

Pushing the envelope

Does the Global Fund's New Funding Model foster country ambitions?

1. A view from the field at a pivotal moment

Since the Global Fund to Fight AIDS, TB and Malaria (GF) cancelled its funding round in 2011, Médecins Sans Frontières (MSF), governments, and people affected by the three diseases have all called for international efforts to scale up HIV, TB and malaria programmes to be put back on track. Despite funding constraints, there has been some notable progress. Commendable efforts have been made in countries like Mozambique, Malawi and Zimbabwe to continue to scale up and strengthen HIV programmes.

However, several key high-impact interventions have been put on hold while waiting for the GF to make new funding opportunities available again. The much-awaited awarding of new grants through the New Funding Model (NFM) in 2014 is probably the single most important opportunity within the next few years, as it will determine whether the fight against the three major killer diseases will be able to pick up speed. But will the GF's New Funding Model allow countries to deliver the scale-up that is necessary?

We therefore call upon the Global Fund and technical partners to provide consistent and clear communication regarding the different components of the New Funding Model, with clear guidance on how their concept notes can effectively reflect the needs in a 'full expression of prioritised demand'.³

Scale-up of access to antiretroviral treatment (ART) is on track to meet the 15 by 15 target.¹ Now, UNAIDS and others are calling for 90% of people to know their HIV status, 90% of people eligible for treatment, successfully linked to care, and 90% of people on ART to have their viral load suppressed to undetectable levels by 2020.²

However, the resources to match these ambitions have yet to be made available. At the end of 2013, the GF fell short by nearly US\$3 billion of what was an already modest request to its donors for the period 2014-16 compared



Andre Francois

to the needs. Ambitious targets for HIV programmes will need to be matched with more ambitious resource mobilisation targets, both for donors and implementing countries.

After years of reforms and measures put in place to cope with a funding shortfall, the Global Fund's New Funding Model presents an unmissable opportunity, and MSF expects to see further progress as countries seize this momentum. However, a lack of clarity at country level regarding the New Funding Model, combined with low-level country funding allocations, may pose a threat to this progress. We therefore call upon the Global Fund and technical partners to provide consistent and clear communication regarding the different components of the New Funding Model, with clear guidance on how their concept notes can effectively reflect the needs in a 'full expression of prioritised demand'.³

This issue brief outlines key aspects of the New Funding Model that are critical for countries to put into practice. While the brief does not provide a broader analysis of the implementation of the New Funding Model, the second section provides observations from MSF teams working in the field of HIV in Democratic Republic of Congo, Guinea, Mozambique and Malawi regarding the current needs and challenges as these countries prepare their strategic plans and concept notes to access funding. July 2014. Contact for information: MSF, Brussels: aau@msf.org

2. Is country demand being curtailed for the sake of funding predictability?

The long awaited Global Fund New Funding Model was expected to increase predictability for countries receiving funding through a shorter and simplified process. Uncertainty about 'winning' a round would be replaced by an envelope or 'allocation' per country. However, combined with a complex set of eligibility criteria, the net effect has been that funding dynamics have essentially turned from pull to push.

Often presented as the answer to the need for more 'predictability', the allocation makes up the majority of funding available to a country. However, the New Funding Model also includes important elements that aim to incentivise country ambitions and to allow countries to obtain an increase in funding, above their allocation. Country programmes can receive additional Global Fund funding through a competitive process from an 'incentive funding' pool. A third opportunity is the register of 'Unfunded Quality Demand' (UQD), where high-quality country demand exceeding funding available (through allocations and any incentive funding awarded) is placed. The UQD will be funded by additional contributions to the Global Fund, or can be funded directly by other donors. Countries are therefore strongly encouraged to submit ambitious concept notes.

While there is no limit to the size of the 'above allocation' request, it needs to be strongly justified to be awarded additional funding. A country's concept note should there-



fore reflect the framework – both funding and programmatic – for future plans in the fight against HIV, TB and malaria (preferably based on a strong National Strategic Plan). It should also signal to the Global Fund's donors those areas where additional contributions are needed.

The New Funding Model thus preserves a key principle laid down at the creation of the Global Fund, and making it fundamentally different from most traditional funders: that countries should be in the driver's seat to define demand and determine their strategic priorities. The built-in mechanisms to incentivise ambition were created to preserve this unique characteristic of the Global Fund. A prerequisite for countries to use these mechanisms, however, is that they receive unambiguous information and clear guidance on the opportunities and how to use them.

3. Donor funding shortfall: a key determinant of country allocations

In March 2014, the Global Fund notified each country of its base funding allocation for the coming years. These allocations were made based on a combination of criteria (such as income level and burden of disease) and on the amount of overall funding available at the Global Fund at the start of 2014.

However, as the Global Fund also recognises, since the allocations are the result of dividing up the available funds at a certain point in time, they do not reflect an implementing country's actual needs, nor its plans or capacity to realise them. The sum also does not reflect potential future funding levels as a result of continued resource mobilisation efforts by the Global Fund and others.

The Global Fund remains a victim of its success, spending significant amounts of money to sustain tangible health results. With stagnating donor contributions well below the original target of US\$10 billion per year,⁴ the Global Fund has revised its eligibility criteria and put on hold new

grants for scale-up while adapting its funding model. A more targeted approach to 'counterpart financing' from implementing countries has been adopted, while several of the Global Fund stakeholders have pointed out the need to keep expectations of significant increases in domestic finances in the short term realistic, particularly in lower-income countries.⁵

While the amount of money made available to the Global Fund by donors for the period 2014-16 may represent an increase over time, it is insufficient to provide funding to countries that need not only to sustain their gains, but also to take on the challenges within HIV, TB and malaria programmes that will curb the human costs of these killer diseases.

Much time and effort has been dedicated to creating the formula that generates each country's allocations, with additional qualitative context-based criteria to mitigate the limitations of a formula-based allocation. However, no matter how sophisticated a certain formula or set of criteria may be, this cannot make up for an overall shortfall in funding. Based on the objective of the New Funding Model to distribute funding more fairly according to a country's disease burden and ability to pay, it also means distributing the damaging impact of a funding shortfall, albeit in a 'fair' manner across eligible countries.

4. Lack of clarity risks undermining country ambitions

The Global Fund acknowledges that limited resources in most countries will entail a funding gap between ultimate goals and available resources. Nevertheless, on the basis of the New Funding Model's principle to incentivise ambition, it encourages countries not to let the funding gap "limit planning of ambitious national strategic plans and concept notes". In a letter to countries announcing their allocations, the Global Fund states: "to defeat these diseases, we all need to think big".

However, in several countries where MSF is working, our partners are confused by the messages received from the Global Fund and technical partners regarding their funding requests. They do not feel particularly motivated to express their full demand, and receive unclear messages regarding the ability to request funding above the allocation, as well as the possibility of shortening the grant implementation period in order to maximise impact of this limited funding allocation. In some cases, countries have been recommended to cut down the size of their requests as they were considered "too high".

Confusion regarding how to use different modalities of the New Funding Model has been noted in several countries which received low allocations compared to the needs, barely at the level of previous years, or funding which represented only a small portion of additional funds to already existing grants. In these countries, full expression of demand is particularly necessary.

In Malawi, the total allocation is likely to barely cover ARV treatment costs, while a range of interventions is needed to strengthen Malawi's burdened programme. In Mozambique, the allocation represents an increase compared to historically very low levels of funding, but it still falls dramatically short of covering the funding needs for the ongoing high-impact interventions needed to accelerate access to treatment.



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The annual amount in the allocations received by Guinea and DRC barely reach the level of funding of previous years, which was a period plagued by major constraints and delays in both funding and implementation. Both countries are in urgent need of a catch-up plan to make up for the backlog in scale-up.

The lack of clear communication about how the Global Fund arrives at the specific amounts has caused confusion and raised questions about the real intentions of the New Funding Mechanism and its ability to realise its promises. For many countries with high disease burdens and low income levels, the allocations will not be able to cover basic funding needs. A formula based on country income levels and disease burdens, which also appears to give significant weight to 'historic disbursement levels', has in several cases generated allocations that dramatically differ from today's needs and implementation capacity.

The disappointingly low allocations that some countries have been offered must not be perceived as the final financing result for the coming years. Countries should remain ambitious and express the full extent of their needs in terms of the fight against HIV, TB and malaria. It is crucial that donors are aware that additional money is needed to reduce morbidity, mortality, and new cases driven by the three diseases.

5. Making the new funding model work for scale-up, impact and innovations

For the Global Fund to remain a driving force in beating the three diseases, it is critically important that, together with technical partners, it proactively encourages countries to make full use of all channels in the New Funding Model and to respond to the invitation for concept notes that fully reflect the country's programme and funding needs for the coming years.

Both MSF's own experience as a care provider in many poor countries and the latest scientific evidence show that barriers which impose funding constraints could not have arrived at a worse time, with crucial new opportunities potentially being lost. These include: a drop in fatalities



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from HIV/AIDS; early treatment that reduces the risk of HIV transmission and development of TB; the arrival of long-awaited new TB drugs; better outcomes demonstrated through decentralised care; and investments made in effective malaria prevention and treatment in view of the development of resistance.

Countries should now seriously consider implementing the key interventions to scale up services and improve the packages of care as recommended in the WHO guidelines for the management of HIV. These include: the roll-out of viral load monitoring for people on ARV treatment⁶; early provision of treatment; integration of HIV and TB care; and expansion of community-based testing and refill dispensing in order to reach more people and improve retention in care.⁷ For improved detection and treatment of TB and drug-resistant TB (DR-TB), strategies include: improved contact tracing and case finding; decentralisation of TB services; testing for drug sensitivity; implementing short-course DR-TB regimens; and use of new effective TB drugs (such as bedaquiline). For malaria, there are critical shortages in the availability of rapid diagnostic tests and artemisinin based combination therapy (ACT), while the replacement cycle of bednets requires further efforts.

Limited resources at the Global Fund must not slow down the pace of efforts to fight HIV, TB and malaria. The allocations from the Global Fund should not be considered a funding ceiling to restrain concept notes or National Strategic Plans.

The attention to practical and technical aspects of the New Funding Model should not overshadow the strategic role played by the Global Fund in the fight against these three diseases, outlined in its 2012-16 strategy "Investing for impact". Now is the time to use the New Funding Model to boost countries' ambitions, allowing them to catch up and setting us on a course to beat HIV, TB and malaria.

The countries, the Global Fund and partners should seize the momentum by making full use of the New Funding Model. We encourage all stakeholders to contribute to this task in the following ways:

- **Countries preparing their concept notes should fully demonstrate their real needs to achieve scale-up and higher impact. Discussions at country level regarding these needs and priorities should take place without considering the allocation as the ceiling for the funding request.**



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- **The Global Fund Secretariat and technical partners should assist in providing urgent and high quality support and guidance to countries that are revising their national plans and preparing funding requests, including:**
 - proactively increasing quality technical support to help the development of concept notes, particularly for countries working on incentive stream requests, in support of prioritising needs without censoring the full expression of demand
 - providing assistance to countries that wish to request a shortening of grant duration period to maximise programme impact
- **The Global Fund, technical partners and all other stakeholders should ensure consistent, clear and quality controlled communication in order to stop inadvertently contradicting messages being sent**
- **The Global Fund, donors and countries themselves should proactively live up to their announced intentions to continuously raise the needed resources to fund quality demand.**

1. UNAIDS global target to have 15 million people on ARV treatment by 2015.
2. Ambitious treatment targets: writing the final chapter of the AIDS epidemic, UNAIDS 2014 http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/JC2670_UNAIDS_Treatment_Targets_en.pdf
3. "Full expression of demand" is the total funding needed for an appropriate response to the disease(s). Countries are encouraged to submit a prioritised request for this full amount in the concept note. See Global Fund's Resource book for applicants, Feb 2014: [file:///C:/Users/kakerfeldt/Downloads/FundingModel_ResourceBook_ForApplicants_Book_en%20\(3\).pdf](file:///C:/Users/kakerfeldt/Downloads/FundingModel_ResourceBook_ForApplicants_Book_en%20(3).pdf)
4. Secretary-General proposes Global Fund for fight against HIV/AIDS and other infectious diseases at African leaders summit, April 2001 <http://www.un.org/News/Press/docs/2001/SGSM7779R1.doc.htm>

5. See UNAIDS report on the global AIDS epidemic 2013 for description of global disparities in increase of domestic funding of the HIV response: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf
6. <http://www.msfastcess.org/content/putting-hiv-treatment-test>
<http://www.msfastcess.org/content/issue-brief-how-low-can-we-go>
http://www.msf.org.za/sites/msf.org.za/files/Publication/Documents/viral_load_toolkit_2013.pdf
http://www.msf.org/sites/msf.org/files/hiv_msf_issuebrief_viral_load_2014_b.pdf
7. See <http://www.msfastcess.org/content/speed-scale-strategies-tools-and-policies-get-best-hiv-treatment-more-people-sooner> and http://www.msf.org.za/sites/msf.org.za/files/Publication/Documents/reaching_closer_home.pdf

DEMOCRATIC REPUBLIC OF CONGO

An unacceptable status quo

The official HIV prevalence for Democratic Republic of Congo (DRC) is estimated at 1.2%.¹ This percentage is low compared to other countries in sub-Saharan Africa, but with an estimated 446,046 people living with HIV in the country, DRC is nevertheless defined as a high-burden country. According to the national AIDS programme, in late-2013, 76,418 people were receiving ARV treatment in DRC² out of 420,000 people eligible to start immediate treatment.³

Treatment coverage is therefore just 18%, which is among the lowest in sub-Saharan Africa. Coverage in the capital, Kinshasa, is only marginally better, highlighting how barriers linked to the health system are as significant as problems of logistics and distance in hindering timely access to care. For certain groups, access is even more difficult. Only about one in ten children in need of ARVs is on treatment, while only 28% of HIV-positive pregnant mothers obtain ARVs to prevent infection to their unborn children and for their own health.⁴

People in DRC generally start treatment late, when the disease has already weakened their health, and when the chance of a successful recovery from severe complications is reduced. In MSF's HIV clinic in Kinshasa, 80% of patients arrive in clinical stages 3 or 4. MSF's experience shows that patients access MSF clinics only after a long, painful and costly search for diagnosis and care, losing not only their health but also their already limited resources to a health system in which practically everything needs to be paid for. The barriers imposed by the cost recovery system prevent patients from knowing their status and whether they qualify for treatment. Many people report they need to pay for consultations, HIV tests, CD4 counts and other lab examinations, before they can start ARV treatment.⁵

Financial support to NGO-managed and community based sites offering tests and care free-of-charge has reduced over the past few years. Meanwhile, the number of health facilities able to provide ARVs has increased, but the number of ART initiations only marginally.

DRC is lagging behind in applying medical strategies and models of care that have proven very effective in other countries in Africa. The country has adopted the 2013 WHO guidelines, but their implementation is limited to NGO-supported clinics. Due to delays in the supply of sufficient quantities of tenofovir (TDF)-based regimens, the government has discouraged health workers to switch from AZT. According to current plans, a formal start of using TDF will take place in 2015 at the earliest.⁶ To improve access to ARV treatment, the country is in dire need of strategies such as: task shifting to nurses and lay workers; ensuring free access to services; community-based treatment;



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patient support groups etc. MSF's experiences in DRC have shown improved outcomes among stable patients who can access their medicines outside the health facility, through structures run by patient associations within the community in Kinshasa, and by self-support patient groups in other provinces. More than 90% of these stable patients remain in care after two years, a far better outcome than in those followed at health-centre level.

Opportunities and constraints related to the GF New Funding Model

In 2013, as a result of a review of its national HIV strategy the government revised its implementation approaches with the aim of overcoming barriers experienced in the past. Some of these barriers were closely linked to the GF's grant management, to implementation challenges and to consistently low funding levels for the HIV programme. The GF remains the main source of funding

“When we see the desperate situation in countries like DRC, we feel like we’re in a timewarp. The severe complications of full-blown AIDS remind us of what we witnessed in southern Africa before the year 2000, when ARV treatment was not available and death was everywhere.”

Dr Eric Goemaere, who started one of MSF's first HIV treatment programmes near Cape Town.

MSF in DRC

MSF provides ARV treatment for some 7,500 patients (as of end-2013). The majority of these patients (6,000) receive care in the capital, Kinshasa, either in health centres supported by MSF, through community dispensing units run by local patients' associations, or in three hospital wards providing dedicated AIDS care for complicated and severe cases. Outside the capital, almost 1,500 patients receive ARV treatment in referral hospitals supported by MSF in the provinces of Nord and South Kivu, Katanga, Orientale and Maniema.

for HIV in the country, financing ARVs for 65,000 out of the total 76,000 patients on treatment. Aside from the GF and PEPFAR, other health donors in DRC make no significant contribution to ARV scale-up.

As one of the early applicants invited in 2013 to submit a funding request through the GF's New Funding Model, DRC submitted a first proposal in January 2014 and is now revising its proposal for resubmission as a joint HIV/TB proposal in August 2014. Since the DRC had received a very limited allocation amount (US\$130 million)⁷ – which represented the same level of GF funding as in previous years – DRC recognised the need to make use of the New Funding Model mechanism by submitting a request for an additional US\$96 million above the allocation amount. However, the request did not cover some of the basic needs and did not propose a strategy change that was ambitious or radical enough to improve access to critical services and to scale up treatment, testing and prevention measures. Notably, the Technical Review Panel (TRP) found the PMTCT targets not ambitious enough. It remains to be seen whether DRC's revised request will include improved targets and better reflect full expression of quality demand.

To ensure that the resources are optimised for an effective response, DRC needs to address problems in service delivery and in grant and supply chain management. It also needs to set more ambitious targets and to put in place more elaborate patient-centred and community-based strategies. An urgent catch-up plan is needed to overcome existing barriers to quality treatment and care. DRC must ensure its request reflects full expression of demand and includes key components discussed during the national dialogue and its national strategic plan for HIV, including:

- **Implementing treatment plans in line with WHO 2013 recommendations, including the roll-out of viral load monitoring, early initiation on treatment, and a fast transition to preferred TDF-based regimens.**
- **Ensuring that PLWHA have free access to HIV testing, CD4 tests, ARV treatment, care for opportunistic infections and treatment services.**
- **Providing diagnostics and treatment for common opportunistic infections such as cryptococcal meningitis.**
- **Improving coverage of diagnosis, care and treatment for children.**
- **Ensuring an uninterrupted supply of commodities, through buffer stocks and contingency plans, with a system for responding fast to low availability at health structure level.**
- **Expanding community-based testing and refill dispensing in order to reach more people and improve retention in care.**
- **Providing psychosocial support, tracking patients lost to follow-up and providing adherence counselling (including by lay cadres) at both health structure and community level.**



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1. Due to limited data and to the most recently available population-based survey being from 2007, we here refer to the latest 2013 estimated prevalence of 1.2%. This figure does not reflect geographical variations, eg prevalence in Katanga province is up to 15% (Kasumbaleza) and in Orientale province is up to 8%.
2. Rapport sur l'état d'avancement de la réponse à l'épidémie du VIH/sida (GARPR DRC), 2014. http://www.unaids.org/en/data-analysis/knowyourresponse/countryprogressreports/2014countries/COD_narrative_report_2014.pdf
3. Global report: UNAIDS report on the global AIDS epidemic 2013. "UNAIDS / JC2502/1/E" - Revised and reissued, November 2013, page A99. See: <http://www.unaids.org/en/resources/campaigns/global-report2013/globalreport/>
4. UNAIDS country progress report 2014, based on DRC National Aids

Programme (PNLS) annual activity report 2013. See: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/COD_narrative_report_2014.pdf

5. In spite of 70% of people in DRC living on less than US\$1 per day, patients are expected to pay equivalents of US\$5 for a consultation, US\$8-12 for laboratory tests before initiation, and up to US\$35 for a CD4 count.
6. Note de service 004/PNLS/MD/BM/2014, Letter from the Ministry of Health to the provincial coordinators of National AIDS Programme (PNLS), May 2014.
7. Indicative amount allocated in addition to the remaining US\$ 34,6 million from existing grant by end of 2013 (Global Fund allocation letter to DRC, March 2014).

GUINEA

Still waiting for expanded access

Although the estimated prevalence of HIV in Guinea is relatively low compared with other countries in Africa, at 1.7 % as of late 2012,¹ many of the estimated 122,000² HIV-positive people in the country cannot access treatment early, and this impacts on their health. Only 25%³ (27,792) of the 110,000 people eligible for ARV treatment⁴ had access to it by the end of 2013. Only 9.5% of HIV-positive children are estimated to be receiving ARV treatment.⁵

Guinea has adopted the WHO's new 2013 guidelines and has updated its National Strategic Plan 2013-2017⁶ to include an adapted target for treatment based on the recommended earlier treatment initiation (at CD4<500). It also includes an improved treatment option for prevention of mother-to-child transmission (option PMTCT B+). However, implementation has been slow and recent delays in the supply of the tenofovir-based regimen have hampered the transition plan.

At health centre level, the availability of medicines for opportunistic infections, paediatric forms of ARVs and second line ARVs is problematic, as is the capacity for and supply of key diagnostic tests, such as for CD4 counts and viral loads. In addition, patients have to pay for tests, which hinders access to HIV testing and CD4 counts. This, in turn, slows the rate at which people are initiated on treatment, and puts the quality of follow-up care under pressure. Patients' associations have been weakened by funding constraints, as well as by the prevailing problem of stigma, which hampers both patient follow-up and the overall success of the response.

In the absence of US or other donor funding for HIV programmes in Guinea, there is a significant gap between the country's plans and the funds available. This threatens to put on hold several crucial investments, such as the implementation of prevention of mother-to-child transmission (PMTCT option B+).

Although Guinea has some of the weakest health indicators in the world, few health actors – including both implementing and funding organisations – work in the country. The Global Fund provides the majority of funds for fighting HIV in Guinea. While the government's investment for HIV has increased in the past couple of years,⁷ there are few alternative sources of funding to strengthen the response in the foreseeable future.



Ikram Ngadi/MSF

Guinea's catch-up efforts face challenges in the GF concept note request

The GF's new funding allocation of US\$45 million for HIV in Guinea for the period 2014-17 appears very limited when compared with the country's strategic plan and funding needs. Guinea's National Strategic Plan (NSFP 2013-2017) was costed⁸ at US\$101 million for 2014, of which some US\$19 million was budgeted for drugs. The current GF allocation of an average US\$11.3 million per year over four years falls below the estimated cost of the drugs, and represents only a marginal increase compared to previous levels of funding available in the most recent GF grants.

In 2010, Guinea had also submitted a limited funding request under Round 10 with the intention of submitting a more robust proposal in Round 11. However, Round 11 was subsequently cancelled. Due to the limited funding available in Round 10, a cap was placed on the number of new initiations possible with the funding. Several key interventions planned with available funds from Round 10 were postponed due to delays in signing the grant (March 2012) and starting implementation (June 2013). Delays in drug delivery through the GF's pooled procurement mechanism almost caused a stock-out in 2013, which was averted at the last minute by an emergency order. The delays in drug delivery, however, led to health facilities further reducing the number of new initiations on treatment.

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MSF in Guinea

MSF is present in Guinea since 1984 and has been providing HIV and TB services since 2003. Currently the programme provides support to 7,500 patients on ARV treatment in the capital, Conakry, in collaboration with the Ministry of Health. MSF staff offer diagnosis, treatment and psychosocial support at four health centres across the city through a decentralised approach, as well as at an outpatient clinic in Matam district. MSF handed over the HIV programme in Guéckédou in late 2013 after its activities had been integrated into the district hospital.

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laboratory capacity. HIV testing is also at risk. Coverage of testing is currently below 20%, and since the US withdrew funding for testing in September 2013, the gap may remain or even worsen if GF funding does not cover these activities.

Guinea's HIV programme faces significant and urgent challenges in terms of improving and expanding ARV treatment. Innovative and better support for prevention and adherence, planned for the coming years, are at risk of coming into competition with other essential activities within the limited GF allocation. Without adequate funding, key interventions at risk of not being implemented, or of being reduced or delayed, include:

- **Early treatment initiation and follow-up on patient adherence through viral load monitoring.⁹**

- Better and improved coverage of diagnosis, care and treatment for children.
- An adequate supply of diagnostic tools and treatment for common opportunistic infections (such as cryptococcal meningitis).
- Plans to introduce and expand psychosocial patient support and adherence counselling (including through civil society organisations and the use of lay cadres).
- Expansion of community models, including community-based testing and refill dispensing in order to reach more people and improve retention in care.
- Support to local associations for peer support and advocacy in order to improve accountability and fight stigma.
- Improved and expanded laboratory capacity
- Ensuring an uninterrupted supply and distribution of commodities, including strengthening transport systems to health facilities, and putting in place buffer stocks, contingency supplies and a rapid response
- Strengthening targeted interventions for vulnerable groups (such as prisoners, sex workers, men who have sex with men etc.) and expanding access to ARV treatment outside the capital.

Based on early drafts of the concept note and country discussions regarding the funding request, there seems to be uncertainty around Guinea's ability to extend its request beyond the allocation. Guinea should be encouraged to submit an application that reflects its "full expression of quality demand" and, as necessary, with an aim to access additional funding through either the GF or other donors, while continuing to increase its national contribution. Technical partners should provide unambiguous support in this process.

1. EDSOMICS, 2012. With HIV, great variations exist between urban (2.7%) and rural populations (1.2%), as well as between women (2.1%) and men (1.2%).
2. Based on 121,951 people living with HIV as estimated by Spectrum 2013. See annual report 2013 of the Programme National de Prise en Charge Sanitaire et de Prévention des IST/VIH/Sida (PNPCSP 2013) and UNAIDS country progress report, GARPR 2014: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/GIN_narrative_report_2014.pdf
3. UNAIDS country progress report, GARPR 2014: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/GIN_narrative_report_2014.pdf
4. UNAIDS Global Report on the AIDS Epidemic 2013: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf
5. Rapport annuel 2013 du Programme National de Prise en Charge

Sanitaire et de Prévention des IST/VIH/Sida (PNPCSP 2013), UNAIDS country progress report, 2014: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/GIN_narrative_report_2014.pdf

6. Cadre Stratégique National de Lutte contre les IST/VIH/Sida 2013-2017: http://www.cnlsguineeconakry.org/index.php?option=com_jdownloads&Itemid=47&view=finish&cid=62&catid=15&m=0
7. CNLS, Cartographie des financements Avril 2013 (USD 2.1 million in 2012; 2,6 million in 2013)
8. The funding needs for 2013 were estimated at US\$53 million, with US\$21 million available, leaving a gap of US\$33 million. The need for increased funding in 2014 is partly due to including a significant but necessary investment in diagnostic and follow-up lab tests.
9. Treatment coverage for children under 15 years is just 16.52%, according to CNLS, Rapport annuel 2012 de la riposte au IST/VIH/Sida, 2013, page 61.

MALAWI

Ambitious response in jeopardy

Malawi, one of the world's least developed countries, is among the ten countries with the highest HIV prevalence worldwide. An estimated 1.1 million people, or 10.6% of the adult population, are living with HIV.¹ In the Southern region, where MSF is supporting the Ministry of Health to implement national HIV and TB programmes, the prevalence – estimated at 14–16% – is even higher than the national average.

At the end of December 2013, 472,865 patients in Malawi were on ARV treatment (with 102,586 initiated in 2013 alone),² which represents 50% of the estimated 950,000 people eligible for treatment, according to WHO 2013 eligibility criteria.³

Malawi has demonstrated that high coverage of testing and counselling, as well as ARV treatment for pregnant women, can be achieved even in resource-limited settings, through the effective use of human resources (including task shifting), through decentralising services, and through adopting the PMTCT Option B+ strategy. At the end of 2013, 73% of HIV-positive pregnant women were receiving treatment for preventing mother-to-child transmission of the virus.⁴

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The significant scale-up in ARV treatment coverage in Malawi has largely been made possible by the country's public health approach to the epidemic. This has included simplified treatment protocols, decentralising HIV care to community levels, and task-shifting amongst healthcare workers in the face of critical human resource shortages (with 91% vacancies for medical specialists and 61% for clinical staff⁵). Access to treatment has increased substantially, with ARV treatment services now available in 68%⁶ of the country's public health sector facilities.

A further improvement of ARV treatment outcomes is expected from the adoption of the 2013 WHO recommendations for ARV eligibility, including universal treatment for children



Giulio Domini/UNITAID

under five as well as raising the CD4 count threshold to 500). These changes have been confirmed in the latest versions of Malawi's HIV guidelines of June 2014. Additionally, CD4 count testing in pre-ARV treatment patients now takes place every three months, regardless of their previous CD4 count. In 2013, Malawi also adopted tenofovir-based regimens, the WHO-recommended first-line drug. Malawi plans to further scale up towards universal access to treatment by 2020.

However, despite Malawi's best intentions, the full implementation of the updated WHO guidelines, as well as improvements to other programmes and targets, has been and will continue to be hindered by severe funding and human resources constraints. Due to persistent internal economic constraints, the country remains almost entirely dependent on external funding for its HIV response, with more than 90% of the national HIV programme funded by international funds.⁷ The majority of the external funding comes from the Global Fund, which is responsible for procuring most of the country's HIV test kits and drugs, including ARVs.

Preparing for the Global Fund concept note

With a funding allocation for HIV of US\$471.3 million available for the four-year period 2014–17, Malawi is now taking the steps necessary for producing its concept note to the Global Fund. As requirements had been reinforced to strengthen the governance structure of the Country Coordinating Mechanism (CCM), as well as making a programme review necessary, Malawi decided to delay its submission until the last quarter of 2014. While the envelope offered by the Global Fund may seem substantial, it may fall below the necessary level to sustain programmes and implement Malawi's scale-up plan. According to national budget estimates for ARV and related drugs, the cost for commodities

MSF in Malawi

MSF has been supporting the Malawian Ministry of Health since 1987 and is currently working in Chiradzulu, Thyolo and Nsanje districts, providing support to people living with HIV/TB. In 2014, MSF started a three-year project at Chichiri and Maula prisons to screen inmates for communicable diseases and reduce HIV/TB-related morbidity and mortality. In 2014, MSF launched a programme to provide a comprehensive package of care for HIV/TB and sexually transmitted infections to mobile populations, with a focus on sex workers and truck drivers along the route between Beira and Tete, in Mozambique, and Zalewa, in Malawi.



Giulio Donini/UNITAID

alone would be around US\$100 million per year.⁸ Malawi is relying on the Global Fund for its ARV supply, and would therefore have little room left within its allocation to support other key components of the HIV programme.

Malawi should submit a robust request based on its full expression of demand and, if required to meet certain objectives, should aim to obtain incentive funding, be considered as unfunded quality demand and access further funding from additional donor contributions. Malawi should also consider significantly shortening the implementation periods to maximise the use of its allocation. However, in meetings held in Malawi since the allocation was announced, very limited information has been shared by the Global Fund and other partners around strategies to access additional funds.

In view of the needs within Malawi and the ambitions that should be prioritised – by the Malawian authorities and stake-

holders during the country dialogue – MSF recommends the following critical components to be included and combined with ambitious targets in the concept note:

- **Scaling up treatment according to the WHO 2013 guidelines, including early initiation of treatment and completing the switch to the TDF-based regimen.**
- **Increasing the number of healthcare workers in Malawi, including further progress on task-shifting towards lay cadres.**
- **Implementing routine viral load monitoring on a national level.**
- **Supporting the rollout and implementation of community treatment, care and support approaches.**
- **Testing and treating more key vulnerable groups, including commercial sex workers, prisoners, men who have sex with men.**

1. 2010 Malawi Demographic and Health Survey (MDHS), see Malawi Global AIDS Response Progress Report (GARPR) 2014 http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MWI_narrative_report_2014.pdf
2. Malawi Global AIDS Response Progress Report, GARPR 2014 http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MWI_narrative_report_2014.pdf
3. UNAIDS Global report on the AIDS epidemic 2013 http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf
4. According to WHO 2010 eligibility criteria (ART initiation at CD4 cell

count of <350) – GARPR 2014 http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MWI_narrative_report_2014.pdf

5. Malawi Health Sector Strategic Plan 2011-2016
6. Malawi GARPR 2014 report http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MWI_narrative_report_2014.pdf
7. Estimated for the period 2010-2012, see Malawi GARPR 2014 report http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MWI_narrative_report_2014.pdf
8. Draft HIV commodities gap analysis for the period ending Dec 2017 presented to CCM June 2014

MOZAMBIQUE

Acceleration plans under threat

With an estimated national HIV prevalence of 11.5%¹ in the adult population, Mozambique faces a severe, generalised HIV epidemic that has put a heavy burden on its already fragile health system. Nearly 1.6 million people are living with HIV in Mozambique, of whom nearly 500,000 were on ARV treatment at the end of 2013. Only 39% of health facilities provide ARV treatment, up from just 22% in 2012.²

Commendable efforts have been made by the Ministry of Health in the past couple of years to increase treatment coverage in Mozambique, raising it from 41% in 2012 to 59% in 2013 among those eligible for treatment,³ based on a treatment acceleration plan that seeks to achieve 80% coverage by 2015.

Additionally Mozambique has implemented the WHO's new 2013 treatment recommendations including tenofovir-based ARVs and universal treatment for pregnant women (OptionB+) and children under five years old. Mozambique is also scaling up integrated services, with 72%⁴ of HIV patients detected in the TB wards benefiting from ARV treatment. Mozambique's TB epidemic is driven mainly by HIV/TB co-infection which, at 58%, is among the highest in the world.

Aside from the scale of the epidemic in Mozambique, challenges include a very limited skilled workforce. Mozambique has just 68.6 healthcare workers per 100,000 population,

Despite limited funding available over recent years, in 2013 Mozambique developed an ambitious acceleration plan to scale up access to treatment, including for children under five and an improved protocol for prevention of mother-to-child transmission.

which is well below the the recommended WHO staffing norms of 228 per 100,000.⁵ Over recent years, MSF has also witnessed prevailing problems with the supply of commodities, including frequent stock-outs of TB drugs, drugs for opportunistic infections and lab supplies.

Despite recent progress, particularly in treatment scale-up, low government spending and irregular international support have previously slowed the HIV response and today constitute a real threat. Sustaining the gains achieved recently, ensuring the quality of programmes and patient retention in care, as well as tackling problematic areas such as procurement and supply management in-country, will require additional investments in coming years.



Brendan Bannon

Funding situation challenged by the GF allocation

Mozambique is still far from complying with the Abuja target of dedicating 15% of its GDP to health [at just 6.4 % in 2012]⁶. Although domestic expenditure as a share of the total overall health expenditure has increased significantly in recent years, Mozambique still depends for 95% of the funding for its HIV response on external resources.⁷

Despite limited funding available over recent years, in 2013 Mozambique developed an ambitious acceleration plan to scale up access to treatment, including for children under five and an improved protocol for prevention of mother-to-child transmission. While Mozambique was given support and encouragement by donors to go ahead with its plan, based on the success with which it had increased treatment coverage, the Global Fund's announcement of its country allocation for HIV was received with great disappointment in Mozambique.

Mozambique received a total allocation of US\$242.2 million, of which US\$238.6 million was existing funding by end 2013 [ie only US\$3.6 million was 'new' funding for the period 2014-17]. This falls well below the funding needed to meet even the original, less ambitious targets. With the current level of funding from the GF allocation, and the current accelerated pace of response to unmet needs, Mozambique risks running out of funds for commodities sometime next year, which could lead to serious drug shortages in early 2016.

According to the Global Fund's requirement for countries with high rates of HIV/TB co-infection to present a joint proposal,

MSF in Mozambique

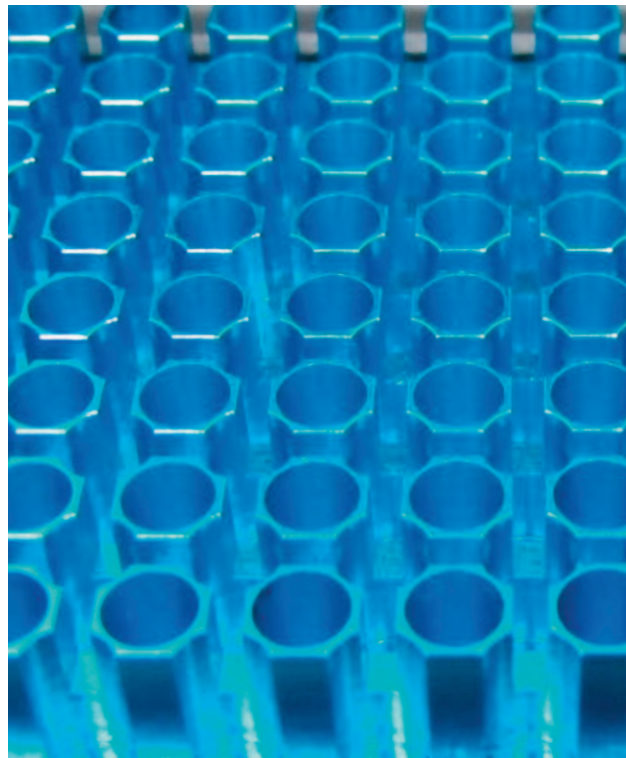
MSF has been working in Mozambique since 1984. Since 2000, MSF has provided HIV/AIDS care in a number of locations in collaboration with the Ministry of Health, with a focus on: integrating HIV and TB care; simplifying treatment; supporting task shifting; decentralising the follow-up of patients, with special attention to children and adolescents; and the prevention of mother-to-child transmission (option B+). MSF provides specialised care in the capital, Maputo, including second and third-line ARV treatment and managing complications such as Kaposi's sarcoma, cervical cancer and or co-morbidities, in particular multidrug-resistant TB. With the support of UNITAID, it has also introduced routine viral load monitoring. To improve retention on ARV treatment, MSF – alongside the Ministry of Health and patients – has piloted a community-based ARV distribution and adherence monitoring model through Community ART Groups (CAGs) in Tete.

Mozambique started working on better integration of services as well as on stronger community health approaches. However, with the limited funding available through the allocation, and with signals of less funding from PEPFAR, Mozambique may now be forced to revise its plans. It will now be imperative that Mozambique presents a strong proposal to the Global Fund and applies for additional funding above the allocation amount.

Mozambique should also use other measures to maximise the use of the currently available funding, such as shortening its implementation period. While there has previously been some confusion over the ability to use this option, Mozambique should now be given clear guidance on how to exercise this flexibility.

Mozambique has experienced challenges in the process of preparing the concept note and will need significant support to strengthen its proposal. Among the components that Mozambique should include in its concept note, based on full expression of demand, are:

- Continued scale-up of ARV treatment with the aims of:
 - reaching 750,000 people by 2015, according to WHO recommendations for early initiation of treatment.
 - using treatment as prevention for specific sub-groups; and strengthening the focus on retention and adherence.
- Using counsellors to provide quality adherence support, as well as to ensure the success of community models for adherence support, as demonstrated by MSF's experience in the country.
- Expansion of community models, including community-based testing and refill dispensing, in order to reach more people and improve retention in care.
- Ensuring an uninterrupted supply and refill of three months of ARV drugs, and monitoring of stock-outs at health centre level.
- Rolling out viral load monitoring for people on ARV treatment.
- Integrating HIV/TB care and scaling up the diagnosis and treatment of drug-resistant TB.



Sarah-Eve Hammond/MSF

1. 2009 National Seroprevalence Survey. There is a large variation in the prevalence between geographical areas, ranging from 25.1% in Gaza province in the south to 3.7% in Niassa province in the north.
2. Relatório Anual das Actividades Relacionadas ao HIV/SIDA, Relatório Anual 2013, Ministry of Health, April 2014.
3. Mozambique Global AIDS Response Progress Report(GARPR) 2014 http://www.unaids.org/en/dataanalysis/knowyourresponse/country/progressreports/2014countries/MOZ_narrative_report_2014.pdf 59% is based on updated epidemiological projections (Spectrum) However, Coverage of eligible people, however, according to WHO

- 2013 (initiation at CD4 500) eligibility criteria is lower around 30%, based on UNAIDS 2013 estimates of at 1.3 million people eligible. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf
4. Relatório Anual das Actividades Relacionadas ao HIV/SIDA, Relatório Anual 2013, Ministry of Health, April 2014.
5. Annual Report Human Resources 2013, Ministry of Health, Mozambique.
6. See: <http://www.who.int/countries/moz/en/>
7. CNSC MEGAS 2013, UNAIDS April 2013