TB, finding the remaining 30% is challenging and according to the WHO, more investment, particularly for community screening, is needed. Major gaps are also opening up for NCDs, with only a fraction of the costed national NCD plan being funded.^{xiv}

4. CONCLUSIONS AND RECOMMENDATIONS

Zimbabwe is at a critical juncture. While funding from external donors is not increasing, the number of people requiring treatment is growing. The country's commitment to ensuring treatment for all is unwavering, but the financial burden of ensuring life-long treatment for PLHIV is beyond the country's financial capacity. Looking at the available resources, funding is seen as increasingly skewed towards commodities which are far from fully covered, while other critical elements such as prevention, community-based support, treatment literacy, quality of care, retention, advanced HIV care, laboratory

services and the management of co-morbidities, remain underfunded.

The financial crisis in Zimbabwe is acute and is having a profound effect on the functioning of the health system. Zimbabwe cannot be expected to function in a 'business as usual' situation. Yet, the country is confronted with contradicting influences, with donors strongly pushing it to hit its elimination targets as quickly as possible, while hesitating to increase their financial commitments in the face of a growing cohort and an economy in tatters.

RECOMMENDATIONS:

- Both donors, the government and other stakeholders should ensure optimal use of available resources, and promote a more patient focused care that takes integration of HIV/TB/NCD into account.
- For donors to recognize current limitations and to support efforts towards medium-term increased domestic financing for health, while ensuring continued and reinforced financial support to HIV and TB services during the current economic crisis - and to desist from over-optimistic expectations around 'transitioning'.

HIV/AIDS data, 2018 (UNAIDS)^{xv}

Prevalence (15-49 years)	12.7%
Number of PLHIV (all ages)	1,300,000
New infections (all ages)	38,000
Number of deaths (all ages)	22,000
Treatment coverage (all ages)	88%

TB data (WHO)^{xvi}

	2017
Incidence rate (per 100,00 per year, incl. HIV)	221
Incidence (number of new cases, incl. HIV)	37,000
Incidence (number of TB+HIV cases only)	26,401
Incidence (number of TB HIV positive cases)	23,000
Treatment coverage (all)	71%
Number of deaths (incl. HIV positive)	8,300
Incidence MDR/RR-TB (number of cases)	2,300

^{xiv} Main report on the costing of the Zimbabwe National Health Strategy 2016-2020, MoHCC, 20166

^{xv} UNAIDS Data 2019 [Available online from] <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data>

^{xvi} WHO Global Tuberculosis report, 2018, page 230 <http://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf>

MSF OPERATIONS IN THE NINE COUNTRIES

INFORMATION BASED ON MSF INTERNATIONAL ACTIVITY REPORT 2018ⁱ

Central African Republic

MSF is working in CAR since 1997, running projects for local and displaced communities in eight provinces and in the capital, Bangui, providing primary and emergency care, maternal and paediatric services, trauma surgery and treatment for malaria, HIV and tuberculosis (TB). HIV/AIDS is a leading cause of death among adults in CAR. To mitigate the daily challenges of living with HIV, MSF supports patients in Bossangoa, Boguila, Kabo, Zemio and Batangafo to form community-based groups so they can take turns to pick up each other's antiretroviral medication at health facilities. In Carnot, where we provided care to 1,775 people living with HIV in 2018 (including children cohort), we continue to work on decentralising HIV/AIDS treatment. In Bangui, MSF is providing PMTCT services within the SRH programme to pregnant women and newborns.

Democratic Republic of Congo

Apart from the support to the ongoing Ebola and measles emergency responses, MSF runs 54 medical projects across DRC. Services range from basic healthcare to nutrition, paediatrics, treatment for victims of sexual violence and care for people living with HIV/AIDS. MSF is running a major HIV/AIDS program at the Centre Hospitalier de Kabinda in Kinshasa, where we provided care for more than 2,500 people, including patients with advanced HIV. MSF teams support the HIV/AIDS activities of two other hospitals in Kinshasa, and run HIV-mentoring programmes in three of the city's

health centres. MSF also provides technical and financial support to health facilities in Goma, Mweso Walikale, Fizi and Kimbi-Lulenge, to improve the provision of HIV care and increase access to antiretroviral treatment.

Eswatini

MSF has been working in Eswatini since 2007. In Manzini and Shiselweni regions, our teams offer community-based testing for HIV and TB, oral HIV self-testing for hard-to-reach groups and provide specialised, integrated care for people living with HIV, including second- and third-line ARV therapy for those whose previous treatment has failed to work, and point-of-care screening and treatment for other diseases, such as cervical cancer, drug-resistant TB and cryptococcal meningitis. In 2018, MSF managed 6,230 people on first line ART; 610 people on second and third line ART; and 580 people started on treatment for TB including 100 for DR-TB.

Guinea

In the capital, Conakry, MSF runs testing, treatment and follow-up services for stable HIV patients through eight health centres, and provides specialized care for AIDS patients in Donka hospital. One program enables stable patients to get drug refills and check-ups every six months rather than monthly, to mitigate stigma and improve adherence to treatment. More than 12,500 PLHIV are benefiting from the support of MSF in Guinea. In Kouroussa, in the northeast, MSF runs a child health program

ⁱ MSF International Activity Report 2018.
[Available online from]
<https://www.msf.org/international-activity-report-2018>

since 2017, providing staff and logistical support to the provincial hospital as well as supporting care at community level through 120 specially trained community volunteers, which serve a population of 315,000. MSF also provide emergency response, such as support to epidemic outbreak (including the ongoing measles vaccination in Conakry). MSF is present in the country since 1984.

Kenya

In Kenya, MSF provides a wide range of services including HIV care in Homa Bay (with a focus on treatment failure, advanced HIV and programmes for adolescents); vital obstetric care in Mombasa; health services for people who use drugs in Kiambu; and comprehensive healthcare to over 70,000 refugees living in Dagahaley camp in Dadaab and the local community. We also mentor Ministry of Health staff in Embu county to improve the management of NCDs in primary healthcare facilities; assist victims of violence in Nairobi; and continue to respond to disease outbreaks and emergencies. MSF has been present in the country since 1987.

Malawi

In Malawi, Médecins Sans Frontières is working to reduce mortality from HIV and TB by facilitating earlier treatment and more advanced care. We target particularly vulnerable people as people living in remote rural areas with limited access to health care, sex workers and prisoners. In Nsanje district, we support the severely underfunded district management team in running a decentralized HIV and tuberculosis (TB) program. MSF has worked in the country since 1986, providing HIV and TB services, as well as natural disaster response.

Mozambique

MSF has been present in the country since 1984. In 2018, after 16 years of activities, our teams handed the HIV project in Tete to the Ministry of Health. Current activities aim at improving the detection and rapid treatment of opportunistic infections among people with

advanced HIV in both Maputo and Beira. In the capital, MSF teams also offer drug-resistant TB (DR-TB) care with 160 patients who were started on treatment in six health centres; run a pilot project to prevent mother-to-child transmission of hepatitis B in one of the biggest hospitals; and partnered with a local organisation to open a drop-in centre for people who use drugs and implement harm reduction approach. In Beira, we offer SRH services for key populations as well as for girls and women (including safe abortion). In Cabo Delgado, MSF is providing access to health care, and improved water and sanitation for people affected by the recent cyclone and the violence.

Myanmar

MSF has been working in Myanmar since 1992 and is currently providing healthcare in Kachin, Rakhine and Shan states, as well as Yangon, Sagaing and Thanintharyi regions. Over 1,100 international and national staff work closely together to provide high-quality care and treatment through a network of health centres, health posts and mobile clinics to provide care for HIV/AIDs, TB/DR-TB, Malaria, Primary Health and Emergency Response. MSF is one of the largest HIV providers in the country. In 2018, MSF managed 55,500 outpatient consultations; 20,500 people on first-line ART; 770 people started on TB treatment; and 110 people treated for Hepatitis C.

Zimbabwe

MSF has been present in Zimbabwe since 2000. We provide care in several rural areas to people living with HIV, TB, Cervical Cancer and NCDs. In Beitbridge, we run primary healthcare services for migrants and in Harare there is an Adolescent Sexual Reproductive Health program. Beyond having an Environmental health project with focus on groundwater, in 2018 our teams also supported the health ministry to respond to numerous outbreaks of water-borne diseases across the country, including the second-biggest cholera outbreak in its history.

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**For more information on MSF
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www.msf.org

