



MSF BRIEFING PAPER

BRIDGING THE GAPS

**THE NEGLECTED PANDEMICS:
HIV/AIDS, TUBERCULOSIS
AND MALARIA**





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CONTEXT BACKGROUND

In 2019, MSF released a report based on what our teams were witnessing in several countries which illustrated the risks and shortcomings of HIV and tuberculosis (TB) service delivery and gave a reality check on the financial resources available for these diseases worldwide.¹ Not only did the findings highlight gaps in diagnosis, prevention and care services, but it underlined the impact of dwindling international resources, increasingly pushing the burden to tackle HIV and TB prematurely onto the shoulders of countries scrambling to mobilize sufficient resources.

Three years later, as the world will convene in September 2022 in New York for the replenishment of the Global Fund (GF) to Fight HIV/AIDS, tuberculosis and malaria, one of the main program funders of the fight against the three killer diseases since two decades, **the situation has not improved.** Worse still, against the backdrop of the Covid-19 pandemic combined with escalating social and economic crises, the fight against HIV/AIDS, TB and malaria **has lost ground and is slipping backwards.**

The GF reported that in 2020, for the first time in a decade, there was a rolling back of gains made in all three diseases, with targets missed to keep the world on track to reach the 2030 Global Goals.²

People affected by TB were particularly hard hit with increased mortality and morbidity and a clear rolling back of previous gains made. TB deaths increased from 1.2 million in 2019 to 1.3 million in 2020, back to 2017 levels in spite of it being a preventable and curable disease. An estimated 10 million people fell ill with the disease worldwide in 2020, including 1.1 million children.³

¹ See MSF, *Burden sharing or burden shifting? How the HIV/TB response is being derailed*, 2019. [Available online from] *Burden sharing or burden shifting* | MSF

² The Global Goals are a set of 17 commitments made by 193 world leaders, to end extreme poverty, inequality, and climate change by 2030, including goal 3 on good health and well-being. For more information, see: <https://www.globalgoals.org/>

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The overall number of people treated for TB fell by over one million. Multidrug-resistant TB (MDR-TB) remains a public health crisis. Only about one in three people with drug resistant TB accessed treatment in 2020.⁴ In places covered by the GF, the number of people treated for the resistant form of the disease dropped by 19%, while treatment for people with extensively drug-resistant TB fell by 37%. While the number of HIV-positive TB patients on both antiretroviral therapy and TB treatment dropped by 16%.⁵

Although the estimated number of deaths due to HIV continued to slightly decline, the world missed every global HIV target in 2020. In line with the concerns, UNAIDS gave its Global AIDS Update 2022 the title: 'In Danger!'

Prevention services were hardest hit: HIV testing fell by 22%, prevention services by 11%, and medical male circumcision down 27%.⁶ UNAIDS reported that in 2021 out of an estimated 38.4 million people living with HIV (PLHIV), 9.56 million (10 million in 2020) were still not on antiretroviral treatment (ART), with 1.5 million new infections in 2021 (same as in 2020) and around 650,000 deaths from AIDS-related illnesses (limited reduction from 680,000 deaths in 2020).^{7,8}

⁴ WHO, *Key facts Tuberculosis*, October 2021. [Available online from] <https://www.who.int/news-room/fact-sheets/detail/tuberculosis>

⁵ The Global Fund to fight AIDS, Tuberculosis and Malaria, *Fight for What Counts: People and Impact*, Investment Case for the 7th replenishment, 2022. [Available online from] [publication_seventh-replenishment-investment-case_report_en.pdf](https://www.globalfund.org/publication_seventh-replenishment-investment-case_report_en.pdf) (theglobalfund.org)

⁶ *Ibid.*

⁷ UNAIDS data 2021, [Available online from] https://www.unaids.org/sites/default/files/media_asset/JC3032_AIDS_Data_book_2021_En.pdf

⁸ UNAIDS Factsheet 2022. *Global HIV statistics*. July 2022. [Available online from] https://www.unaids.org/en/resources/documents/2022/UNAIDS_FactSheet

Progress on HIV prevention of mother to child transmission (PMTCT) has slowed since 2016, with 9 in 10 pediatric HIV infections occurring in Sub-Saharan Africa in 2020.⁹ Almost a third of people entering care in low- and middle-income settings have advanced HIV disease (AHD¹⁰), because they accessed HIV testing and treatment too late, or due to treatment interruption or failure.¹¹

Some neglected contexts and population groups have seen an increase in HIV incidence and mortality, as is the case in the Eastern Europe and Central Asia region (where between 2010 and 2020 new infections rose by 43% and AIDS related deaths by 32%). In the Middle East and North Africa region, new infections increased by 7% over the same period.¹² West and Central Africa (WCA), a region that has long been left behind in the fight against HIV and TB compared to other parts of the continent¹³, saw HIV infections decreased by 37%, but this is still far from the target of 75% agreed by the UN Assembly in 2016. Globally, in 2020, a third of all new infections among children were from WCA, with only 24% of children living with HIV having suppressed viral loads, while 44% of seropositive pregnant women in WCA were not receiving antiretroviral therapy.¹⁴

Moreover, in areas with new or ongoing conflict, people with TB or PLHIV face interruptions of treatment, due to inaccessible care, drugs stock-outs or displacement. Without measures to rapidly re-start treatment, the risk significantly increases for mortality and deterioration of their health status.

⁹ UNICEF, *Elimination of mother-to-child transmission*, July 2021. [Available online from] <https://data.unicef.org/topic/hivaids/emtct/>

¹⁰ WHO defines Advanced HIV Disease (AHD) as patients with a CD4 cell count below 200 cells/mm3, or a clinical stage 3 or 4, or all children under the age of 5 years at the presentation of care. For more information, see WHO's *Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy*, WHO, July 2017 [Available online from] <https://www.who.int/publications/i/item/9789241550062>

¹¹ *Ibid.*

¹² UNAIDS data 2021. *Op.Cit.* https://www.unaids.org/sites/default/files/media_asset/JC3032_AIDS_Data_book_2021_En.pdf

¹³ For more information on that point, see MSF report: *Out of Focus: How millions of people in West and Central Africa are being left out of the global HIV response*, 2016 https://www.msf.org.za/news-and-resources/publications/out-focus-report-hiv-west-and-central-africadocuments/2022/UNAIDS_FactSheet

¹⁴ UNAIDS data 2021. *Op.Cit.*

Case incidence for malaria (i.e. cases per 1000 population at risk), which had been reduced from 81 in 2000 to 56 in 2019, increased to 2015 levels at 59 in 2020. This increase is mainly related to the disruption of services due to the Covid-19 pandemic. Testing for malaria fell by 4%, yet some 241 million people were estimated to be infected in 2020, increasing from 227 million the year before. Sub-Saharan Africa still bears the brunt of the malaria pandemic, with 95% of all cases. Estimated deaths linked to malaria worldwide increased by 12% in comparison with 2019, to approximately 627,000, while it is estimated that a child dies every minute because of the mosquito-borne parasite.^{15, 16}



This grim reality is occurring in a world where humanitarian needs and request for aid have reached unprecedented levels. The UN's Economic and Social Council Humanitarian Affairs Segment held in June 2022 estimated that 300 million people are currently in need of humanitarian assistance, a 42% increase since before Covid-19. The collective humanitarian ask is reaching 46 billion US dollars in aid.¹⁷

This is concerning because, as needs are rising and political and moral commitments to people affected by HIV, TB and malaria are yet to be met, **funding is flatlining.**

While humanitarian assistance had been growing by an average of 12% per year between 2012 and 2018, it has maintained a plateau at around US\$ 31 billion since 2019. Support for non-Covid-19 humanitarian needs fell, with key donors such as the UK abandoning its commitment to 0.7% gross national income for aid¹⁸ and resulting in local partners receiving only 1.2% of needed assistance (and non-earmarked funding to UN agencies falling to 13%, the lowest in six years).^{19, 20}

Exacerbated by the Covid-19 pandemic, donor fatigue as well as competing priorities at national and international levels has contributed to this trend. But as highlighted by Stop TB Partnership, Roll Back Malaria, UNAIDS and the GF, the human, social and economic costs of prolonging the fight against HIV, TB and malaria far outweigh the additional investments needed. Stop TB partnership recently calculated that if the status quo is maintained, TB will continue to kill between 4,000-5,000 people daily, an additional 43 million people will develop TB and the cost in human life and disability would translate into a global economic loss of US\$ 1 trillion over eight years (2023-2030).²¹

¹⁵ WHO, *World malaria report 2021*, <https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2021>

¹⁶ Global Fund, *Results Report 2021*. September 2021. [Available online from] <https://www.theglobalfund.org/en/news/2021/2021-09-08-global-fund-results-report-reveals-covid-19-devastating-impact-on-hiv-tb-and-malaria-programs/#:~:text=In%202020%2C%2011.5%20million%20pregnant,prevented%20an%20even%20worse%20outcome.>

¹⁷ The New Humanitarian, *Needs rise as aid funding flatlines, again*, 24 June 2022. [Available online from] The New Humanitarian | Taliban quake response, Amhara massacre, and South Asia's monsoon-hit millions: The Cheat Sheet

¹⁸ BOND, *UK aid cut to 0.5%: billions diverted from world's most marginalised*, November 2020. [Available online from] UK aid cut to 0.5%: billions diverted from world's most marginalised | Bond

¹⁹ Development Initiatives, *Global Humanitarian Assistance: Report 2021*. [Available online from] Global Humanitarian Assistance Report 2021 (devinit.org)

²⁰ The New Humanitarian, *Needs rise as aid funding flatlines, again*. Op. Cit.

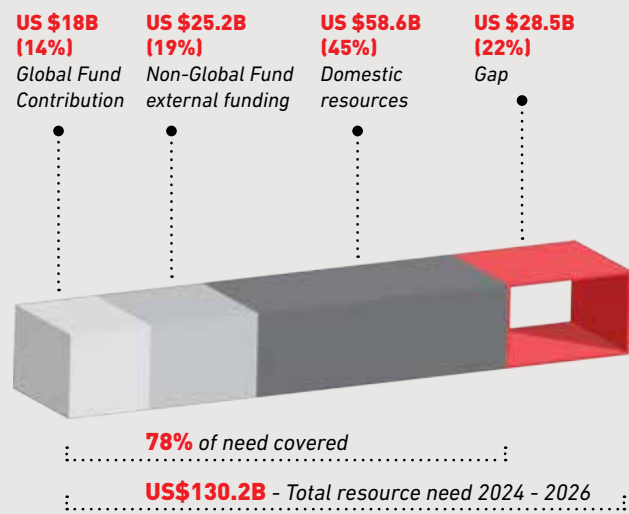
²¹ Stop TB Partnership, *Global Plan to End TB 2023-2030*. [Available online from] Global Plan to End TB 2023-2030 | Stop TB Partnership

A failure to step up investments in fighting the three pandemics translates into abandoning the globally endorsed goals needed to reach Universal Health Coverage (UHC) and the health-related Global Goals by 2030²². Knowing that the Global Fund partnerships have succeeded in cutting the combined death rate from all three diseases by more than half over the past two decades²³, **collectively, we cannot allow that to happen.**

The estimated total resources needed for HIV, TB and malaria for 2024-2026 amount to US\$ 130.2 billion in countries where the Global Fund invests.²⁴ The Global Fund is seeking to raise minimum US\$ 18 billion in 2022, for its 7th replenishment which will cover the 2024-2026 implementation period (see Figure 1). This equates to 14% of overall needs (an increase from US\$14 billion to US\$18 billion) and maintains the GF's contribution ratio of the last replenishment. The contribution by recipient countries (or domestic resource mobilization) is expected to reach 45% of the global needs (i.e. US\$ 58.6 billion), with 19% coming from other international donors (a 4% decrease from 2019). Domestic funding was predicted to increase by 37% in the 2018-2020 implementation cycle, and by 33% in the current one. Acknowledging the challenges faced by many countries, not least the ongoing Covid-19 response and competing health priorities, this may be overly optimistic, particularly given present world economic trends.

Civil society estimated that the present ask from the Global Fund fell short by US\$10 billion. This is reflected in the overall unfunded gap of 28.5 billion or 22% which rose by 4% and translates into uncovered needs, necessary to achieve the Global Goals by 2030 (see Table 1). At present there is little indication as to how this considerable gap will be filled in 2024-2026.

Figure 1: Overall resources needs and projected available resources for HIV, TB and Malaria in countries where the Global Fund invests



Source: The Global Fund to fight AIDS, Tuberculosis and Malaria, *Fight for What Counts: People and Impact*, Investment Case for the 7th replenishment, 2022. <https://www.theglobalfund.org/en/fight-for-what-counts/>

With only 8 years remaining before the 2030 deadline, it seems evident that the US\$18 billion ask by the Global Fund is a minimum commitment from governments and funders. Millions of patients rely on these lifesaving preventive and curative interventions, with dangerous gaps as illustrated in the country examples used throughout the document. There is a small window of opportunity to reverse the downward trends in the global fight against these pandemics, which disproportionately affects the most vulnerable. **It is time to act and bridge the gaps before it's too late.**

Table 1: Overview of the Global Fund Investment Cases for 5th, 6th and 7th replenishments

	Need in Global Fund eligible countries (billion)	Global Fund "minimum" Ask (billion)	Minimum Ask as a % of total need	Unfunded gap (billion)	Unfunded gap (% of need)
7th replenishment	130.2	18	13.85%	28.5	22%
6th replenishment	101	14	13.86%	18	18%
5th replenishment	97.5	13	13.3%	19.5	20.6%

Source: The Global Fund Advocates Network, Briefing on the Investment Case for the 7th replenishment, March 2022.

²² Target 3.3 of the globally-endorsed Sustainable Development Goal 3 on Health calls for ending by 2030 the epidemics of AIDS, TB, malaria and neglected tropical diseases, and combating hepatitis, water-borne diseases and other communicable diseases. [Available online from]: <https://www.globalgoals.org/3-good-health-and-well-being>

²³ The Global Fund, *Fight for What Counts*, 2022. *Op.Cit.*

²⁴ *Ibid.*

SHORTFALLS AND GAPS OBSERVED TODAY IN SOME PLACES WHERE MSF WORKS

Prior to Covid-19, MSF teams and partners were already observing persistent and expanding gaps in essential prevention, diagnostic and treatment services. These included stockouts and shortages of essential medicines; insufficient health workers; underfunded prevention, health promotion, case finding and diagnosis activities; and shortfalls in programs targeting people with specific needs such as people with AHD, children, people who inject drugs, migrants and other key populations.

Over the past two years, with the Covid-19 crisis compounded by various shocks and fragility, further gains against the three diseases have been lost.

HIV and TB testing are lagging behind, stock-out of medicines and other barriers such as user fees, distance to health facilities or stigma are preventing patients to access health services and to adhere to treatment. AHD is a serious concern, with about 30–40% of people living with HIV starting antiretroviral treatment (ART) in low- and middle-income settings having a CD4 cell count of less than 200 cells/mm³, and 20% less than 100 cells/mm³. In some settings, half of the people presenting to care have an advanced form of the disease.²⁵ TB cases are on the rise, including the major public health threat of drug and multi-drug resistant forms of the disease. Meanwhile, malaria is still a major killer for children under five, with the global death toll again increasing since the Covid-19 pandemic.

Where acceleration is needed to recuperate losses and get ahead of these pandemics, instead we observe:

- Erosion of gains: lack of scale-up, standstill and slide back
- Forced de-prioritization and rationing
- Substandard care
- Insufficient implementation of innovation
- Lack of preparedness and response to crises
- Patients paying the brunt of the funding gaps.

In this briefing paper, MSF describes some of the service gaps and their real-life consequences for patients, health providers and communities facing all three diseases.²⁶

Clearly more investment is needed to address existing shortfalls and prevent widening gaps.

²⁵ WHO, *Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy*, Op.Cit.

²⁶ The information included in this briefing document was provided by MSF teams and partners in several countries of intervention between April and July 2022, completed by a desk review of data at national and international level.

AFTER YEARS OF CONTINUED STEADY GAINS, AN IMPORTANT DOWNTURN IS NOTED IN 2020-2021. THIS TREND IS ALSO OBSERVED BY MSF TEAMS.



MSF's programs in the country have shown:

- A **50% drop** in antiretroviral treatment (ART) initiations.
- **Intensive adherence counseling** efforts are **reduced** by more than half
- **Downward trend** in the volume of **HIV RNA Viral Load (VL) tests** done in 2020.
- **Decrease** of TB treatment initiations.



The eight facilities supported by MSF in Conakry saw:

- **Reduced ART initiations** (by 25% in the second quarter of 2020)
- An **increase in appointment delays and lost-to-follow-ups** (20.5% LTFU in 2020 vs. 16.8% in 2019).
- **Community testing collapsed** (23 screenings performed in Q2 of 2020 vs. 1,330 in Q1).



At MSF ART clinics in Kachin and Shan state:

- Approximately **10%** of patients **did not continue treatment or died** between February 2021 and May 2022.
- An **increase** from **54.8% to 82.3%** in the proportion of patients presenting with **advanced HIV disease (AHD)** among newly diagnosed HIV patients.



In MSF-supported facilities:

- **High number** of patients presenting with **advanced HIV disease (AHD)** (1,686 patients in the Kinshasa hospital in 2021, and 21% of the newly diagnosed patients at the primary health care level there.
- Of the latter, **73% had TB** and **22% had a cryptococcal infection**.
- **Lack of screening tools for AHD** at primary health care to ensure early diagnosis and avoid unnecessary mortality.



Gaps in pediatric HIV care include:

- A **lack of well-developed protocols and human resource capacity** for the follow-up of exposed children.
- The **absence** of the pediatric form of the better tolerated **antiretroviral DTG (Dolutegravir)**.

Obstacles in HIV and TB care:

- **Payment** by patients of initial consultation fees or on admission.
- **Para-clinical examinations** such as X-rays which are **not free and difficult to access**.
- **Transport costs** due to the distance of testing and treatment sites.



- Countrywide reported TB incidence has **increased by 2%**. There is also **insufficient GeneXpert capacity** for TB diagnosis.

- Many patients present with **AHD**, but in donor plans there is **no priority given to CD4 count capacity**.

- In conflict-affected Cabo Delgado Province, services have been severely disrupted. **HIV testing of pediatric patients** in March 2022 in the MSF-supported Mueda hospital showed over **30% positivity in children**. In addition, many **women** in the maternity ward had **no HIV-screening** during their pregnancy.

- Continuity of services has also been vulnerable to **extreme weather events** in recent years resulting in **stocks of medicines destroyed**, facilities closed and **people displaced**.



- **Several key interventions** to boost progress against **malaria ended up deprioritized**, raising major concerns.



- In the MSF in-patient ward in the town of Malakal, **one third of the deaths** are due to **HIV/TB**. AHD remains outside the funding priorities in the country.

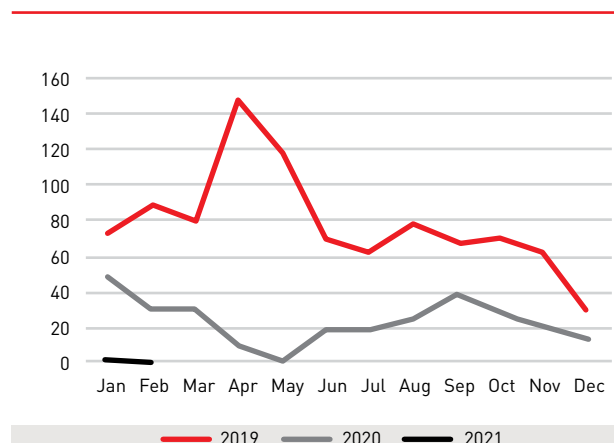
I. EROSION OF GAINS – LACK OF PROGRESS, STANDSTILL AND SLIDE BACK

Years of continued steady gains showed an important downturn in 2020-2021, with key indicators brought to a standstill or even sliding back. This means that the starting points for coverage rates for diagnosis and treatment and other indicators in 2022 are significantly lower than expected, leaving more work to be done to recuperate this erosion of gains.

In **Uganda**, data from the Ministry of Health (MoH) indicates a decline from 43.4% to 27.7% in the percentage of patients who attended clinic screening for TB at the beginning of the first wave of the Covid-19 pandemic.²⁷ Recent analyses regarding HIV predict reductions in detection of new infections and initiation to treatment, with up to 20% of patients on treatment lost-to-follow up (LTFU) and mortality rates returning to 1990 levels.²⁸

A preliminary study by Epicentre on the impact of Covid-19 on MSF's TB and HIV programs in the country²⁹ has shown a drop in ART initiations by 50%. Intensive adherence counseling efforts are reduced by more than half, and there is a downward trend in the volume of HIV RNA Viral Load (VL) tests done in 2020. When they compared TB data from 2019 and 2020, a decrease of treatment initiations can be seen at the start of the Covid-19 pandemic and for the remainder of 2020 (see Figure 2).

Figure 2: TB Treatment initiations in the MSF Arua project in Uganda per month stratified by year: 2019, 2020 and Q1 2021



Source: Epicentre/MSF/OMS: Covid impact on HIV-TB services in Malawi and Uganda, October 2021.

In **Guinea**, the use of healthcare facilities by the population dropped since the start of the Covid-19 crisis, explained by the limitations in movements, the reduction in available transport, combined with stigma or fear of going to health facilities. National data shows that HIV testing rates in key populations fell between 2019 and 2020 from 96.45% to 85.29% for sex workers (SW) and from 86.70% to 83.70% for men having sex with men (MSM). While TB national data demonstrating reductions linked to Covid-19 were not yet available, a Global Fund study on impact of Covid-19 reported that the similarity between TB and Covid-19 symptoms, may deter patients from seeking health care as a result of social rejection and fear surrounding the new virus.³⁰

²⁷ Fred C Semitala and al., *Integration of COVID-19 and TB screening in Kampala, Uganda -Healthcare provider perspectives*. 7 June 2022

²⁸ David Bell, Kristian Schultz Hansen, Agnes N. Kiragga, Andrew Kambugu, John Kissa, Anthony K. Mbonye, *Predicting the Impact of COVID-19 and the Potential Impact of the Public Health Response on Disease Burden in Uganda*, September 2020. [Available online from] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7470592/>

²⁹ Epicentre/MSF/OMS, *COVID impact on HIV-TB services in Malawi and Uganda*, October 2021.

³⁰ The Global Fund, *Impact du Covid-19 sur les services de lutte contre le VIH, la tuberculose et le paludisme et les systèmes de santé : Aperçu de la situation dans 502 établissements de santé en Afrique et en Asie*, April 2021. [Available online from] [covid-19_2020-disruption-impact_report_fr.pdf](https://www.theglobalfund.org/publications/covid-19-2020-disruption-impact-report_fr.pdf) (theglobalfund.org)



In the eight HIV health facilities supported by MSF in the capital Conakry, our teams noted a decrease in attendance in the second quarter of 2020, at the beginning of the Covid-19 pandemic. Our data show appointment delays (3,095 contacted in the second quarter 2020 vs. 2,321 in the first one).

Community testing collapsed over the same quarters (23 screenings vs. 1,330) and treatment initiation reduced by 25% in Q2. Significantly worsened lost-to-follow-up (LTFU) rates were also recorded in 2020 (20,5% LTFU in 2020 vs. 16,8% in 2019).

Difficulties in repairing the broken CD4 measurement devices have always been challenging (parts or expertise not found locally) but worsened during the pandemic because of restrictions to import and travel. In 2020, out of 2,485 initiations, one third of patients were not able to benefit from a CD4 count.

While worldwide commitments were aiming to reduce TB incidence in all countries by 20% in 2020 as compared to 2015, **Guinea** saw instead a 1,3% increase, as did other countries such as **South Sudan** (+2%) or **Mozambique** (+2%). Similarly, TB deaths, with a target of 35% reduction in 2020, saw countries such as **the Central African Republic (CAR)**, **Guinea** and **the Democratic Republic of the Congo (DRC)** fail to meet the target, with respective reductions of 16%, 23% and 25%.³¹

In **DRC**, provider-initiated counseling and testing (PICT), key in the fight against HIV as it allows testing of symptomatic patients at the level of the care provider, is not covered by the GF grant due to lack of funding. With no financial support and considering that voluntary counselling and testing (VCT) is not supported either, the cost of HIV testing is passed to patients via a user fee or is simply not available, constituting a financial burden to the patient and a barrier to care. Lack of testing contributes to late diagnosis and increased numbers of patients presenting with AHD. The coverage of Early Infant Diagnosis (EID), allowing the early detection of HIV infection in infants born to mothers living with HIV to allow prompt treatment initiation, is also of critical concern at only 9,1%.³²

Gaps in HIV testing are also common in **CAR**. In some public health facilities, MSF teams saw staff cutting rapid test strips to make limited stocks go further, thereby increasing the risk of false results.

This is a very worrying sign.



³¹ WHO, *Summary of tuberculosis data* (shinyapps.io)

³² PNLS 2022, "Programme VIH/SIDA", Presentation made at the Biannual Revue of the Global Fund Grant NMF3 for 2021. Kinshasa, 2022.



In **Myanmar**, the context has significantly changed following the military takeover in February 2021. Public health facilities were either shut down or occupied by the military, with service delivery severely disrupted and medical staff striking in protest. A few months later, another wave of the Covid-19 pushed the health system to near paralysis, resulting in dysfunctional medical programs including the national AIDS and tuberculosis program. Increased armed conflict in different parts of the country have resulted in rising humanitarian and medical needs, while violence and insecurity hinder the provision of care and patients' access to services. According to the United Nations High Commissioner for Refugees (UNHCR), as of July 2022, 1,204,500 people are internally displaced.³³ Some 314 attacks on healthcare were recorded by WHO up to mid-2022³⁴, while other sources reported 492 attacks on healthcare workers between February 2021 and the end of March 2022, with 564 health workers arrested, 126 hospitals raided, and 36 health workers killed.³⁵

³³ UNHCR Myanmar Displacement Overview [Available online from] <https://data.unhcr.org/en/documents/details/94319>

³⁴ WHO surveillance system for attacks on health care [Available online from] https://extranet.who.int/ssa/LeftMenu/Index.aspx?utm_source=Stopping%20attacks%20on%20health%20care%20QandA&utm_medium=link&utm_campaign=Link_who

³⁵ Insecurity Insight, *Violence or Obstruction of Health Care in Myanmar*, May 2022 update [Available online from] <https://www.burmalibrary.org/sites/burmalibrary.org/files/obl/2022-05-24-Violence-Against-Health-Care-in-Myanmar-en.pdf>

In mid-2022, public health facilities were only partially functioning, if at all, with reduced workforce, compromising patients' access to prevention services, such as HIV testing and initiation. The number of secondary or tertiary care facilities is largely insufficient especially in the public sector. This is observed on a daily basis by MSF teams facing challenges to refer patients for specialized treatment.

Between February 2021 and May 2022, at MSF ART clinics in Kachin and Shan state, due to access barriers, approximately 10% of patients did not continue treatment or died, and the total number of people on ART slightly decreased (from 8,392 to 8,378), with people LTFU, who died, or transferred to another facility (844) cancelling out the new initiations (830). The teams saw increased numbers of new patients presenting late for HIV treatment. These patients presented with very low CD4 counts and life-threatening opportunistic infections like disseminated TB and Cryptococcal meningitis. By May 2022, 680 individuals out of 830 (or 82% of newly diagnosed HIV patients compared to 54.8% of new patients in 2020) presented with AHD. In addition, more than 39 DR-TB patients were newly registered at MSF clinics over the same period, while this number was at 16 in 2020.

On top of this bleak situation, MSF remains concerned about increased difficulties faced by patients in need of VL testing, EID, TB treatment and methadone maintenance therapy (MMT).



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South Sudan is a challenging context where years of conflict have slowed the pace of gains, leaving millions of people with unmet needs and limited access to healthcare. According to the 2022 Humanitarian Needs Overview of OCHA (the United Nations Humanitarian Office for the Coordination of Humanitarian Affairs), needs are increasing, with an estimated 8.9 million people in need of humanitarian assistance. There are over 4 million people displaced: 2 million internally and more than 2.3 million as refugees. It is estimated that 2022 will see a 25% increase in risk of sexual and gender-based violence (SGBV) exposure compared to 2021, increasing the risk of exposure to HIV and other health consequences.³⁶ Given the severely inadequate access to quality health services, SGBV survivors -and others exposed to HIV- face significant barriers in accessing post-exposure prophylaxis (PEP), HIV testing and treatment.

South Sudan is one of the countries most lagging behind in the response against HIV/AIDS. Insufficient investment in primary HIV prevention in the past was compounded by large technical and operational gaps.³⁷ Approximately 29% of people know their HIV status, of whom 23% are on ART. Treatment coverage is even lower amongst children, at around 14%.³⁸ Nevertheless, ART coverage targets for 2021-2023 are flatlined [48,720]³⁹, although an increased pace of roll-out is acutely needed.

In the MSF neonatology and pediatric ward in the town of Malakal, our teams see neonates and children living with HIV whose mothers were not screened for the virus due to unavailability of tests and other structural problems. For similar reasons, some blood banks in South Sudan do not screen blood products for potential infections prior to transfusion.

For patients already on ART in the country (42,247⁴⁰), food security critically impacts adherence.⁴¹ In an environment already facing severe retention issues due to constant shocks (flooding, displacement, violence, etc.), the most recent Integrated Food Security Phase Classification (IPC) report paints a worrying picture for South Sudan. The IPC predicted for the lean season of April to July 2022, an estimated 7.74 million people (62.7% of the population) would face high acute food insecurity, with the situation for 87,000 people likely to be catastrophic.⁴² Despite increased food insecurity indicators, food rations have been significantly reduced.⁴³

³⁶ OCHA, *Humanitarian needs Overview 2022 South Sudan*, February 2022. [Available from] South Sudan Humanitarian Needs Overview 2022 (February 2022) - South Sudan | ReliefWeb

³⁷ Funding request form to the GF for South Sudan: HIV/TB Allocation components for the period 2020-2022. [Available online from] <https://data.theglobalfund.org/location/SSD/documents>

³⁸ UNAIDS data 2021. [Available from] https://www.unaids.org/sites/default/files/media_asset/JC3032_AIDS_Data_book_2021_En.pdf

³⁹ Funding request form to the GF for South Sudan: HIV/TB Allocation components for the period 2020-2022. *Op Cit.*

⁴⁰ UNAIDS data 2021. *Op.Cit.*

⁴¹ Young S. et al., *A review of the role of food insecurity in adherence to care and treatment among adult and pediatric populations living with HIV and AIDS*, *AIDS Behav* Oct. 2014, [Available online from] A review of the role of food insecurity in adherence to care and treatment among adult and pediatric populations living with HIV and AIDS - PMC (nih.gov)

⁴² IPC, *IPC food security and nutrition snapshot*, 9 April 2022 [Available online from] https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_South_Sudan_Acute_Food_Insecurity_Malnutrition_2022_Snapshot.pdf

⁴³ The Guardian, *Millions at risk in South Sudan as Ukraine war forces slashing of aid*, 14 June 2022 [Available online] <https://www.theguardian.com/global-development/2022/jun/14/millions-at-risk-in-south-sudan-as-ukraine-war-forces-slashing-of-aid-world-food-programme>

A similar trend is impacting health care, with the Health Pooled Fund (HPF)⁴⁴ announcing in 2022 drastic cuts of 30% to their budget, which will leave about 200 health facilities unsupported.⁴⁵

This will have an adverse impact on health outcomes, as access to timely diagnosis and treatment for different diseases becomes more limited, including for malaria.

HPF, although primarily funding primary healthcare activities, provides part of the rapid diagnostic tests (RDT) for **malaria** (+/- 8 million RDTs out of 28 million needed for 3 years) as well as Artemisinin-based combination therapies (ACTs). This reduction in funding is additional to the foreseen gap of 4.3 million ACTs for 2023 that have not been covered by any international stakeholder. Moreover, some states in the country did not receive long-lasting insecticidal nets (LLIN) through mass campaign distributions for more than three years, with the next campaign foreseen at the end 2023 or beginning of 2024. With LLIN coverage per household already low and malaria cases that increased by 10.5% in 2020 compared to 2015⁴⁶, gaps in the malaria response raise serious concerns.

Since 2021, the US President's Emergency Plan for AIDS Relief (PEPFAR) stopped funding any **HIV** commodities in South Sudan and the need to fill this gap is one of the biggest problems facing current programming. As a result, the majority of funding for HIV under the GF Funding Request had to be allocated to cover the cost of antiretroviral (ARV) commodities, leaving very little for other components such as prevention or civil society engagement, among others.⁴⁷

⁴⁴ The Health Pooled Fund, led by the United Kingdom's Foreign, Commonwealth and Development Office -UK FCDO- and other international donors, and which covers 8 out of the 10 former states

⁴⁵ Eye Radio, HPF scaling down, 8 major hospitals to be affected, 8 April 2022 [Available online from] HPF scales down funding, 8 major hospitals to be affected - Eye Radio

⁴⁶ WHO, *World Malaria Report 2021*, *Op.Cit.*

⁴⁷ Funding request form to the GF for South Sudan: HIV/TB allocation components for the period 2020-2022. *Op.Cit.*



II. FORCED DE-PRIORITIZATION AND RATIONING

Insufficient funds to comprehensively cover health needs result in de-prioritization that deprives patients of much needed care, resulting in choices whereby activities and approaches recognized as highly effective in the fight against HIV, TB and malaria are dropped. This often leads to the exclusion of specific population groups or certain geographical areas, limiting and delaying much-needed life-saving actions.



Over-optimistic expectations about materialization of committed domestic resource mobilization (DRM) and co-financing, creating gaps

A prime example of this type of de-prioritization is the Global Fund's Unfunded Quality Demands register (UQD).⁴⁸ This is the system through which the Global Fund keeps track of technically sound health service activities or commodities that were proposed by the country but due to lack of funding could not be covered by the grants. The UQD list indicates priorities to be funded as soon as additional funding becomes available, either from GF (e.g. savings under the current grant) or from other donors.

Shortfalls in a country's budget for HIV, tuberculosis and malaria result from different reasons at different times and accordingly have varying consequences. The initial grant can impose limitations, but some shortfalls will materialize only in the midst of the funding cycle due to changes or concurrent shocks (epidemics, conflict, displacement, etc.) in contexts, thereby impacting the original plans. In many countries, MSF has observed that optimistic projections of domestic financing and co-financing have not materialized, resulting in gaps in medical supplies, services and other interventions.

⁴⁸ Countries are encouraged to include with their funding application a Prioritized Above Allocation Request (PAAR) with priority interventions that are part of the country's strategic plan, which cannot be funded. The request is reviewed by the Technical Review Panel so that strategically focused and technically sound interventions can be added to the register of Unfunded Quality Demand. This ensures availability of a pre-approved list of interventions that countries can integrate into grants when savings or efficiencies are found during grant-making, or if additional funding becomes available. For more information, see: [core_uqd_faq_en.pdf](#) ([theglobalfund.org](#))

Without alternative funding sources, important activities and key strategies enter into competition with other essential investments and end up being cancelled, postponed or cut back.

The assumption that progress towards the Global Goals and UHC should primarily be achieved through increased domestic funding is stronger than ever. Yet, analysis of past experience shows that even when political will exists, there are often limited viable options to mobilize additional resources within the expected timeframes. Premature or overly optimistic transfer of responsibilities to national governments, particularly in challenging environments, contributes to a dynamic of counter-financing. Borrowing or shifting resources from one part of the national budget to cover another result in different but still shortages of essential services and stock-outs of key medical supplies. This tends towards a worrying trend to accept these widening gaps rather than actively working to resolve them.

In **Guinea**, the government's co-financing remains a major challenge. For ARVs, the share of the national development budget (NDB) is set to gradually increase until it covers approximately 30% of ARV targets in 2023 (26,080 out of 91,810⁴⁹). Yet, no NDB orders materialized in 2021. The 2021 budget has been rolled over to 2022 and orders are starting to trickle in, however it is unclear that even if authorities catch up on 2021 orders in 2022, that this will sufficiently cover actual needs.



⁴⁹ It should also be noted that the target of 91,810 patients on ARVs by 2023 only represents 73% of PLHIV, already leaving a gap.



HIV positive pregnant women among first victims of the de-prioritization

Moreover, in **Guinea**, in order to make the country plans fit with the budget, the national programs together with the Global Fund team further ruled out a number of priorities for HIV and TB activities in order to “rationalize” some interventions. Examples of impacted activities included training, supervision of HIV sites or planned research studies.

This tendency creates a valid concern on the impact of the quality of services for patients, based on previous experiences in 2018, that impacted programs aimed at reducing mother-to-child transmission of HIV (PMTCT programs). Since that year the number of PMTCT sites in the country directly supported by the GF's sub-recipient in charge of these activities decreased five-fold from the 2015-2017 period, from 396 to 66 sites due to a drastic decrease in funding. In the current grant cycle, the number of supported PMTCT sites grew up to 86. While these might be the most strategic ones, those women living outside the selected sites are left out. Treatment coverage amongst the general population differs greatly from one district to another, with some areas at less than 30% while nationwide coverage was at 61% in 2021.⁵⁰

In **CAR**, currently only 186 antenatal care (ANC) sites out of the 326 existing in the country offer the PMTCT package and the number of testing kits funded is widely insufficient to test all women. Moreover, lab tests such as CD4 cell counts are not included in the GF grant since 2018, meaning that patients must pay out-of-pocket to have their CD4 levels assessed.

Voluntary Counseling and Testing (VCT) services in CAR are also no longer covered by the GF despite good results shown during the roll-out of the catch-up plan launched in the WCA region in 2017: 63,750 people were tested with a positivity rate of 7.4%.⁵¹ Rolling out testing services is the way to improve the treatment coverage in the country (64% in 2021).

⁵⁰ République de Guinée, *Rapport national annuel de la riposte VIH en Guinée*, 2021

⁵¹ Funding Request Form to the GF by the Central African Republic: HIV/TB/HSS components for the Allocation period 2020-2022. [Available online from] <https://data.theglobalfund.org/location/CAF/documents?status=Active>

While in **DRC**, out of 24 provinces supported by the GF, the offer of PMTCT is restricted to 15 provinces, and within each health zone only in 10 health facilities (health zones often have more than twenty clinics). In North Kivu, East DRC, only 55,3% of the women who attended ANC in 2021 were tested for HIV. This is far from necessary coverage.⁵²

Due to poor ANC coverage rates and scarce availability of PMTCT services in ANC sites, PMTCT coverage remains low, at 43%, in **South Sudan**. Drastic funding cuts from the HPF risk to aggravate this further and prevent plans to improve PMTCT coverage.



Preventive and therapeutic services for Key populations (KP) suffering from financial gaps and budget constraints.

In **DCR**, key populations testing is available in only 25 “KP friendly centers”⁵³ in 19 cities covered by the GF grant, and pre-exposure prophylaxis (PrEP) is only available for 10% of men having sex with men (MSM) and 5% of female sex workers (FSW) in 53 cities.⁵⁴

In **Guinea**, PrEP is not largely available, as the extension of the pilot was not retained in the GF grant but was put in the UQD register. Furthermore, available funding from GF for the ongoing 2022 integrated biological and behavioral surveillance survey (IBBS) among key and vulnerable populations presently only targets the three key populations: the MSM, SW and injecting drug users (IDU), while in the past it covered eight (the 3 KP and 5 vulnerable). The risk is lack of information and a reduction in the support towards differentiated strategies targeting all vulnerable populations, thereby decreasing diagnosis and treatment initiation of those worst affected and carrying the burden of new infections.

In **South Sudan** HIV prevention programs are foreseen both in PEPFAR and GF grants, mostly for female SW (FSW), adolescent girls and young women (AGYW) and populations in humanitarian crisis, but major gaps in services still exist.⁵⁵ A study in Wau and Yambio found an HIV prevalence among FSW of 13.6% and 6.7% respectively, compared to the 2,3% in the general population in the country.⁵⁶



Malaria services also impacted by de-prioritization

Malaria in **South Sudan** is of key concern. Additional to the gap of ACT (4,3 million doses), there are also several key interventions to boost progress that ended up in the UQD register, as it couldn't fit the budget grant, such as: 1,4 million doses of Artesunate to treat severe malaria, the training of 700 health workers across 10 states in the effective use of malaria diagnostics, training of 350 health workers in case management of uncomplicated and severe malaria, seasonal malaria chemoprevention (SMC) for children, indoor residual spraying (IRS) in camps for internally displaced and refugees and adjacent communities, newer generation nets for two states with documented resistance to the pyrethroid insecticide, and a staggering 1,9 million LLIN for distribution to people attending ANC and vaccination services under the expanded Program for Immunisation (EPI).



⁵² Plan d'action opérationnel des activités de lutte contre le VIH/Sida 2022, Division Provinciale de la Santé, PNLS, Bureau Provincial de coordination du Nord Kivu, Janvier 2022.

⁵³ Friendly centers are facilities that specialize in providing various services to specific populations. These include centers specifically dedicated to key populations or youth and adolescent-friendly centers.

⁵⁴ Global Fund, *Global Fund Investments to Support HIV National Response: Priorities and Feedback to PEPFAR*. Presentation made during PEPFAR's Country Operational Plan for DRC. Geneva [online], 2022

⁵⁵ Funding request form to the GF for South Sudan: HIV/TB allocation components for the period 2020-2022. *Op.Cit.*

⁵⁶ *Ibid.*



Gaps in TB diagnosis are the tip of the iceberg of unmet needs

Whilst GeneXpert is the recommended first diagnostic test of patients with possible TB, many countries have not been able to widely implement this test, due to cost and HR challenges. Therefore many countries rely initially on poorly performing sputum microscopy followed by the transport of samples to centres equipped with GeneXpert and Xray. This lack of roll-out leads to delays in diagnosis, increased mortality and missed cases.

Mozambique lacks a comprehensive sputum transportation system and GeneXpert diagnostic tools are limited to certain health facilities only. Without equitable access, diagnosis of TB is difficult in many areas.

In **CAR**, the means for TB diagnosis (via TB-LAM, Sputum Microscopy, X-Ray, GeneXpert) are even less available. Where sputum specimen collection and testing with microscopy is available (and free of charge), patients still have to pay for the consultation (between the equivalent of US\$ 0.75 and US\$ 1.5), which may discourage them from getting tested. People living in Bangui with a high suspicion of TB despite a negative sputum microscopy result, are referred to the Pasteur Institute for an X-ray or GeneXpert. Patients must pay themselves out-of-pocket for travel costs (up to US\$ 2.3 one way). Those living far away from cities where X-Ray and GeneXpert capacity is concentrated, simply have no access to TB diagnosis.

Since February 2021 in **Myanmar**, TB diagnosis continues at international non-governmental organization (INGO) clinics, but access to sputum microscopy examination and chest radiography is irregular. GeneXpert for TB diagnosis is limited to health facilities in possession of the machine, which includes MSF in Yangon, Shan and Kachin. In mid-2022, with some support from MSF staff, only one reference laboratory was operational nationwide to receive MDR samples from across the country.



Major challenges in the treatment of drug resistant TB faced in 2021 in the country included the difficulty to choose the appropriate regimen in the absence of DST (Drug Sensitivity Testing to identify the resistance profile of the TB) and the shortage of one of the new medications for multi-drug resistant TB, which delayed the implementation of shorter and all-oral regimen. The lack of second line drugs distribution, low detection of DR-TB and lack of follow-up of side effects, as well as lack of social support for patients add to the many challenges.

In **South Sudan**, progress to improve the low TB treatment coverage (at 62% in 2020⁵⁷), is impeded by persistently unmet funding needs. Partners flagged missed opportunities during the current GF financing cycle with no integration between HPF activities for children and TB diagnostics. Under HPF, between October 2018 and March 2019, 480,000 children (under 5 years of age) were screened for malnutrition and 160,000 were treated for malaria, using a facility-community-based approach. However, no children were screened for TB. Despite needs there is a risk that the decrease of support by HPF might further prevent the integration of TB components into existing services.⁵⁸ Efforts need to continue between the MoH, the HPF partners and the World Bank to achieve greater integration of HIV, TB and malaria programs within these interventions.

⁵⁷ WHO, *Tuberculosis profile: South Sudan, 2020*. [Available from]: TB profile (shinyapps.io)

⁵⁸ *Ibid.*



Availability of essential health commodities being threatened by lack of investment in stronger supply chains

Guinea was not kept on the priority countries to receive additional funds under a GF initiative to improve its essential commodities supply chain in 2018. The fragile supply chain is one of the contributing factors to the repeated stock-outs across the country.

In Kouroussa, in the North-Eastern part of the country, MSF has been supporting the Ministry of Health in tackling high rates of malaria (32% incidence rate and 4 196 430 cases nationwide in 2020⁵⁹) as well as associated health comorbidities in children under five through a community-based program. Stock-outs of malaria rapid tests and treatment in this vast prefecture have been recurrent, often requiring the reallocation of supplies from one health center to another, and for MSF to regularly fill gaps over the years. Similarly, stock-outs for HIV and TB care have been hampering progress.

The initial plan in **Mozambique** was to build up 20 to 30 warehouses at provincial level, in order to counter storage capacity deficiencies. Yet, only five were built so far, with no funds available to build others.

⁵⁹ WHO, *World Malaria report 2021*, Op.Cit.

III. SUBSTANDARD CARE

In the face of important shortfalls in resources, elements of standard care come under heavy pressure and lead to substandard quality of care. This is not only undermining effectiveness and impact of care, but possibly harming patients. It can also have the unwanted effect of loss of trust between the patients and service providers, impacting service uptake and further reducing coverage.



Lack of access to HIV viral load testing

HIV RNA viral load testing (VL) is presently the gold-standard to measure the amount of HIV virus in the blood. It is used to assess and adapt a patient's treatment against the virus, notably to verify therapy fidelity and potential resistance, and is essential to monitor viral suppression. Yet, in many countries, this essential test is not systematically offered.

Barely 50% of PLHIV in **DRC** had access to VL testing as of end 2021. Coverage differs widely from one province to the other, which is indicative of different levels of funding to the different provinces. PEPFAR supports part of Kinshasa and two other provinces (annual budget of around US\$100 million), while the GF is also supporting the capital and the remaining 23 provinces (around US\$160 million over three years). This goes some way to explaining the difference in access and availability of services. Lualaba province, supported by PEPFAR, has a VL coverage of 100%, while Sankuru, under GF grant support, has none.⁶⁰ The GF estimates that US\$ 4,5 million are needed to bridge the gaps in VL and EID testing in the provinces they are supporting.⁶¹ In Goma, a city of 2,1 million inhabitants with an HIV prevalence of 1,85%⁶², MSF is the only stakeholder providing VL testing.

The knock-on effect of the multiple challenges to access care in North Kivu (e.g. few health facilities offering the HIV service package, geographical barriers, recurrent stock-outs of ARV and other essential medicines), has led to Congolese nationals crossing the border to Uganda to seek care, including in the MSF-supported HIV clinic of Arua hospital.

In **CAR**, VL is the only laboratory test funded by the GF, but less than 20% of the patients on treatment have access to it⁶³. In Bangui, although the test is free, structural barriers remain, preventing people from accessing VL testing. Barriers include a lack of funding to train the staff to prescribe and perform the test, combined with inadequate sample transportation. Consequently, patients have to go to the Pasteur Institute or the National Laboratory which constitutes a major financial and geographical barrier. Ad hoc campaign VL testing by these two major laboratories offers punctual support but does little to alleviate the problem. A further decentralized approach to VL is needed.



⁶⁰ PPT Revue biannuelle S2 2021 des subventions du Fonds Mondial NFM3, Programme VIH/Sida, 17-18 Mai 2022.

⁶¹ The Global Fund, Presentation on the Global Fund investments to support HIV response: 2022 priorities and feedback to PEPFAR, Regional PEPFAR COP 2022 meeting. March 2022

⁶² Plan d'action opérationnel des activités de lutte contre le VIH/Sida 2022, Division Provinciale de la Santé, PNLS, Bureau provincial de coordination du Nord Kivu, Janvier 2022.

⁶³ UNAIDS, *Accélérer et étendre les services anti-VIH en République centrafricaine*, March 2021. [Available online from] Accélérer et étendre les services anti-VIH en République centrafricaine | ONUSIDA (unaid.org)



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In Guinea, the national objective was to increase VL coverage targets under the current GF funding cycle from 51% in 2019 to 76% in 2023. By 2021 however, only 22% of PLHIV had access to VL testing (about 25,000 patients)⁶⁴, a far cry from the target of 62%. This is mainly attributed to failure in the government's contribution to cover nearly half of the VL needs (through the National Development Budget or NDB). As a consequence, VL testing cannot be performed according to international recommendations⁶⁵, obliging prioritization between patients. In the MSF HIV/TB project that caters for over 15,000 patients on treatment, only 2,560 patients underwent a VL testing in 2021. Important delays in communicating test results further hamper the management of patients.

Similarly, CD4 count measurements, an essential diagnostic tool recommended by guidelines for identifying high-risk patients for AHD, needed 80% contribution by the NDB that did not materialize, resulting in long stock-outs of CD4 commodities.

Viral load coverage remains relatively low in **Mozambique**, albeit with a slight improvement in 2021 (reaching 61% in 2021 from 56% the year before).⁶⁶ Challenges around sample and result transportation combined with inadequate sites to perform viral load testing are some of the barriers to adequate VL testing. Results of VL are also problematic with only 78% of patients on ART receiving their VL results in 2021. Delays in implementing activities to strengthen health systems, such as expanding the electronic laboratory information system, further aggravate progress in treating HIV patients.



No early diagnosis and treatment for patients with advanced HIV disease (AHD)

As previously mentioned, in **South Sudan**, many patients arrive to MSF health facilities in Bentiu, Lankien, Malakal and Ulang with AHD. In 2021, 81% of the 226 active HIV patients (81%) seen in MSF projects in Upper Nile presented with the advanced form of the disease. These severely immunocompromised patients are more prone to opportunistic infections, including TB⁶⁷ and cryptococcal meningitis, resulting in an increased risk of death. In the in-patient ward in Malakal, one third of the deaths are due to HIV/TB. Nevertheless, AHD remains outside the funding priorities.

⁶⁴ ONUSIDA, *Lutte contre le VIH/sida en Guinée - analyse des gaps en intrants*, 2022.

⁶⁵ For more on the international recommendations, see WHO, *What's new in treatment monitoring: Viral load and Cd4*, July 2017 [Available from] <https://apps.who.int/iris/bitstream/handle/10665/255891/WHO-HIV-2017.22-eng.pdf>

⁶⁶ PEPFAR, *Panorama Spotlight 2021*. [Available online from] PEPFAR Panorama Spotlight

⁶⁷ Statistically, people living with HIV are 18 times more likely to develop active TB disease than people without HIV [source: WHO: <https://www.who.int/news-room/fact-sheets/detail/tuberculosis>].



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In **DRC**, the annual allocation from the GF grant foresees to cover the needs for 1,800 patients with AHD in five hospitals per year. Given the size of the country and that in 2021 in the MSF- supported hospital in Kinshasa alone, 1,686 patients presented with AHD, the number of severely ill patients left out of care risks to be greatly underestimated. MSF also screens patients for AHD at the primary healthcare level in several public facilities in the capital. Last year, 21% of the 346 newly diagnosed patients had AHD. Of those 74 patients, 54 were diagnosed with TB and 16 had a positive serum CrAg test (Cryptococcal infection screening test)⁶⁸. This shows the importance of patients accessing screening tools at the level of primary health care to ensure early diagnosis and avoid unnecessary mortality.

In the MSF Arua project in **Uganda**, 25% of the 1,236-patient cohort had a CD4 count <200 cells/mm³; 21% of them tested positive for TB-LAM and 9% for cryptococcal infections (CrAg serum) in 2020.

While in **CAR**, the lack of drugs such as Amphotericine, Flucytosine, Fluconazole, Prednisolone or key antibiotics in facilities makes it difficult to properly manage AHD patients. Many patients admitted to the hospital with AHD require long and uninterrupted treatment at other health care levels once they are discharged. This is often not available and contributes to additional mortality and morbidities. Some 955 patients treated for AHD were discharged from the MSF hospital in 2021.

⁶⁸ Cryptococcal Antigen (CrAg) reflex testing: CrAg lateral flow assay (CrAg LFA) is a dipstick test for the detection of the antigen of *Cryptococcus* species complex (*C. neoformans* and *C. gattii*) in serum, plasma or CSF samples. CrAg LFA can detect Cryptococcal Meningitis 22 days before onset of symptoms (asymptomatic antigenemia) thereby triggering treatment. For more information, see: https://samumsf.org/sites/default/files/2019-07/CrAg%20POCT_Job%20Aid_MSF_0.pdf



Substandard pediatric care

Pediatric care for HIV+ children is one of the largely neglected areas of HIV care and is sadly often substandard in settings where MSF works.

Moreover, for children with tuberculosis, detection rates are low as diagnosis relies both on clinical examination and on X-ray, which requires access to hospitals. In many settings where MSF is working, access to paediatric formulations for TB treatment is lacking. As a consequence of all this, many children are not put on treatment. In 2017 a study estimated that 96% of children who die from TB were never put on treatment.⁶⁹

In **CAR**, gaps include a lack of well-developed protocols and HR capacity for the follow-up of HIV- exposed children, and the absence of the pediatric form of the better tolerated antiretroviral DTG (Dolutegravir). The current regimen requires a high number of pills to swallow and resulting side effects, making adherence to treatment difficult.

In addition, there are few countries with differentiated service delivery (DSD⁷⁰) for children, which is better suited for their needs and increases retention in care.⁷¹

Legal barriers, as encountered in many countries in West and Central Africa, prevent the HIV testing of minors without prior consent from the parents, and thus prevents children from timely accessing essential healthcare. These harmful and discriminatory restrictions result in insufficient pediatric coverage because of lack of diagnosis and late treatment start.

⁶⁹ Dodd P. et al. *The global burden of tuberculosis mortality in children: a mathematical modelling study*. The Lancet Global Health Volume 5, Issue 9, September 2017, pages e898-906. [Available online from] <https://www.sciencedirect.com/science/article/pii/S2214109X17302899>

⁷⁰ Differentiated service delivery (DSD), previously referred to as differentiated care, is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences, expectations and needs of people living with and vulnerable to HIV, while reducing unnecessary burdens on the health system. [Available online from] https://differentiatedservicedelivery.org/about_DSD

⁷¹ See details about when, where, how and what to propose for DSD for children in *Differentiated care for HIV: a decision framework for differentiated ART delivery for children, adolescents and pregnant and breastfeeding women* [Available online from] https://differentiatedservicedelivery.org/Portals/0/adam/Content/9ErIJtsSfUmj_Ska6BoN0Q/File/Decision%20Framework%20for%20children%20adolescents%20and%20pregnant%20and%20breastfeeding%20women.pdf



Lack of support to community health and civil society organizations

Workers and facilities at the community health level - and in particular peer-led community interventions - are playing a key role in delivering care to communities that face physical and financial access barriers.^{72, 73}

Guinea aims to cover 75% of its municipalities through Community Health by 2023. The Global Fund grants support to 18 municipalities of Kindia and Téliélé, the World Bank 53 municipalities in Kankan and Kindia regions, and GAVI a further 27 municipalities of Dinguiraye. Sadly, the necessary funding for this activity fell short with an additional 17% needed to achieve the 75% coverage. It is now waiting for funding on the Global Fund UQD register.

Civil society organizations (CSO) are key contributors in the response to all three pandemics. They often drive innovative care models, better adapted to patient and community realities. CSOs can implement preventive activities and monitoring of stock-out of essential drugs and unaffordable user fees/out-of-pocket payments, as well as fight discrimination and stigmatization. Working in complement with the public health system and compensating for some of its structural weakness, community-based organizations need adequate remuneration for their work, but also support to build institutional capacity.

However, they tend to be insufficiently supported and are often overlooked by funding mechanisms.⁷⁴ Moreover, CSOs face additional challenges under the Covid-19 crisis.^{75, 76, 77}

In **Mozambique**, donors, particularly the US government, estimate that the sustainability of community-based HIV activities is hampered by the lack of availability and capacity of CSOs. The PEPFAR programmatic transition to shift financial support for community work from INGOs to national or local CSOs is taking longer than expected. Currently, only one in three organizations funded by PEPFAR in the country is a local or national CSO.



⁷² Mwai G.W, et al. *Role of outcomes of community health workers in HIV care in Sub-Saharan Africa: a systematic review*, J Int AIDS Soc 2013; 16(1): 18586. [Available online from] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3772323/>

⁷³ MSF. *Community-led interventions: Sound investment for an effective HIV response in West and Central Africa*. 2020. Community and civil society organizations brief ahead of UNAIDS PCB Meeting (December 2020) [Available online from] https://www.doctorswithoutborders.org/sites/default/files/documents/WCA-Community%20Brief_Eng%2BFr-%20FINAL.pdf

⁷⁴ Mariam Amissen (2016); *We Exist: Mapping LGBTQ Organising in West Africa*. See: <https://www.42d.org/2020/10/05/we-exist-mapping-lgbtq-organising-in-west-africa/>

⁷⁵ Wood G. & Majumdar S., 2020, *COVID-19 and the impact on CSO working to end violence against women and girls: through the lens of CSO funded by the TRUST FUND to END Violence against Women* – six months after the global pandemic was declared. New York, UN Trust Fund to end violence against women, September 2020. [Available online from] <https://reliefweb.int/report/world/covid-19-and-impact-civil-society-organizations-csos-working-end-violence-against-women>

⁷⁶ Saul Mullard and Per Aarvik; U4 Guide 2020:1; *Supporting civil society during the Covid-19 pandemic*. [Available online from] <https://www.u4.no/publications/supporting-civil-society-during-the-covid-19-pandemic.pdf>

⁷⁷ Edge Effect Briefing note: *Impacts of COVID-19 on LGBTIQ+ people* 2020. [Available online from] [IMPACT OF COVID-19 ON LGBTIQ+ People: A Briefing Note and Recommendations | edge effect](https://www.edgeeffect.org/impacts-of-covid-19-on-lgbtq-people)

IV. INSUFFICIENT IMPLEMENTATION OF INNOVATION

Funding gaps impact countries' capacity to adopt or develop innovative models of care or have access to innovative tools and treatments. These innovations allow for more affordable, effective and better quality patient care. Without these improvements, the necessary progress in coverage and effectiveness of preventive and curative response, particularly in challenging environments, will continue to stall.

There are multiple examples of key innovations that currently can be game changers for the HIV, TB and malaria response including: Injectable ARV, long-acting PrEP, new TB diagnostic tools such as TB-LAM, TB preventive therapy (TPT) and other innovative preventive and therapeutic tools, treatment for opportunistic infections/cryptococcal disease for PLHIV, prevention of TB amongst household contacts, improved long lasting insecticide-treated nets (LLINs) for malaria, new insecticide spraying techniques and malaria vaccines, etc. Failing to put in use such innovative tools and strategies is preventing significant progress in the responses against the three diseases.

In **Guinea**, a lack of technical support delayed the switch to the better tolerated, more effective DTG -both for adults and children-, while the recent arrival of a late NDB order from 2020 of the previous regimen of abacavir sulfate/lamivudine plus efavirenz (ABC/3TC + EFV) now risks to further delay this much needed transition.

In **CAR, DRC** and **South Sudan**, the WHO -recommended use of GeneXpert as the first diagnostic test for TB is extremely low, as shown by respectively 0.59%, 4.8% and 2.2% of all new diagnoses. Without accelerated innovation and improved supply chain systems, this will further prevent access to timely TB- treatment.⁷⁸

In **CAR**, there are delays in adoption of new and shorter

TPT regimens, and recommended pediatric treatments are missing. Prophylaxis for PLHIV against opportunistic infections is not systematically available. In spite of the fact that these population groups face the highest risk of progression to active TB disease, TB prophylaxis with Isoniazid (INH) is lacking. With TB being responsible of most hospitalizations and deaths among PLHIV in the country, prevention needs to be ramped up.

In **DRC**, cotrimoxazole in GF-funded provinces is reserved for children and patients newly initiated patients on ART, while it is indicated more broadly in high malaria transmission areas to prevent co-morbidity in PLHIV.

HIV and TB drug resistance and antimicrobial resistance (AMR) are also poorly addressed and funded in many countries burdened by HIV, TB and malaria, in spite of considered a worldwide priority.

South Sudan's funding request to the GF states that emergence and transmission of drug resistance is expected to occur for both older and newer ART regimens. Monitoring assessments should guide national action plans. However, funding to conduct an HIV drug resistance (HIVDR) monitoring survey in both adults and children in 2023 has been referred to the UQD register.⁷⁹

⁷⁸ WHO, *Summary of tuberculosis data*, [Available online from] Summary of tuberculosis data (shinyapps.io)

⁷⁹ Funding Request Form South Sudan to the GF, *Op.Cit.*



V. LACK OF PREPAREDNESS AND RESPONSE TO CRISES

During crises and in so-called 'fragile contexts', multiple shocks (climatic, financial, political, health-related, conflicts, etc.) destabilize or exhaust existing health services. Increased access barriers often lead to worsening indicators for uptake of care, coverage, continuity of services and retention in care, setting back years of steady advances in health and the fight against the three diseases. To mitigate this, specific efforts are needed to ensure continuity of services for those already on treatment and for those that need to initiate treatment rapidly. Mitigation measures could include patients' access to care free of charge, drug distribution for longer periods of time and closer to home, community outreach, etc.

The concept of resilience frequently emphasizes how patients and communities should adapt in times of crisis. However, to mitigate the impacts of these shocks on the health of communities, patients and key vulnerable groups, donors and implementing partners also need to show agility and build-in the capacity to rapidly adapt investment, to ensure continuity of care and protect hard-won gains.

The Global Fund developed a policy of Challenging Operating Environments (COEs)⁸⁰ acknowledging the need for context-adaptable support to overcome specific challenges linked to weak or inequitable systems. This should allow for a high degree of flexibility in programming and methods of support to specific needs and contexts. However, the implementation of the policy is not optimal as it is often in tension with other endeavors, such as the policies linked to sustainability and transition from external support to domestic resource mobilization.

Lack of flexibility in donors financing modalities often contribute to funding shortfalls, undermining the possibility to react swiftly with the necessary adaptations to maintain services and mobilize rapidly much needed extra resources. Funding of investment in contingencies and preparedness cannot be squeezed into overly restrictive budgets.

⁸⁰ 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] [bm35_03-challengingoperatingenvironments_policy_en.pdf](#) ([theglobalfund.org](#))

In Northern **Mozambique**, where the conflict has been active for five years, all 40 HIV sites supported by PEPFAR had to be closed. With services interrupted, the lack of retention in care of patients previously on ART is dramatic, while treatment initiation has come to a standstill. Recent attempts to reopen 10 HIV sites combined with mobile clinic support are positive developments, but the overall situation in the North regarding the lack of HIV and TB care remains worrying. In March 2022, HIV testing of pediatric patients (including in the malnutrition ward) in the MSF-supported Mueda Rural Hospital showed over 30% positivity in children under five years of age. In addition, many women in the maternity ward had no previous screening during their pregnancy.

The reported treatment interruptions highlight the need to increase screening for AHD, with extra diagnostics and therapeutic tools to bring people back into care. However, the use of point of care for CD4 is not foreseen in plans of the MoH nor of international donors.

The experience with widespread floods in Mozambique over several years shows how continuity of services is vulnerable to extreme weather events resulting in stocks of medicines destroyed, facilities closed for months, and people displaced, creating the need for alternative treatment channels.

In the North Kivu province of **DRC**, where approximately 1,9 million people are internally displaced⁸¹, nothing is foreseen to ensure continuity of care, much like other provinces constantly facing deteriorating humanitarian situations. The lack of free care for people affected by HIV, TB and malaria, with the continued imposition of user fees, particularly for patients impacted by the on-going conflict and crisis, is extremely concerning.

In **South Sudan**, although the GF has targets for retention in HIV care of 85% by 2023, limited access to an already weak health system, forced displacement and other continuous shocks (environmental, violence, economic, food insecurity) makes this extremely challenging. The MSF programs in Ulang and Malakal see high rates of patients LTFU, respectively 73% and 66%, in part because services are not decentralized in the Upper Nile.

During rainy season in Nyirol and Uror counties (Jonglei state), already-poor physical access is worsened when roads are flooded, with patients that often can only be transported by stretcher. This may involve an 11 or 12-hour journey by foot in order to reach the nearest facility, with families often forced to sell their limited livelihoods (cows, goats) to cover transportation costs. As a result, many do not seek health services, leading to deterioration of treatable conditions and patients dying at home. The worsening food insecurity in 2022 further exacerbated adherence issues for HIV and TB, and other conditions including Hepatitis and diabetes.

Climate change has also significantly affected South Sudan with more frequent and more intensive rains, occurring beyond the usual rainy season. This results in more malaria and unforeseen needs for diagnostics, treatment and prevention, and difficulties to supply health facilities due to floods. Alert signs of increased food insecurity point to the risk of malnutrition effects on lowering immunity and therefore higher vulnerability to illness and death, in particular linked to malaria.

In Uganda, at the peak of the Covid-19 pandemic in 2020, access to care was limited or impossible for some patients due to transportation restrictions and curfews, lack of access to adequate services and staff at facilities and lower quality of service delivery. To mitigate this, the MSF team responded with a series of creative alternative ways to counsel and deliver medicine via tele-consultations and video call tele-counselling, direct phone consultations with patients, messaging via WhatsApp and community ART distribution. MSF also organized HIV drug deliveries to some patients, including those across the border in DRC.



⁸¹ UNHCR, *UNHCR deeply concerned by renewed violence displacing thousands in North Kivu, DR Congo*, 27 May 2022. [Available online from] UNHCR - UNHCR deeply concerned by renewed violence displacing thousands in North Kivu, DR Congo

This points to the urgent need for donors and implementing partners to mobilize and both develop and support models that mitigate the impact of service shortcomings and shocks on patients, including:

- Multiple months dispensing of medicines;
- Buffer stocks, including sufficient therapy kept by the patients, in case access is blocked by insecurity, displacement, lockdowns or during the rainy season;
- Programs that address knowledge barriers and stigma, which are meant to empower communities and stimulate autonomy;
- Context adapted approaches for contact tracing of people lost to follow up and welcoming disengaged people back into care⁸²;
- Dedicated funding and verification of suspension of user fees, ensuring care is obtained free of charge;
- Independent monitoring availability and access to essential medicines;
- Decentralized models to increase access to preventive and curative tools for hard-to-reach populations;
- Support to health workers in ensuring correct working and living conditions, and protection from violence;
- Targeted investment in CSOs to ensure first line reaction and continuity of care;
- Further development of flexibilities in the modalities and policies of aid and funding.

⁸² Keene C et al. Médecins Sans Frontières' *Welcome Service: a collaborative reorganisation of HIV services to address disengagement from care in Khayelitsha, South Africa*. [Available online from] <https://samumsf.org/sites/default/files/2019-06/Welcome%20Services.pdf>



VI. PATIENTS BEARING THE BRUNT OF THE FUNDING GAPS

To ensure access to HIV, TB and malaria care in both stable and crisis contexts, in line with UHC aspirations⁸³, financial barriers must be removed. This avoids or mitigates the negative effects of direct payments by patients on medical outcomes and on socio-economic strains on households. Retention in care of TB and HIV patients is critically affected by user fees, as is timely initiation of treatment. Financial barriers also cause delays in timely malaria treatment and the possibility to obtain a complete, quality treatment. Recent studies showed that under free-care policies, women were significantly more enabled to access care for themselves or their child.⁸⁴

In many settings, patients continue to bear the brunt of the funding gaps, leading to catastrophic health expenditure and damaging coping mechanisms, including forced lending, pawning assets or foregoing other essential household expenditure.

Gaps in availability of key medicines or inadequate remuneration of health workers are drivers of out-of-pocket expenses of patients. In order to ensure the latter's access to supplies or services already paid for by international or domestic funding, clear conditions are needed for effective implementation of free care policies and their independent monitoring.

In Myanmar, during the Covid-19 pandemic and socio-political turmoil, the United Nations Development Program (UNDP) projected that without functioning public institutions, nearly half of the country's population or some 25 million people risk ending up living below the national poverty line, backsliding the country to poverty levels not seen in a generation.⁸⁵ In 2021, a study by the WHO concluded that 60% of TB affected households in Myanmar faced catastrophic health costs, with the poorest hit the hardest.⁸⁶ Out-of-Pocket (OOP) spending on health pushes or keeps households in poverty. Patients are expected to have "cash in hand" when seeking care, regardless of whether they are seeking it from a private or public provider. Poorer households and those in rural areas spend significantly less on every component of health spending, signaling their lower capacity to seek care.



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⁸³ MSF, *Taxing the ill: how user fees are blocking universal health coverage*, 2017. [Available online from] <https://www.msf.org/report-taxing-ill-how-user-fees-are-blocking-universal-health-coverage>

⁸⁴ Samb O. et al; *The impact of free healthcare on women's capability: A qualitative study in rural Burkina Faso*. *Social Science & Medicine*; Volume 197, January 2018, Pages 9-16. [Available online from] <https://www.sciencedirect.com/science/article/abs/pii/S0277953617307189>

⁸⁵ UNDP, *Myanmar urban poverty rates set to triple, new United Nations survey finds*, December 2021. [Available online from] <https://www.undp.org/press-releases/myanmar-urban-poverty-rates-set-triple-new-united-nations-survey-finds>

⁸⁶ Si Thu Aung et al., *Measuring catastrophic costs due to Tuberculosis in Myanmar*, *Trop Med Infect Dis*. 2021 Jul 14; 6(3) : 130. [Available online from] [Measuring Catastrophic Costs Due to Tuberculosis in Myanmar - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/35444444/)



In **DRC**, direct payment of households on health expenditure represented a staggering 42% of total health expenditure in 2019.⁸⁷ It is estimated that 17% of households spend more than 10% of their total household expenditure on health.⁸⁸ Even if diagnostic and therapeutic tools for HIV are largely subsidized by the Global Fund and PEPFAR, user fees continue to constitute a significant barrier, with patients unable to afford prices asked for key elements of care, such as VL testing, laboratory services for HIV and TB diagnosis, detection and treatment of opportunistic infections, hospital admission and repeated consultations. PLHIV, including those in need of urgent care, are facing exclusion, delayed initiation, retention barriers, substandard care and catastrophic health expenditure.⁸⁹ Regularly the CSO observatory of UCOP+ reports a wide range of fees required from patients for HIV and TB care; they also report stock-outs of key tests or drugs, making people dependent on private pharmacies or resulting in interrupted treatment when unaffordable.⁹⁰

In 2020, 71% of the population in **CAR** were living below the international poverty line (< 1.9 US\$/day, PPP).⁹¹ Financial barriers constitute a major obstacle to access care in general, and more specifically for HIV-services despite a declaration of free care policy for PLHIV. According to testimonies collected by MSF teams and other stakeholders, patients face user fees at almost every stage of the patient circuit:

- A fee of about US\$ 3 is charged in all facilities for initial HIV-testing (VCT, PICT, Index Testing, etc.);
- Many patients are not initiated on ART on the same day of their testing (in spite of the test-and-treat recommended approach) because some health facilities impose an unnecessary pre- initiation biological assessment with an outrageous cost (from US\$ 45 to US\$ 90 per test);
- PLHIV are often forced to pay for their consultation and tests to avoid relegation to a “non- priority” circuit for their follow-up, with a high risk of delays, incomplete care and neglect, as they are not contributing financially to the health staff or facilities. This is both a source of stigma and increased risk of LTFU;
- Because of a lack of financing, free of charge AHD medicines are missing in public health facilities. Patients are obliged to buy their medication for opportunistic infections either in the health facilities pharmacy or in private pharmacies. If they cannot afford it, they have to do without.

Similar obstacles of unavailable and unaffordable care are also omnipresent in TB care, such as: payment of initial consultation fees or on admission, para-clinical examinations such as X-rays, which are not free and difficult to access; and the transport costs due to the distance of testing and treatment sites. All this makes the access to diagnostic and treatment particularly challenging.

⁸⁷ DRC's Ministry of Health. Annual Health Report 2020, Kinshasa: 2021.

⁸⁸ Eze P. et al. (2022); *Catastrophic health expenditure in sub-Saharan Africa: systematic review and meta-analysis*. Bull World Health Organ 2022; 100-337-251J; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9047424/pdf/BLT.21.287673.pdf>

⁸⁹ Carillon S., Ridde V. (2021) *Permanence et invisibilité des paiements directs pour le VIH en RDC*. In : *Une couverture sanitaire Universelle en 2030 ?* Québec, Canada : Editions science et bien commun, 2021 ; 503-30. [Available online from] <https://scienceetbiencommun.pressbooks.pub/cus/>

⁹⁰ UCOP+ (Union Congolaise des Organisations de PvVIH) monthly HIV/TB Observatory Reports from 2022, DRC. [Available online from] <https://ucopplus.org/rapports>

⁹¹ The World Bank in Central African Republic, last accessed 14 July 2022. [Available online from] Central African Republic Overview: Development news, research, data | World Bank



Guinea's population continues to struggle with instability, recurrent epidemic outbreaks and economic problems, which affects its health needs and ability to access care. In spite of a nationwide policy declaring malaria care free of charge (as is also the case for HIV and TB), the civil society health access watchdog OCASS (Observatoire Citoyen d'Accès aux Services de Santé) reported that over the first quarter of 2022 up to 28% (55 out of 197) malaria patients interviewed declared that they had been asked to pay for their treatment (between US\$ 5.7 and US\$ 23), while 18% paid for their tests and lab exams (between US\$ 2.3 and US\$ 6.9).⁹² Additional hidden costs for malaria treatment include paracetamol and Oral Rehydration Salts at all levels of healthcare, while people also have to pay for perfusion liquids, syringes, needles, disinfectants, gloves, etc. in health centers and hospitals. None of these are included in external funding support for malaria-. This often represents a real burden for patients and deters them from seeking care. It also questions the application and monitoring of policies of free care for HIV, TB and malaria.

⁹² OCASS (Observatoire Citoyen d'Accès aux Services de Santé), *Bulletin OCASS : 1er trimestre 2022*.

CONCLUSIONS AND RECOMMENDATIONS

The Covid-19 crisis and the current worldwide economic downturn are widening service gaps and shortfalls in funding for key health interventions necessary to respond effectively to the urgent needs of people affected by HIV, TB and malaria. Worldwide figures show a worrying trend in the loss of coverage and pace of the response. Countries and communities facing additional difficulties are hit disproportionately and need dedicated additional support to catch up on losses, stagnation and gaps in care.

In this briefing paper, MSF described some of the real-life consequences for patients, health providers and people facing these (risk of the) three diseases resulting from service gaps and funding shortfalls.

Funding shortfalls affect medical supplies and weaken its last mile support, resulting in stock-outs, discontinuous or insufficient availability of key medical supplies and increased financial barriers for patients. In several countries, MSF teams see a standstill or sliding back of coverage and stagnation in scaling-up: less HIV testing and treatment initiation, reduced PMTCT services, lower and slower tuberculosis diagnosis and treatments, more patients on ART and TB treatment LTFU, gaps in malaria treatment coverage in spite of increasing number of cases, delays and gaps in insecticide-treated nets, etc.

Patients bear the brunt of these shocks and shortfalls. Very often, important services are de-prioritized or delayed; certain communities go without the necessary support or see significant cutbacks. Lack of resources opens the door for substandard care, with countries unable to neither implement evidence-based care packages nor adhere to guidance by the WHO. Innovative approaches and possible game changers in making progress cannot be implemented without realistic funding. Moreover, preparing communities for shocks and maintaining the needed response during times of crisis often fails.

Consequently, people affected by HIV, tuberculosis or malaria face more clinical complications and higher mortality risks. This places an extra burden on already stretched health services and vulnerable communities. Such strains can further erode gains made and impact the epidemic dynamics, such as shown by the growing risks for resistance and increased transmission and incidence. As known, dedicated support for HIV, TB,

malaria services contributes to stronger health services overall and the experience in fighting the three diseases provides useful lessons learned to strengthen health care systems.⁹³

In the 2019 report 'Burden Sharing or Burden Shifting?', MSF drew attention to much needed and crucial actions which remain just as valid today. Several international donors have withdrawn further from supporting HIV/AIDS, tuberculosis and malaria programs in countries most affected. Often funds were diverted to the Covid-19 response or to aid closer-to-home, with an overall negative net effect on health grants to many low resource countries. International donors targeting general health improvements, health systems strengthening and contributions to Universal Health Coverage, mobilize insufficient resources and rarely include specific needs or dedicated investments for people affected by HIV/tuberculosis/malaria.

In the Global Fund investment case for the response against the three diseases, the expected contributions of domestic finances from affected countries are the main launch pin, but particularly in the current economic reality and with many competing expenses, these projections are likely overestimated. As a consequence, foreseen funding gaps are likely to grow, and additional gaps appear as overly-optimistic plans fail to materialize. It is necessary to replace current plans with higher, more realistic commitments in line with the urgent need to bridge these gaps.

Even the Global Fund's ask for the replenishment keeps the course (14% of estimated overall need for all three diseases in countries supported by the Global Fund) instead of requesting an additional resource injection in line with necessary catch up efforts and the growing unmet needs.

Pandemic preparedness and response for future pandemics, presently much discussed, cannot be envisaged without proper investment to prevent and treat three major pandemics of today, namely HIV/AIDS, tuberculosis and malaria.

⁹³ Samb B. et al. (2009) *An assessment of interactions between global health initiatives and country health systems*. The Lancet Volume 373. Issue 9681. Pg. 2137-2169. [Available online from] [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60919-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60919-3/fulltext)



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To have any pretension to reach the 2030 Global Goals, and more importantly to secure the health and welfare of highly vulnerable and poor populations, the international donor community must act now to:

Reclaim gains with sustained, focused and expanded funding to reduce transmission, morbidity and mortality related to all three diseases. This means that the US\$18 billion ask from the Global Fund must be understood as the floor and not the ceiling. Many countries depend on the GF as only international funding source for HIV, TB and malaria. This is the absolute minimum to avoid sliding further off track.

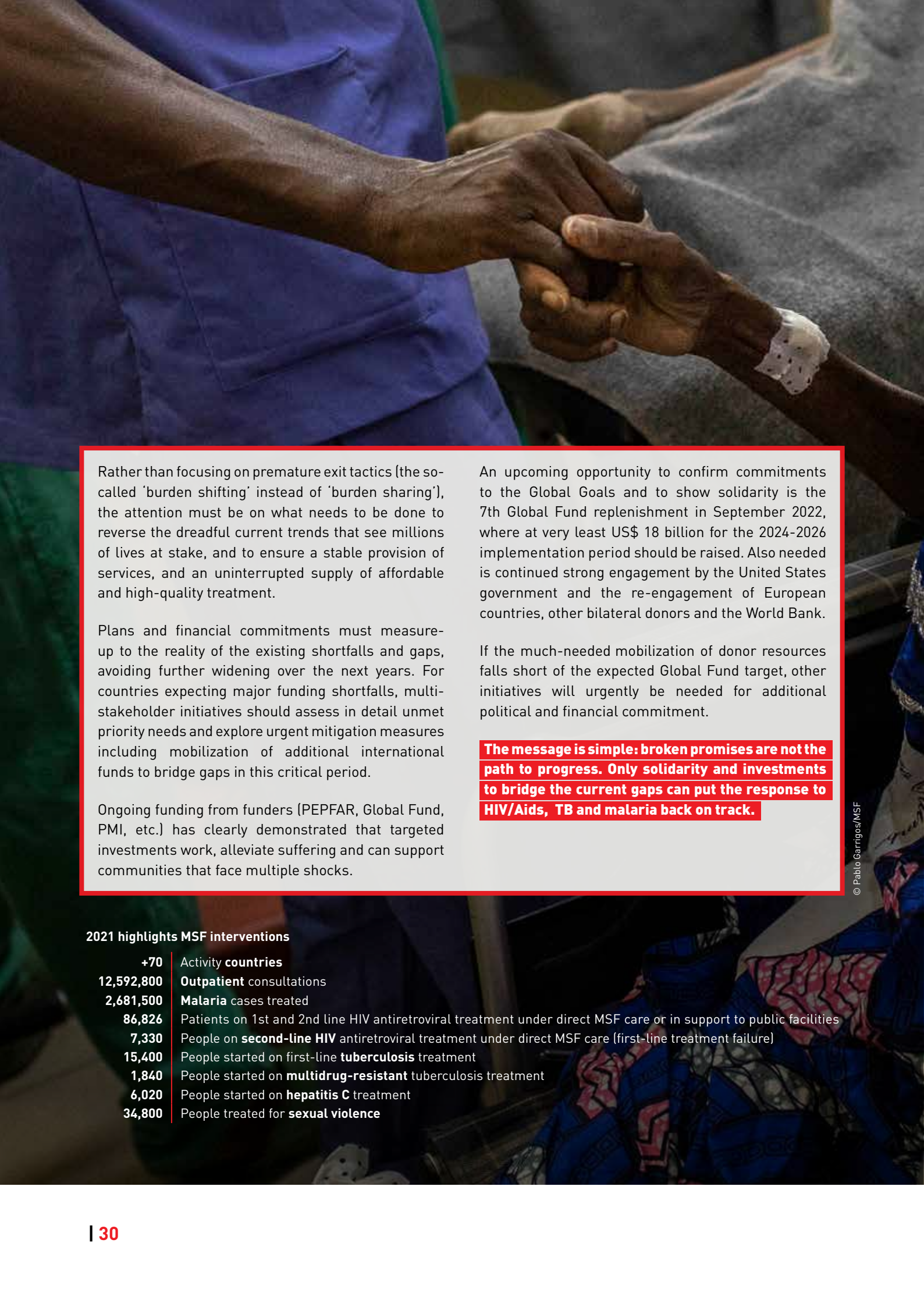
Re-engage international donors in the response to HIV/tuberculosis/malaria, directly, and in addition to the Global Fund. In view of the current challenges to mobilize sufficient domestic funding and to compensate for withdrawing international funders, increasing overall international contributions from multiple sources is important. Right now, there is an urgent need in gap-filling for unfunded interventions, such as those identified by countries and accepted by the Global Fund in the UQD register.

Prioritize without rationing or cutting effective interventions: Equitable approaches to health care require managing competing priorities, not eliminating those that are deemed essential but unaffordable. De-prioritization, leading to rationing and budget reduction, as witnessed by MSF teams, means less people have access to get tested, diagnosed, treated and get the necessary follow-up, more are LTFU. Novel approaches as well as essential support of communities and CSO risk being left off the table.

Focus on people and communities facing the deadliest gaps: Resources should, in priority, be channeled to interventions known and shown to reach patients effectively, avoiding unnecessary excess deaths and suffering. Children and women bear the deadly brunt of the unmet needs in HIV, tuberculosis and malaria. Vulnerable groups and victims of exclusion and discrimination face more severe gaps. Certain communities are disproportionately affected and vulnerable to further deterioration, especially those susceptible to multiple shocks (natural disasters, epidemics, food insecurity, conflict, etc.). People in crisis contexts and depending on fragile (health) systems need more attention.

Ensure last mile delivery to patients by insisting on realistic assessments of investments needed: Acknowledge existing gaps in services, in the context of present world realities is essential to get the HIV/AIDS, TB and malaria response back on track. Any pretension that things are better than they are or wishful 'resource mobilization thinking' risks to aggravate gaps causing costs to be pushed back on to patients (out-of-pocket payments), increased stock-outs, the erosion of quality and access to essential services and innovative care models, including investments into community led-approaches.

Push innovative models of care and the latest up to date evidence-based commodities: Those with the greatest needs, living in the most challenging environments need innovative approaches that increase detection, reduce transmission and create the best chance of treatment adherence. Adopting improved strategies and tools have been shown to be potential game changers to control pandemics. This includes **targeted investment for CSOs** to ensure that they are recognized and valued partners in the fight against all three diseases.



Rather than focusing on premature exit tactics (the so-called 'burden shifting' instead of 'burden sharing'), the attention must be on what needs to be done to reverse the dreadful current trends that see millions of lives at stake, and to ensure a stable provision of services, and an uninterrupted supply of affordable and high-quality treatment.

Plans and financial commitments must measure-up to the reality of the existing shortfalls and gaps, avoiding further widening over the next years. For countries expecting major funding shortfalls, multi-stakeholder initiatives should assess in detail unmet priority needs and explore urgent mitigation measures including mobilization of additional international funds to bridge gaps in this critical period.

Ongoing funding from funders (PEPFAR, Global Fund, PMI, etc.) has clearly demonstrated that targeted investments work, alleviate suffering and can support communities that face multiple shocks.

An upcoming opportunity to confirm commitments to the Global Goals and to show solidarity is the 7th Global Fund replenishment in September 2022, where at very least US\$ 18 billion for the 2024-2026 implementation period should be raised. Also needed is continued strong engagement by the United States government and the re-engagement of European countries, other bilateral donors and the World Bank.

If the much-needed mobilization of donor resources falls short of the expected Global Fund target, other initiatives will urgently be needed for additional political and financial commitment.

The message is simple: broken promises are not the path to progress. Only solidarity and investments to bridge the current gaps can put the response to HIV/Aids, TB and malaria back on track.

2021 highlights MSF interventions

+70	Activity countries
12,592,800	Outpatient consultations
2,681,500	Malaria cases treated
86,826	Patients on 1st and 2nd line HIV antiretroviral treatment under direct MSF care or in support to public facilities
7,330	People on second-line HIV antiretroviral treatment under direct MSF care (first-line treatment failure)
15,400	People started on first-line tuberculosis treatment
1,840	People started on multidrug-resistant tuberculosis treatment
6,020	People started on hepatitis C treatment
34,800	People treated for sexual violence

ABBREVIATION LIST

ABC/3TC + EFV	abacavir sulfate/lamivudine + effavirenz	KP	Key population
ACTs	ACT Artemisinin-based combination therapy	LLIN	Long lasting insecticide-treated net
AGYW	Adolescent girls and young women	LTFU	Lost to follow-up
AHD	Advanced HIV disease	MDR-TB	Multidrug Resistant Tuberculosis
AIDS	Acquired immunodeficiency syndrome	MMD	Multi-Month dispensing
AMR	Anti-microbial resistance	MMT	Methadone maintenance treatment
ANC	Antenatal Care	MoH	Ministry of Health
ART	Antiretroviral therapy	MSF	Médecins Sans Frontières
ARV	Antiretroviral	MSM	Men having sex with men
CAR	The Central African Republic	NDB	National Development Budget
CD4	Cluster of differentiation 4	OCASS	Observatoire citoyen sur l'accès aux services de santé
COE	Challenging Operating Environment	OCHA	United Nations Office for the Coordination of Humanitarian Affairs
CrAg	Test detecting cryptococcal antigen	OOP	Out-of-pocket expenses
CSO	Civil Society Organization	ORS	Oral Rehydration Solution
DOT	Directly observed treatment	PEP	Post-exposure prophylaxis
DRC	The Democratic Republic of the Congo	PEPFAR	US President's Emergency Plan for Aids Relief
DRM	Domestic resource mobilization	PICT	Provider-initiated counseling and testing
DR-TB	Drug-resistant Tuberculosis	PLHIV	People living with HIV
DSD	Differentiated service delivery	PMI	The US President's Malaria Initiative
DST	Drug sensitivity testing	PMTCT	Prevention of Mother-to-Child Transmission
DTG	Dolutegravir	PPP	Purchasing power parity
EID	Early Infant Diagnosis	PrEP	Pre-exposure prophylaxis
EPI	Expanded Program on Immunization	RDT	Rapid Diagnostic Test
FSW	Female Sex worker	SGBV	Sexual and gender-based violence
GAVI	The Vaccine Alliance	SMC	Seasonal Malaria Chemoprevention
GF	The Global Fund to fight AIDS, tuberculosis and malaria	SW	Sex workers
HF	Health Facility	TB	Tuberculosis
HIV	Human immunodeficiency virus	TPT	TB preventive treatment
HIVDR	HIV drug resistance	UHC	Universal Health Coverage
HR	Human resource	UN	The United Nations
HPF	The Health Pooled Fund	UNDP	United Nations Development Programme
HZ	Health Zone	UNAIDS	The Joint United Nations Programme on HIV/AIDS
IBBS	Integrated Biological and Behavioral Surveillance Survey	UNHCR	United Nations High Commissioner for Refugees
IDP	Internally Displaced Population	UQD	Unfunded Quality Demand
IDU	Injecting Drug User	VCT	Voluntary Counseling and testing
INGO	International Non-governmental Organization	VL	Viral Load
INH	Isoniazid (TB preventive treatment)	WCA	Western and Central Africa
IPC	Integrated food security Phase Classification	WHO	The World Health Organization
IRS	Indoor residual spraying		





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