Tuberculosis in 2017: Searching for new solutions in the face of new challenges

6th TB Symposium – Ministry of Health of the Republic of Belarus, Republican Scientific and Practical Center for Pulmonology and Tuberculosis, and Médecins Sans Frontières

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Policy and funding shifts-implications for TB and how to mitigate harm

Sharonann Lynch

MSF Access Campaign

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Global targets

- Sustainable Development Goals (SDG) target adopted by UN member states in 2015:
  To end TB by 2030
- Global plan to End TB: *”A sustained increase in funding for TB programmes and TB R&D, with significant frontloaded investments in the period of the Global Plan, will be required to end TB”*

Overview of global TB financing
in low and middle income countries

- USD 6.6 billion available for TB in 2016 in low- and middle income countries, of which 84% was from domestic sources.
- Investments fall almost USD 2 bn short of the USD 8.3 bn needed in 2016. Annual gap will widen to USD 6 bn in 2020 if current funding levels do not increase.
- TB funding low compared to e.g. HIV and Malaria

Where will the money come from?

- New, innovoative and optimised approaches for TB financing will be needed, including increase in **domestic investments.**

- **BUT increased international investments also needed**

Global TB burden and financing in MICs

Majority of global TB burden in MICs:

- 13% of notified cases in LICs
- 84% is in MICs (58% in LMICs, 26% in UMICs)

Investments needed in MICs:

- Total investments for TB in LMICs need to increase from USD 2.2 bn annually in 2016 to USD 3.5 bn in 2020 = 59% increase
- In UMIC from USD 3.8 bn in 2016 to 5.2 bn in 2020= 37%
- Many MICs with high TB burden still rely on international funding.

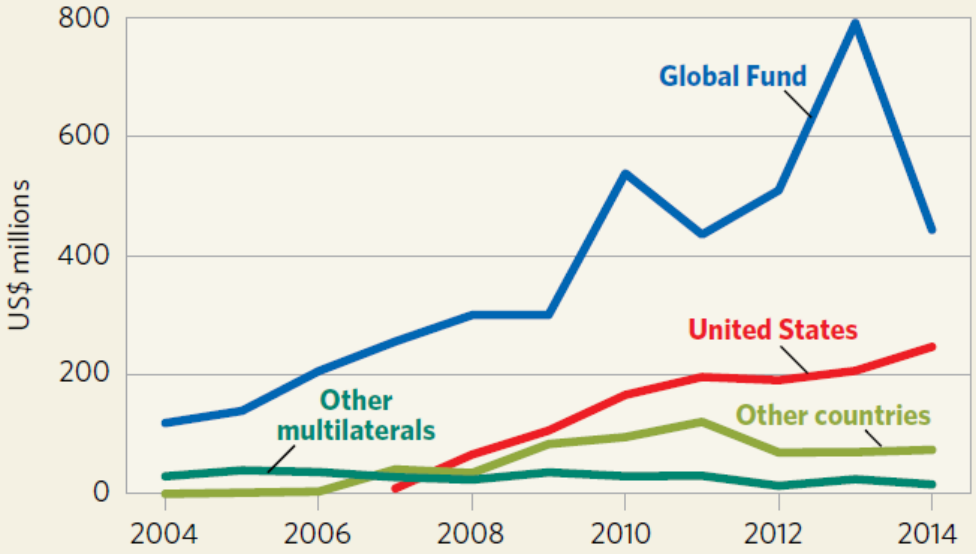
The role of the Global Fund in TB financing

Replenishment results:

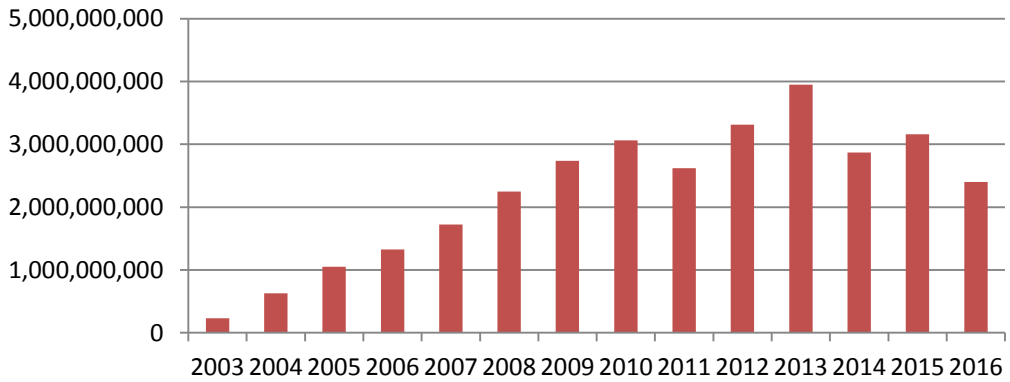
2008-2010: USD 9.7 bn
2011-2013: USD 11.7 bn
2014-2016: USD 12.2 bn
2017-2019: USD 12.9 bn (12.2)

18% of GF resources availalble to countries is for TB

International donor funding for TB prevention, diagnosis and treatment by region, 2004–2014



Annual disbursements (mid year data)



The GFATM is the single largest source of international donor funding.

GFATM allocations – transition through funding decreases

- GF allocating funds based on country income (GNIpc) and disease burden
- Decreases expected for MICs, e.g. Eastern Europe Central Asia
- CONCERN: Economic growth has not been accompanied by similar scale-up and strengthening of TB and HIV programs

Global Fund investment guidance for HIV and TB in EECA (2014-2017)

Overall objectives for TB (all forms of TB, incl M/XDR-TB):

- Promote universal access to timely and quality diagnosis and treatment (incl exapansion of new diagnostic technologies, supply, patient centred approaches etc)
- Special attention to migrans, (ex)prisoners etc.

Targets, domestically funded by end of current allocation (Dec 2017):

- ALL countries to cover diagnostic and treatment for DS TB
- LICs: 30% of ARVs and 2nd line TB drugs covered by domestic funds
- LMICs: 60-75% ARVs, (GF new initiations) and 50-75% for 2nd line TB
- UMIC: GF funded ARVs for new initiations and key pops only, 100% existing patients, and 2nd line TB drugs fully on domestic funds.

Foreseen cuts in Eastern Europe Central Asia (EECA)

Accelerated transitions through funding cuts:

- The Eastern Europe Central Asia (EECA) region has the fastest-growing HIV epidemic and highest prevalence of MDR-TB with 8 of the 16 MDR-TB high-burden countries.

- However, EECA experienced the deepest Global Fund cuts with a reduction of 15% in the 2014-2016 allocation period. The region is estimated to lose a further X % in the next allocation period (2017-2019).

Concerns with policy and funding shifts

- Limited time to adjust to accelerated co-financing of core activities (procurement of HIV and TB drugs, Human Resources for Health)
- Transition of core activities carried out without Risk and Readiness Assessment
- Too little attention to country and epidemiological context in policies restricting countries' use of GF funding

Recommendations

- Apply for *Catalytic funds* available to individual countries through matching funds and regional grants:
  - Finding missing cases: active case finding, scale up Gene Xpert, DR-TB case finding and treatment, private sector care, HIV/TB, data collection
  - Multi-country grants
  - WHO, Stop TB policy dev, technical assistance

- **ALL** countries expected to submit Prioritised Above Allocation Requests (PAAR)

Recommendations (cont.)

- Carry out thorough risk assessment of the co-financing and transition policies on LMIC countries' ability to improve TB practices to reflect WHO guidelines and take up new tools. This includes a specific procurement risk assessment.

- Freeze the implementation of the EECA investment guideline

- Increase BOTH domestic and international investments in TB programming for the region

Next applications – for implementation 2018-20

- Global Fund's general TB guidance to countries:

- **innovative approaches** to find all missing TB cases (DS and DR TB), treatment in line with WHO End TB strategy and global plan
- follow normative guidelines for **optimal use of new diagnostic technologies** for early and accurate detection
- seek **prompt access to most adequate treatment**, incl introduction of new drugs
- attention to new recommendations on the use of **shorter treatment regimens for DR-TB**

Extra slides

Which countries should prepare for transition?

- Transition/sustainability planning required in LMICs with low and moderate disease burden:
  Armenia, Kosovo

- Transition/sustainability planning in all UMICs:
  Azerbaijan*, Belarus, Kazakhstan*, Romania,

- Currently in transition (UMICs):
  Albania, Bulgaria,, Turkmenistan

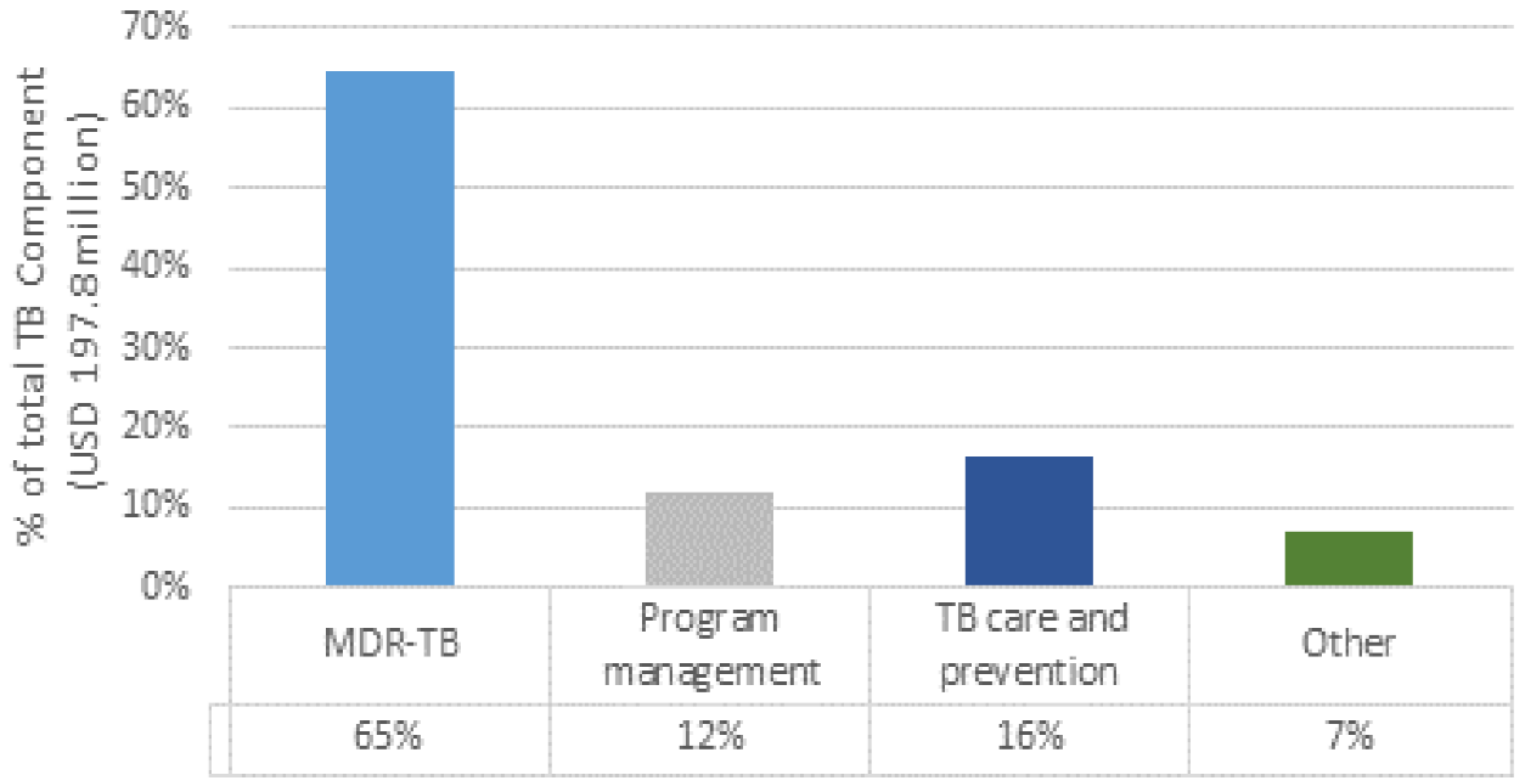
- LICs and LMICs with higher disease burden, not yet actively transitioning: Georgia, Kyrgyzstan, Moldova, Tajikistan, Ukraine, Uzbekistan

* = severe or extreme TB burden

Differentiated approach, sustainability and co-financing targets

	Low-Income (LI)	Lower Low-Middle Income (Lower LMI)	Upper Low-Middle Income (Upper LMI)	Upper Middle-Income (UMI) + High Disease Burden	No Longer Eligible for New Global Fund Financing
Counterpart financing	Minimum threshold: 5%	Minimum threshold: 20%	Minimum threshold: 40%	Minimum threshold: 60%	N/A
Harm reduction	• Not less than 50% of Global Fund HIV programming is dedicated to the provision of and advocacy for harm reduction and linkage of key populations to care. • All countries develop and implement SMART plans for gradual transfer of harm reduction services to domestic sources of funding.				
HIV prevention, treatment, diagnosis and adherence support	• Global Fund programs maximize prevention coverage, linkage and retention in care of key populations. • Prevention among key populations to be included in national AIDS programs and gradually transferred to domestic or alternative sources of funding. • All countries develop and implement SMART plans for the transfer of ARV therapy provision and adherence support services to domestic sources of funding.				
	• Minimum 30% funding for ARV therapy, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation. • Elimination of mother-to-child transmission to be transferred to domestic or alternative sources of funding before end of current allocation.	• Minimum 60% funding for ARV therapy, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation.	• ARV therapy funding from Global Fund prioritizes treatment initiation and scale up among key populations. • Minimum 75% of funding for existing ARV therapy patients, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation.	• ARV therapy funding from Global Fund only for treatment initiation and scale-up among key populations. • All funding for existing ARV therapy patients, lab services and adherence support to be covered by domestic or alternative sources, before end of current allocation.	• Funding for ARV therapy, lab services and adherence support to be covered by domestic or alternative sources, before end of current grants.
TB treatment, diagnosis and adherence support	• Diagnostic and treatment for susceptible TB in all countries is covered by domestic or alternative sources of funding. • Not less than 10% of Global Fund funds should be programmed for TB/HIV collaborative activities and other co-morbidities. • National multidrug-resistant TB expansion plans, including transition to domestic financing, are developed or reviewed for appropriate targets and endorsed by Green Light Committee.				
	• Minimum 30% funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• Minimum 50% funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• Minimum 75% of funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• All funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current allocation.	• All funding for second-line drugs, lab services and adherence support to be covered by domestic sources, before end of current grants.
Sustainability	• Limited incentives and pay for performance to governmental service providers to be gradually transferred to domestic or alternative sources of funding. • All countries to improve regulatory framework for nongovernmental organizations financing and develop social contracting mechanisms. • All countries to submit sustainability plans with concept note or within first year of new funding allocation.				• All countries required to implement transition plans.

Request in TB Component



Key challenges PSM chain systems

- Sustaining programme quality
- National procurement laws incompatible with GF parallel systems.
- Product selection which may not always support optimal care either in terms of the molecule selected or the selection of single vs fixed-dose formulations
- Maintaining uninterrupted supply of quality assured medicines (e.g. legislative barriers on buffer stock, procurement cycles)
- Budget-driven vs patient-driven forecasting & quantification
- Addressing barriers to high prices
- Improving the identification and management of adverse events as a means to retaining patients in care