MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

DEADLY GAPS:
DON'T TURN AWAY FROM SAVING LIVES

NOW IS THE TIME TO PROTECT THE GLOBAL FUND'S VITAL LIFELINE FOR PATIENTS AND COMMUNITIES AFFECTED BY HIV, TB AND MALARIA

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EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

The 2025 Global Fund replenishment (grant cycle; GC8) is taking place during a moment of extreme global instability. Economic uncertainty, shifting donor commitments, and a retreat from multilateralism are threatening decades of progress in global health. These pressures are compounded by intersecting crises - climate change, growing political conservatism, and increasingly complex and protracted conflicts - that are disproportionately affecting low- and middle-income countries (LMICs). For people and communities on the frontlines of these crises, the consequences are being felt now. Disruptions to health services, shortages of essential medicines, and the withdrawal of key funding streams are translating into real harm: delayed diagnoses, unavailable or interrupted treatments, which are causing preventable deaths, and widening inequities in access to care. Without urgent and sustained investment, the global response to HIV, tuberculosis (TB), and malaria risks unravelling, reversing hard-won gains, increasing death, ill-health and transmission of infections, fuelling drug resistance, and further weakening already fragile health systems.

As a medical humanitarian organisation working in over 70 countries, Médecins Sans Frontières/Doctors Without Borders (MSF) provides healthcare in contexts of conflict, displacement, epidemics, and system collapse - often where no or few other actors are present. Independently funded and without alignment to any government donor, MSF can speak freely about the critical gaps we see on the ground. Across a wide range of contexts, our teams are already witnessing the impact of shrinking donor support: antiretroviral, antimalarial and TB drug stockouts, people travelling long distances only to be turned away, community health workers unpaid or under-supported, and critical prevention activities left unfunded. These challenges are not confined to 'fragile' settings, but also in countries with functioning health systems that are simply under-resourced. This report draws on MSF's operational experience and field-level evidence from multiple countries (included in the following pages are insights from MSF projects in Burundi, Central African Republic (CAR), Democratic Republic of Congo (DRC), Guinea, Kenya, Malawi, Mali, Mozambique, Pakistan, Philippines, South Sudan and Sudan) to assess critical gaps in the HIV, TB and malaria responses.

The Global Fund to Fight AIDs, Tuberculosis and Malaria (Global Fund for short) plays a fundamental role in financing the fight against HIV, TB and malaria, particularly in countries where domestic funding capacity is limited and with fragile health systems, undermining future progress against the three diseases. However, the Global Fund's investment case for the 8th replenishment is proposing **a minimal ask to the donors when compared to the immense needs.** While economic challenges, like conflict, inflation, debt burdens, and fragile tax bases, hinder many LMICs' ability to increase health funding, the withdrawal of donor funding and over-reliance on domestic resource mobilisation (DRM) is creating significant funding gaps. The financial burden of timely accessing care is then increasingly shifted onto people, requiring them to pay out- of- pocket (OoP) or to forego care when unaffordable. Fragile and conflict-affected states, where health systems rely heavily on external support, are particularly vulnerable to the collapse of services. Transitioning to greater domestic financing without appropriate safety nets risks severe consequences, such as **reduced health service coverage and rising financial barriers for patients.** Innovative financing solutions, while proposed, have yet to prove effective. To prevent deepening health inequities, financial plans must align with economic realities, involve civil society input, and prioritise short-term needs over theoretical long-term goals. Continued international support remains essential to avoid worsening global health disparities.

IMPACT OF SHRINKING DONOR SUPPORT:

- ANTIRETROVIRAL, ANTIMALARIAL AND TB DRUG STOCKOUTS
- PEOPLE TRAVELLING LONG DISTANCES ONLY TO BE TURNED AWAY
- COMMUNITY HEALTH WORKERS UNPAID OR UNDER-SUPPORTED
- CRITICAL PREVENTION ACTIVITIES LEFT UNFUNDED

Significant funding shortfalls undermine lifesaving interventions and need urgent mitigation. Without the necessary financial commitments, gaps in essential services will deepen and widen further, with increased mortality, ill health and epidemic spread as a consequence. The Global Funds' country registers of Unfunded Quality Demand (UQD) and Prioritised Above Allocation Request (PAAR) already give some visibility as to how funding shortfalls put important supplies and services on hold. For instance, in DRC, funding was unable to fund better coverage of prevention of mother-to-child transmission (PMTCT) - services, nor needed expansion of care for advanced HIV (AHD) patients. In CAR, the training of service providers for case management of Malaria in three Health Regions (RS1, RS2 and RS6) have been put in the UQD, although key to ensure quality of care. In Guinea, means for genotyping and the study on resistance of anti-TB drugs had to be put on the UQD considering the lack of space in the grant and in the Philippines, the current US$225 million PAAR request for 2024–2026.[1] Additional deficits exist but are not always acknowledged as such, nor reported in transparent ways.

People who face specific vulnerability and access barriers to essential services are at particular risk of seeing lifesaving interventions de-prioritised by funding shortfalls. These include key populations (KPs), people in crisis including refugees and displaced, people most at risk of dying rapidly due to severe illness, and children.

Key populations face exclusion, criminalisation, and systemic barriers that prevent them from accessing essential HIV, TB, and malaria services. Stigma, punitive laws and hostile environments undermine both prevention and care efforts, leaving those most at risk without support. The growing rollback on rights for key populations, including **LGBTQI+ communities, sex workers, and people who use drugs,** infringes on the goal of ensuring equitable access to quality healthcare, and now takes away the ability of the most at risk to access lifesaving care. Recent political and legal changes reinforced stigma and exclusion, among others in Kenya and DRC.

The urgent health needs of people affected by crisis - including **conflict, displacement and epidemic outbreaks - tend to be neglected,** due to slow and ill-adapted aid for continuity of treatment, care and prevention. As emergency situations are increasing in scale and complexity, growing pressure is placed on the few humanitarian actors who cannot meet the gaps, nor have the capacity of health actors, including the Global Fund, to respond effectively. More flexibility is needed in grant modalities to allow for better-adapted interventions and alternative grant holders. MSF has witnessed delayed or inadequate responses to malaria outbreaks (as noted in the following pages, contexts including Burundi, Mali and Sudan, to name a few), often due to rigid funding structures that prevent rapid scale-up or reallocation of resources. Inability to adapt funding in real time leaves communities exposed and underserved.

Without early detection and treatment of alarm signs and severe complications, **people with advanced HIV disease (AHD) or Acquired Immunodeficiency Syndrome (AIDS) cannot be saved**, and high fatality rates are reported by MSF teams in many countries, such as Mozambique, South Sudan, DRC, CAR and Guinea.

Children's needs in HIV, TB and malaria are underserved and affected by funding shortfalls. High mortality is a consequence of insufficient coverage of adapted diagnostics and therapies in Mozambique, the Philippines, DRC, CAR, and South Sudan.

During these times of funding cuts or shortfalls the risk is real that **crucial strategies** will fail to be supported financially. Without the specific added value and demonstrated effectiveness of these approaches funded by the Global Fund, results will fail to be achieved.

One of the vital and unique roles of the Global Fund is its capacity and mandate to **support communities** most affected by HIV, TB and malaria, particularly those who are marginalised or excluded from mainstream health systems. Global Fund support to civil society and community-based organisations is crucial, as they play a key role in more effective service delivery and independent monitoring of supply gaps, including for the most neglected or marginalised communities. Evidence shows the usefulness of **community approaches, decentralised care and differentiated service delivery models** in bringing adapted services and tools closer to affected people. However, insufficient priority is given to roll out these mechanisms more systematically.

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1 The Global Fund. Data explorer – Philippines https://data.theglobalfund.org/location/PHL/access-to-funding

Insufficient funding is given towards **prevention tools** for the three diseases. The promise of rolling out game-changing new tools such as malaria vaccination, innovative vector control methods, oral and injectable Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP), and long working medicines for HIV such as Cabotegravir (CAB LA) is at risk due to funding cuts. Examples in this report of low or missing prevention coverage are provided from Mozambique, South Sudan, CAR, Malawi, DRC, Mali, the Philippines and Pakistan.

Additional lack of funding for **medical supplies** compounds problems created by fragile and inefficient supply chains, leading to recurring stockouts. Without rapid mitigation, this leads to long periods of exclusion of necessary care for people, forcing them to interrupt treatment, switch to less effective medicines or rely on unaffordable and lower quality options in private outlets.

The US funding cuts have created additional shortfalls in key medical supplies, leading to dangerously empty pipelines. For instance, shortfalls are expected in **rapid diagnostic tests (RDTs) and artemisinin-based combination therapy (ACT)** within three to six months in Burundi, Nigeria, South Sudan and Sudan.

With funding for HIV, TB and malaria under strain, it is imperative to keep the existing tools available, not derail progress made and improve opportunities to **lower prices for medical supplies**, make them more accessible. Negotiations and market-shaping efforts can maintain accessibility of vital tools but also create dynamic opportunities for competitive pricing, innovation, supporting regulation, and lowering the costs of essential medicines and diagnostics to ensure a transparent and healthy market. Experience in Guinea, the Philippines and Pakistan shows how high prices place diagnostics and treatment out of reach.

While the Global Fund has played a key role in pooled procurement and price negotiations, too many essential commodities remain unaffordable, particularly **second-line malaria treatments**,[2] new HIV prevention tools, such as **long-acting PrEP**, and **diagnostics for drug-resistant TB and HIV**, **early infant diagnosis (EID)** and **viral-load testing**.

The high cost of GeneXpert tests, produced by the US based company Cepheid, is a stark example of how pharmaceutical companies continue to set prices far above what is affordable for many countries, when compared to public cost-of- goods analyses, despite receiving public funding for research and development.

In conclusion, MSF teams see in their daily work the consequences for people and populations in many countries and communities. The people harmed include the poorest and most vulnerable members of society. Funding deficits and service gaps in many countries and communities have been highlighted in this report. Without urgent mitigation measures, mortality, morbidity, medical complications, new infections and outbreaks will increase, bringing the response to HIV, TB and malaria further off-track and once again overwhelming health systems. Severely ill people and communities crippled and impoverished by ill health and death will replace past progress with fast backsliding.

The Global Fund remains one of the few mechanisms capable of supporting large-scale, inclusive responses to the three diseases. Without its full replenishment, much of the previous efforts, investments and achievements will be lost. The 8th Global Fund replenishment is therefore a decisive moment - an opportunity to reaffirm global solidarity and translate commitment into action. Without urgent and sustained financial support, progress made over the past two decades risks being undone. Failure to secure sufficient funding will lead to rising numbers of new infections, treatment interruptions, growing antimicrobial resistance, and preventable deaths becoming the norm rather than the exception. The consequences will be borne most heavily by the world's most vulnerable communities. **Now is the time to step up - to protect gains already made and ensure a future in which HIV, TB and malaria no longer threaten millions of lives each year.**

2 Second-line malaria treatments are essential for conducting mass activities in emergency contexts, such as mass drug administrations (MDAs), seasonal malaria campaigns where the seasonal malaria chemoprevention (SMC) drug SPAQ (a combination antimalarial medication composed of sulfadoxine-pyrimethamine and amodiaquine) may be less suitable, or for implementation in other WHO recommended interventions such as post discharge malaria chemoprevention to reduce the risk of readmissions in health facilities.

KEY RECOMMENDATIONS

As the 8th replenishment of the Global Fund approaches, Médecins Sans Frontières/Doctors Without Borders (MSF) identifies six critical recommendations that must be addressed in order to sustain and strengthen the fight against HIV, TB and malaria.

Our recommendations to the Global Fund and its donors to address these challenges are as follows:

1. Full replenishment of the Global Fund

Full financing of the 8th replenishment is fundamental – this is the bare minimum; even with this full replenishment, many unmet needs in the global fight against HIV, TB and malaria remain. One cannot pretend that any shortfall will be sufficiently compensated for by hypothetical increases in Domestic Resource Mobilisation (DRM), innovative financing methods such as blended financing. External financing and the Global Fund grants remain at the core of an effective response. As most countries face bleak economic prospects and shrinking fiscal space for health expenses, DRM expectations - including for countries' co-financing and transition plans - need to be adapted, based on an updated and realistic assessment of the specific country's situation, avoiding undue further pressure to shift the financial burden for essential care onto countries unable to increase public health budgets or onto people through out-of-pocket (OoP) payments. Financial sustainability plans need to have built-in flexibility and caution. Such analysis should be made including inputs of civil society and patient organisations.

2. Priority for funding: start with reality, the existing gaps impacting on people now

Key gaps and unmet needs registered in updated UQD and PAAR registers indicate which high-quality interventions that could not be financed during previous grant-making should now get urgent priority. Additional, non-registered shortfalls for important interventions should be analysed. Through meaningful involvement of civil society in grant making, information from community led monitoring (CLM) on existing gaps and civil society organisation (CSO) or community-based organisation (CBO) propositions to tackle those should be included. Ensuring sufficient availability of supplies for diagnostics and treatment at health facility and patient level should be prioritised, mitigating the effects of shortages in essential medical supplies such as treatment interruption, delays in care, and sub-standard quality of care; these lead to death, medical complications, treatment failure and resistance, reduced coverage of preventive measures and financial distress for people through OoP expenses.

3. Focus on interventions supporting most vulnerable people

Some people face worse vulnerability and access barriers to essential services and interventions. These include key populations, people in crisis including refugees, displaced people, and those most at risk of dying rapidly due to severe illness and children. Funding should be prioritised for concrete, effective support to reduce their mortality and morbidity risks, and to protect them from exclusion from care, neglect and abuse.

Where key populations are criminalised, peer-delivered models of care should be expanded and the Global Fund's support to patient protection and human rights approaches should be strengthened.

For people affected by crises, such as conflict, displacement, epidemic outbreaks or natural disasters, specific mitigation measures are urgently needed. The Global Fund's Challenging Operating Environment (COE) policy should be more widely applied to obtain better flexibility. In countries prone to (recurrent) crisis, grant planning should include clear contingency plans that allow rapid mobilisation of additional resources, shifting priorities to life saving interventions and possibly a change in grant holders.

The implementation of detection and treatment packages for people with AHD is urgently needed to mitigate severe complications and high risk of imminent death. This includes early detection, reference and treatment through access to CD4 count, lipoarabinomannan (LAM) and cryptococcal antigen (CrAg) diagnostic tools at primary care level and making treatment for key opportunistic infections available beyond the now limited number of hospitals.

Availability of child-adapted diagnosis and treatment needs to receive more funding, to reduce risk of death by HIV, TB and malaria through decentralised models of care (such as self-management, community-based approaches etc). For HIV there is an urgent need to scale up early infant diagnosis (EID) and improved postnatal prophylaxis; financing child-friendly treatment formulations against HIV and TB can improve coverage and outcomes. Malaria mortality in children should be brought down by countering funding shortfalls for ACT therapy, bed nets and preventive tools, including during outbreaks.

4. Protect the strategies of value

During times of funding cuts or shortfalls, crucial strategies need to be protected because of their added value in effectiveness, coverage and efficiency reaching key results. Previous evidence and experience should inspire priority in promoting those strategies most effective in saving lives and reaching those most in need.

Give priority support to civil society and community-based organisations as they are the backbone of the most effective service delivery and of real-time monitoring of supply or service gaps, including for the most neglected or marginalised communities. In a context of dwindling financial support by other donors, the Global Fund funding to CSO- and CBO- delivering services, advocating for people and holding health systems accountable, should receive enhanced priority and simplified funding application and reporting processes.

Community approaches, decentralised care and differentiated service delivery models (community antiretroviral therapy or ART groups, multi-month dispensing, family-based TB care, integrated community malaria interventions) should be funded as priority, including sufficient availability of tools for early diagnostic and detection at primary health care level (GeneXpert, malaria RDTs, PIMA, or point-of-care integrated monitoring and analysis, CrAg, etc

Prevention tools for the three diseases should be financed, including new tools such as malaria vaccination, innovative vector control methods, oral and injectable HIV PrEP and PEP, and long- working medicines such as CABLA (cabotegravir long-acting. Where PMTCT and tuberculosis preventive therapy (TPT) coverage remains limited, extra efforts need to be funded.

5. Sufficient funding focused on patient and service benefits

Health systems funding should prioritise those interventions that have a direct impact on patient and health benefits, protecting them from disruptions in treatment, care and prevention. This includes a focus on uninterrupted and sufficient availability of essential medical supplies, provided free of charge to people. This implies support to ensure adequately trained, motivated and remunerated frontline health workers (including community and lay workers), in order to avoid essential medicines going missing or becoming unaffordable for people. Without clear direct contribution to improved results, patient- and community- level interventions funded under the general umbrella of 'health systems strengthening' should be critically reviewed - and possibly paused.

6. Price reductions for medicines through negotiation and market shaping

With health budgets under strain, obtaining lower prices for essential products will be key and the Global Fund should increase its role in negotiation and market shaping. Available resources must be prioritised for the improved purchasing of medical supplies, price negotiations and market-shaping efforts. In addition to obtaining more value for money overall in terms of essential medicines and thus providing treatment for more people, specific attention should be paid to reducing the price of now unaffordable products, such as GeneXpert tests, paediatric ARVs, long-acting PrEP, and second-line malaria drugs. As the Global Fund is increasing its proportion in medical purchase for HIV, TB and malaria, the importance of its role increases in the negotiation of more affordable prices, pooled procurement and securing quality supplies. A combination of increased efforts in market-shaping is needed to increase access to life-saving tools to more people in need.

CRITICAL INCIDENTS AS WITNESSED IN THIS REPORT AND EXAMPLES OF POTENTIAL RESPONSES NEEDED

South Sudan:

Each year MSF sections combined spend the equivalent of 50-60% of the entire Ministry of Health budget.

- In Aweil, South Sudan, MSF documented a 3**00% increase in malaria-related deaths** (all ages) between August and September 2024 compared to the same period the previous year.
- Contributing factors included **stockouts of basic malaria commodities in primary care facilities, delays in seeking care due to distance, flooding, cost or insecurity, and gaps in seasonal malaria chemoprevention (SMC)** program where some highly populated health zones as well as 'last mile' areas are not yet targeted by this preventive activity

Mali:

MSF sees increasing need for recognition of the volatile context demanding more support.

- In the region of Douentza MSF projects had an increase of **65% to 61,837 in 2024 versus 37,471 cases of malaria in 2023** (these numbers also reflect increased numbers of refugees and people moving due to conflict).

Kenya:

- MSF has implemented targeted **antistigma interventions** in three sub-counties of Mombasa (Kisauni, Nyali, and Likoni), including healthcare worker sensitisation, facilitated dialogues between key populations and providers, and 'empathy exercises' such as privilege walks. Initial results from
- MSF projects in the first phase show measurable progress: LGBTQI+ stigma among healthcare workers dropped by **12%, drug use stigma by 13%, and sex work stigma by 3%**

Guinea:

- **82%** of pregnant women had access to a HIV test during their ANC visit.
- Around **85%** of the HIV positive ones were put on ARV.

Honduras:

MSF project in San Pedro Sula, opened in 2022 has seen an increase in new patients each year, providing tests, care and treatment for HIV.

The project provided:

- **1,144** consultants in 2022
- **1,838** consultations in 2023
- **2,235** consultations in 2024

CAR:

CAR is among the five countries facing a critical shortage of Health workforce, with a density at less than 0.5 per 1000 population (while WHO recommendation to provide adequate coverage with primary health care is 2,5).

Density per 1000 population:

- **Physician** 0,07
- **Nurses and midwives** 0,26
- **Community health workers** 0,02

DRC:

- In 2022, only **40% of HIV positive pregnant women** were put on ARV. More than 3 million pregnant women didn't get access to HIV test, and 20% of those tested never received their results

Sudan:

- El Fasher alone, MSF-supported facilities were **attacked more than 12 times between May and August 2024**, with Al-Saudi Hospital targeted three additional times in December. Key laboratory equipment necessary for diagnosing HIV, TB and/or malaria have been stolen and/or destroyed, severely limiting the capacity to provide timely and effective treatment.

Pakistan:

- In Keamari district, Pakistan, MSF observed **poor follow-up tracing and inadequate household contact screening**, where only 10% of household contacts were screened in 2023, and no TPT initiation occurred.

Philippines:

- Community activities in an MSF project in an urban slum in Manila, Philippines where the prevalence of **active TB among the population is 5%,** MSF was able to achieve 75% investigation of children under five years old and 76% TPT acceptance.

Burundi:

- **Community health workers (CHWs)**, in Burundi who should be at the frontline of decentralised health delivery, are too often unsupported - lacking the tools, training, remuneration, and supervision necessary to fulfil their roles effectively.

Malawi:

For sex workers, many of whom are unable to negotiate condom use with clients, the need for discreet, long-acting prevention methods is critical.

- In response, MSF has committed to providing **injectable PrEP (Cabotegravir)** in two towns this year, offering an alternative that reduces the need for daily adherence and helps overcome stigma-related barriers

Mozambique:

Decentralisation of services remains weak, despite years of policy commitments and technical guidance.

- For TB, this failure is particularly stark. In Mozambique's Cabo Delgado province, for example, sputum samples from the MSF project in Macomia district have to travel more than 100 km for analysis in Pemba due to the absence of functioning laboratories nearby.

ACRONYMS

ACT	Artemisinin-based combination therapy
AHD	Advanced HIV disease
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral(s)
BHUs	Basic health units
BPaL	Bedaquiline, Pretomanid and Linezolid
BPaLM	Bedaquiline, Pretomanid, Linezolid and Moxifloxacin
C19RM	COVID-19 response mechanism
CABLA	Cabotegravir long-acting)
CAR	Central African Republic
CBO	Community-based organisation
CHW	Community health workers
CLM	Community-led monitoring
COE	Challenging operating environment
CrAg	Cryptococcal antigen
CSO	Civil society organisation
DBS	Dried blood spot
DHA-PQ	Dihydroartemisinin-piperaquine
DRC	Democratic Republic of Congo
DRM	Domestic Resource Mobilisation
DR-TB	Drug-resistant tuberculosis
DS-TB	Drug-susceptible tuberculosis
DTG	Dolutegravir
EID	Early infant diagnosis
FCAS	Fragile or conflict-affected states
GAVI	Global Alliance for Vaccines and Immunization
GC7	7th Global Fund replenishment (grant cycle 7)
GC8	8th Global Fund replenishment (grant cycle 8)
GDP	Gross domestic product
GNI	Gross national income
HIV	Human Immunodeficiency Virus
HRH	Human resources for health
HRP	Humanitarian Response Plan
HSTP	Health Sector Transformation Project
IPT	Intermittent preventive treatment
IPTp	Intermittent preventive treatment in pregnancy
IRS	Indoor residual spraying (vector control)
ITN	Insecticide-treated nets
KPs	Key populations
LAM	Lipoarabinomannan
LHWs	Lady health workers
LIC	Low-income country
LLIN	Long-lasting insecticide-treated bed-nets
LMICs	Low- and middle-income countries
LTFU	Loss to follow-up
MDAs	Mass drug administrations
MDR-TB	Multidrug-resistant tuberculosis
MoH	Ministry of Health
MSF	Médecins Sans Frontières/Doctors Without Borders
MSM	Men who have sex with men
NGO	Non-governmental organisation
NTP	National TB Program
ODA	Overseas development aid
ODA	Official development assistance
OoP	Out of pocket
PAAR	Prioritised Above Allocation Request
PBF	Performance-based financing
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for the AIDS Response
PHC	Primary healthcare
PHCC	Primary healthcare centre
PICT	Provider-initiated counselling and testing
PIMA	Point-of-care integrated monitoring and analysis
PLHIV	People living with HIV
PMC	Perennial malaria chemoprevention
PMI	President's Malaria Initiative
PMTCT	Prevention of mother-to-child transmission
PNP	Paediatric postnatal prophylaxis
PPPs	public-private partnerships
PrEP	Pre-exposure prophylaxis
PTPs	Provincial TB programmes
RDTs	Rapid diagnostic tests
RR-TB	Rifampicin-resistant TB
SMC	Seasonal malaria chemoprevention
SP	Sulfadoxine-pyrimethamine
SPAQ	Sulfadoxine-pyrimethamine and amodiaquine
SSPDF	South Sudan People's Defence Forces
TACTiC	Test, Avoid, Cure TB in Children
TB	Tuberculosis
TPT	Tuberculosis preventive treatment
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UQD	Unfunded Quality Demand
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

INTRODUCTION

Médecins Sans Frontières/Doctors Without Borders (MSF) is an international, independent medical humanitarian organisation that delivers medical care to people affected by conflict, disease outbreaks, natural and human-made disasters, and exclusion from health care in over 70 countries. MSF is supported through private funding ensuring independence. Global Fund is present in some capacity in most of the contexts where MSF have HIV, TB and/or malaria projects.

In 2023, MSF treated 3,724,526 malaria cases, contributed to the care of 44,500 people living with HIV and is the largest non-governmental provider of TB care worldwide, putting 22,700 people on first line TB treatment.[3] Across multiple countries (Honduras, Mali, Nigeria, Burundi, CAR, DRC, Guinea, South Sudan, Mozambique, Pakistan and Philippines, to name a few), we run large-scale treatment and prevention programmes that are providing care to those impacted by HIV, TB and/or malaria, often reaching the most vulnerable and marginalised populations who are frequently excluded from national responses. Our activities span stable contexts as well as emergencies and outbreaks (Haiti, Mozambique, Sudan, CAR and DRC for example), where we provide continuity of care under challenging and rapidly evolving conditions, and we have worked with the Global Fund to highlight the need for flexible and timely interventions in crisis settings.

While MSF does not accept funding from governments, we are deeply concerned by the ongoing reduction in global aid budgets and the direct impact this is already having on the communities we serve, exacerbated further when considering the growing number of complex, fragile and/or conflict-affected contexts. Cuts to external assistance are weakening essential public health programs, disrupting care, and threatening the fragile progress made in the fight against HIV, TB, and malaria.

MSF ACTIVITIES IN 2023:

3,724,526
MALARIA CASES TREATED

44,500
PEOPLE RECEIVING HIV ANTIRETROVIRAL TREATMENT

22,700
PEOPLE STARTED ON FIRST-LINE TB TREATMENT

This report draws on MSF's operational experience and field-level evidence from multiple countries to assess critical gaps in the HIV, TB, and malaria responses. Information for this report was collected through literature reviews, a survey sent to MSF projects across multiple countries, and semi-structured interviews with selected MSF staff. While this report does not provide an exhaustive overview of all MSF activities related to HIV, TB, and malaria, it highlights key gaps and the consequences these have for people seeking care for these diseases. It aims to highlight these interconnected challenges, advocating for a replenishment that allows flexibility in fragile settings, is responsive to emergencies and inclusive of the most marginalised communities

3 MSF (2024). International Activity Report 2023. https://www.msf.org/international-activity-report-2023

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CURRENT GLOBAL RESPONSE TO HIV, TB AND MALARIA PANDEMICS

Despite major gains in the past two decades, the fight against HIV, TB, and malaria remains precarious. In 2023, **39.9 million people were living with HIV**, yet 9.2 million of them were still not on treatment. That year alone saw **1.3 million new infections** and 630,000 AIDS-related deaths. Despite efforts to reach the 95-95-95 targets[4], the global cascade shows significant gaps: while 86% of people living with HIV know their status, only 77% of those are on treatment, and 72% have achieved viral suppression. Progress is uneven across regions. The World Health Organization (WHO) African Region continues to bear the brunt of the epidemic, with 3.4% of adults living with HIV, more than two-thirds of the global total. Between 2010 and 2023 there have been rising epidemics in Eastern Europe and Central Asia (+20% new infections), the Middle East and North Africa (+116%), and Latin America (+9%). These trends are driven by a lack of prevention services for key populations and compounded by punitive laws, stigma, discrimination and violence.[5]


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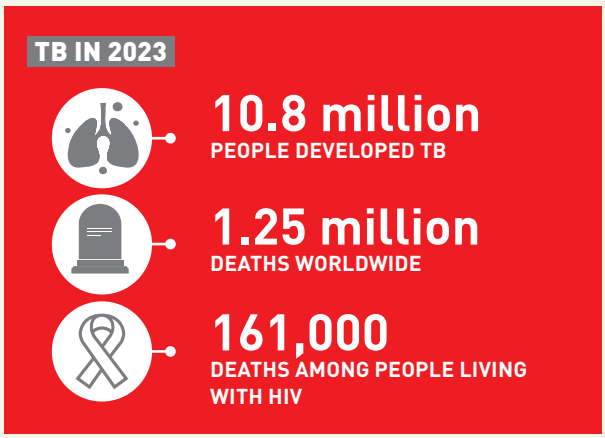
Worldwide, an estimated 10.8 million **people developed TB in 2023** (10.6 million in 2023), up from best estimates of 10.3 million in 2021 and 10 million in 2020. TB remains the world's deadliest infectious disease, causing an estimated 1.25 million deaths in 2023, including 161,000 deaths among people living with HIV.

In 2023, of the estimated 10.8 million people who fell ill with TB worldwide, **1.3 million were children and adolescents** (12% of all cases) This total has increased from estimates of 10.3 million in 2021 and 10 million in 2020. TB incidence rate (new cases per 100 000 population per year) is estimated to have increased by 4.6% between 2020 and 2023, reversing declines of about 2% per year between 2010 and 2020. People living with HIV accounted for 6.1% of the total TB burden.

Eight countries accounted for more than two-thirds of global TB cases, with India, Indonesia, China, the Philippines, and Pakistan alone representing 56% of the global burden. The DRC was also among the top contributors. A major gap remains between the estimated number of people with TB and those diagnosed: in 2023, around 2.7 million people went undiagnosed, including nearly half of all children under 15 and over half of children under five.

Multidrug-resistant and rifampicin-resistant TB (MDR/RR-TB) continues to pose a major public health threat. In 2023, an estimated 400,000 people developed MDR/RR-TB, yet only 175,923 were diagnosed and started on treatment - a slight decrease from 2022 and still below pre-pandemic levels.[6] Among children, the numbers are even worse, with only 14% of children with MDR/RR-TB reported as receiving treatment.



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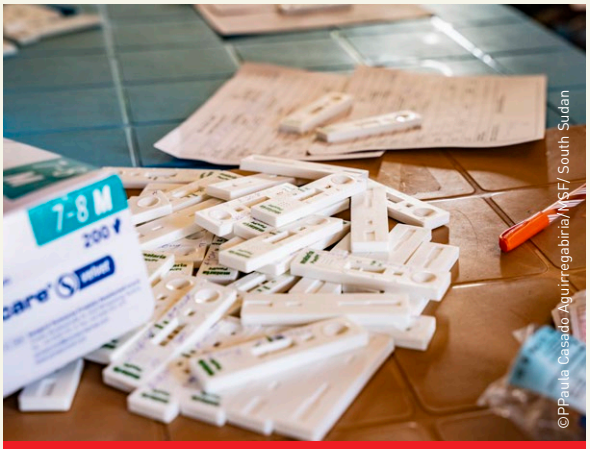
5 UNAIDS (2024). Global AIDS Update. https://www.unaids.org/en/resources/documents/2024/global-aids-update-2024

6 WHO (2024). Global Tuberculosis Report. https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2024

Progress on malaria has stalled. **In 2023, there were an estimated 263 million malaria cases and 597,000 deaths worldwide**, representing an increase of 11 million cases compared to 2022. Multiple factors contribute to this stagnation, including conflicts, climate change, and inequalities in access to healthcare, people with reduced immunity moving to malaria prone regions (Sudan, Mali), resistance to drugs and insecticides poses further challenges. The WHO African Region reported 94% of global malaria cases (246 million) and 95% (569 000) of malaria deaths, with the far majority, nearly 80% of these deaths occurring in children under the age of five[7]. Malaria is preventable, but requires specific combinations of malaria prevention tools tailored to the malaria transmission context. However, not all tools are reaching the most vulnerable populations with enough coverage to have an impact, and the current funding landscape threatens to completely derail malaria control, especially in fragile and humanitarian contexts. In certain countries malaria vaccination was planned, but now the Global Alliance for Vaccines and Immunization (GAVI) funding cuts might jeopardise this game-changing introduction.



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MALARIA IN 2023

263 million
CASES WORLDWIDE

597,00
DEATHS WORLDWIDE

11 million
INCREASE IN CASES

HIV IN 2023

1.3 million
NEW HIV INFECTIONS

39.9 million
PEOPLE LIVING WITH HIV

630,000
AIDS-RELATED DEATHS

The upcoming Global Fund replenishment (grant cycle 8, or GC8) takes place at a moment of unprecedented turbulence in global health. A perfect storm of geopolitical instability, financial uncertainty, and a retreat from multilateral cooperation threatens to unravel decades of progress in the fight against HIV, TB and malaria. The institutions and funding mechanisms that have sustained these efforts are now at risk of being systematically dismantled, placing millions of lives in jeopardy.

At the heart of this crisis is the sharp pivot away from international solidarity, most starkly exemplified by the United States, historically the largest donor to global health programmes. In January 2025, the U.S. administration withdrew from the World Health Organization (WHO) and imposed a three-month freeze on foreign aid funding, including for the Global Fund, the President's Emergency Plan for AIDS Relief (PEPFAR), contributions towards Stop TB and the President's Malaria Initiative (PMI). These initiatives form the backbone of life-saving prevention, treatment, and care programmes across low- and middle-income countries (LMICs).[8] The USA provides a third of the Global Fund funding, by far the biggest donor to the Global Fund.

At the time of writing, the future of global health financing hangs in the balance. A perfect storm of geopolitical instability, financial uncertainty, and a retreat from multilateral cooperation threatens to unravel decades of progress in the fight against HIV, TB and malaria. **What is already an unstable situation could spiral into full-scale collapse if donor commitments falter.** Although some countries have taken action to maintain programming, the immediate disruptions caused by the US funding freeze and unclear waiver-based systems are eroding the continuity of care for vulnerable populations - continuity that is essential to saving lives and preventing the rise of transmission.

7 https://www.who.int/news-room/fact-sheets/detail/malaria

8 https://www.who.int/news-room/fact-sheets/detail/malaria

GLOBAL FINANCING OF HIV, TB AND MALARIA CONSISTENTLY FALLING SHORT

A. SERIOUS DEFICITS IN THE FINANCING OF HIV, TB AND MALARIA

Global funding for the fight against HIV, TB and malaria remains critically insufficient, leaving millions vulnerable to preventable illness and death. The current financial trends are predicting that efforts to reach 2030 targets are severely off-track. This is the climate in which the Global Fund replenishment is taking place, presenting an investment case that by the Global Fund's own admission, is not sufficient to meet the needs – as outlined in the following sections.

HIV

By the end of 2023, only US$19.8 billion was available for the HIV response in LMICs, with 59% coming from domestic sources. This **falls far short of the $29.3 billion required by 2025 to stay on track to end HIV/AIDS** as a public health threat. Despite increased pressure on domestic resources, we see a declining trend **since 2018, and donor government contributions have continued to fluctuate, declining by 5% between 2022 and 2023**. Over the past decade, many donors have moved away from bilateral funding, leaving both PEPFAR and the Global Fund as the main donors for international HIV funding.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the largest commitment by any nation to address a single disease in the world. Since 2003, PEPFAR has been supporting life-saving treatment and services for people living with HIV, saving 26 million lives and enabling 7.8 million babies to be born HIV-free. PEPFAR is working with partners across 55 countries. To date, US funding for PEPFAR has totaled approximately US$120 billion; funding for the 2024 financial year includes $4.8 billion provided for bilateral HIV efforts (including $284 million on ARV procurement) and $1.7 billion for multilateral efforts ($50 million for the Joint United Nations Programme on HIV and AIDS (UNAIDS) and $1.65 billion for the Global Fund).

The Global Fund remains the second largest source of HIV financing after PEPFAR, covering approximately 28% of global HIV/AIDS funding, but overall, the Global Fund has not succeeded in getting a full replenishment to cover the complete set of needs identified. This year, the Global Fund's investment case (prepared before the cuts to US foreign aid were confirmed) is asking for US$18 billion for the three diseases, which Global Fund acknowledges that, although it will save lives will only save approximately 80% of lives at risk by 2029, leaving 20% still vulnerable.[9]

TB

Despite being the **world's deadliest infectious disease (1.25 million deaths in 2023),** TB has long been neglected in global health financing and continues to receive far less funding than HIV and malaria[10]. As in the previous ten years, 80% of the spending on TB services in 2023 was from domestic sources. Global Fund and the United States Agency for International Development (USAID) were the two major donors of TB in 2024. USAID provided $406 million in 2024 for TB global efforts[11], supporting the needs in 24 priority countries (which are mainly in sub-Saharan Africa, South Asia, and Southeast Asia) and focus on preventing, detecting, and treating TB, including drug-resistant TB, as well as research and development. In 2022, the Global Fund accounted for 75% of all international donor funding for TB programmes, underscoring its essential role in the fight against the disease. Yet even with this contribution, TB remains severely underfunded, with global financing falling short of the commitments needed to meet the WHO's End TB targets. **The TB incidence rate (new cases per 100,000 population per year) is estimated to have increased by 4.6% between 2020 and 2023, reversing declines of about 2% per year between 2010 and 2020.** Worldwide, an estimated 10.8 million people developed TB in 2023 (10.6 million in 2023), up from best estimates of 10.3 million in 2021 and 10 million in 2020. A return to the pre-pandemic downward trend has not yet been seen. Without urgent action to close this funding gap, millions will continue to miss out on timely diagnosis and treatment, and the global TB response will continue to fall behind.

©Prem Hessenkamp/India

9 The Global Fund (2025). Eight Replenishment Investment Case. https://www.theglobalfund.org/en/investment-case/

10 https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2023: In 2023, only 26% of t he US$ 22 billion annually needed for TB prevention and care was available, leaving a massive shortfall. TB research is in crisis, receiving just one-fifth of the US$ 5 billion annual target in 2022 – severely delaying advancements in diagnostics, treatments, and vaccines.

11 https://www.kff.org/global-health-policy/fact-sheet/the-trump-administrations-foreign-aid-review-status-of-u-s-global-tuberculosis-efforts/

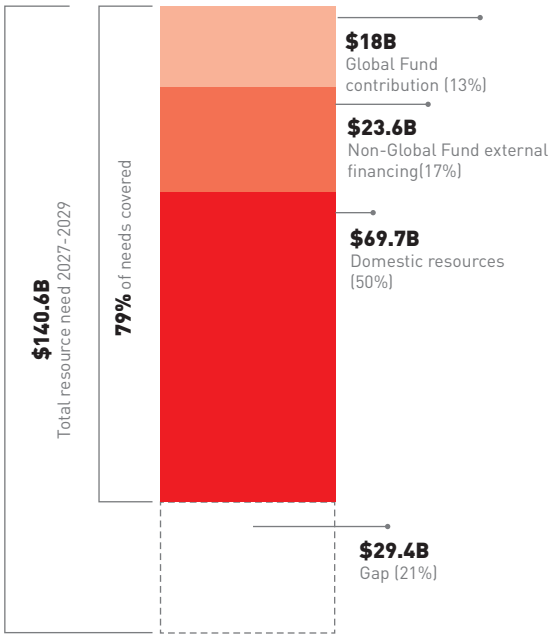
MALARIA

In 2023, **only US$4 billion was available for malaria programmes globally, less than half of the $8.3 billion required to meet global control and elimination goals**. Of this the US is the largest bilateral donor, providing 37% of the worldwide funding for malaria via the President's Malaria Initiative (PMI), now impacted by the US cuts in 2025 and the Global Fund.[12] PMI covered 30 high burden countries modelling suggests that a one-year funding freeze could lead to 14.9 million additional malaria cases and over 100,000 deaths.[13] The Global Fund provides 66% of all international financing for malaria, highlighting its central role in the response. However, stagnant funding levels threaten to stall progress, particularly in the face of emerging challenges, such as increasing insecticide resistance, the spread of drug-resistant malaria strains, and climate-related shifts in transmission patterns. Without sustained investment, these challenges will continue to undermine efforts to control and eliminate malaria, reversing hard-won gains and putting millions of lives at risk.

B. THE GLOBAL FUND INVESTMENT CASE

Between 2027 and 2029, the Global Fund estimates that **US$140.6 billion will be required to combat HIV, TB and malaria, an 8% increase** from the $130.2 billion projected in the last replenishment. Achieving this target is expected to save 23 million lives and avert 400 million cases across the three diseases. Yet, despite this growing need, the Global Fund's contribution remains fixed at $18 billion, while governments are expected to take on an even greater share of health financing. Domestic contributions are projected to rise by 19% from $58.6 billion in 2024-2026 to $69.7 billion in 2027-2029.

The investment case proposed for the eighth replenishment, by the Global Funds own admission is requesting less than the minimum to meet all needs of addressing HIV, TB and malaria. Even before factoring in dramatically shifting donor priorities, **Global Fund projections indicate a 21% funding gap.** The expectation that national governments will close this shortfall is detached from economic realities. While domestic contributions are assumed to grow by 23%, the questions remain: **where will this money come from, and more critically, who will be left behind?**



12 https://www.kff.org/global-health-policy/fact-sheet/the-presidents-malaria-initiative-and-other-u-s-government-global-malaria-efforts/

13 https://malariaatlas.org/project-resources/pmi-2025/

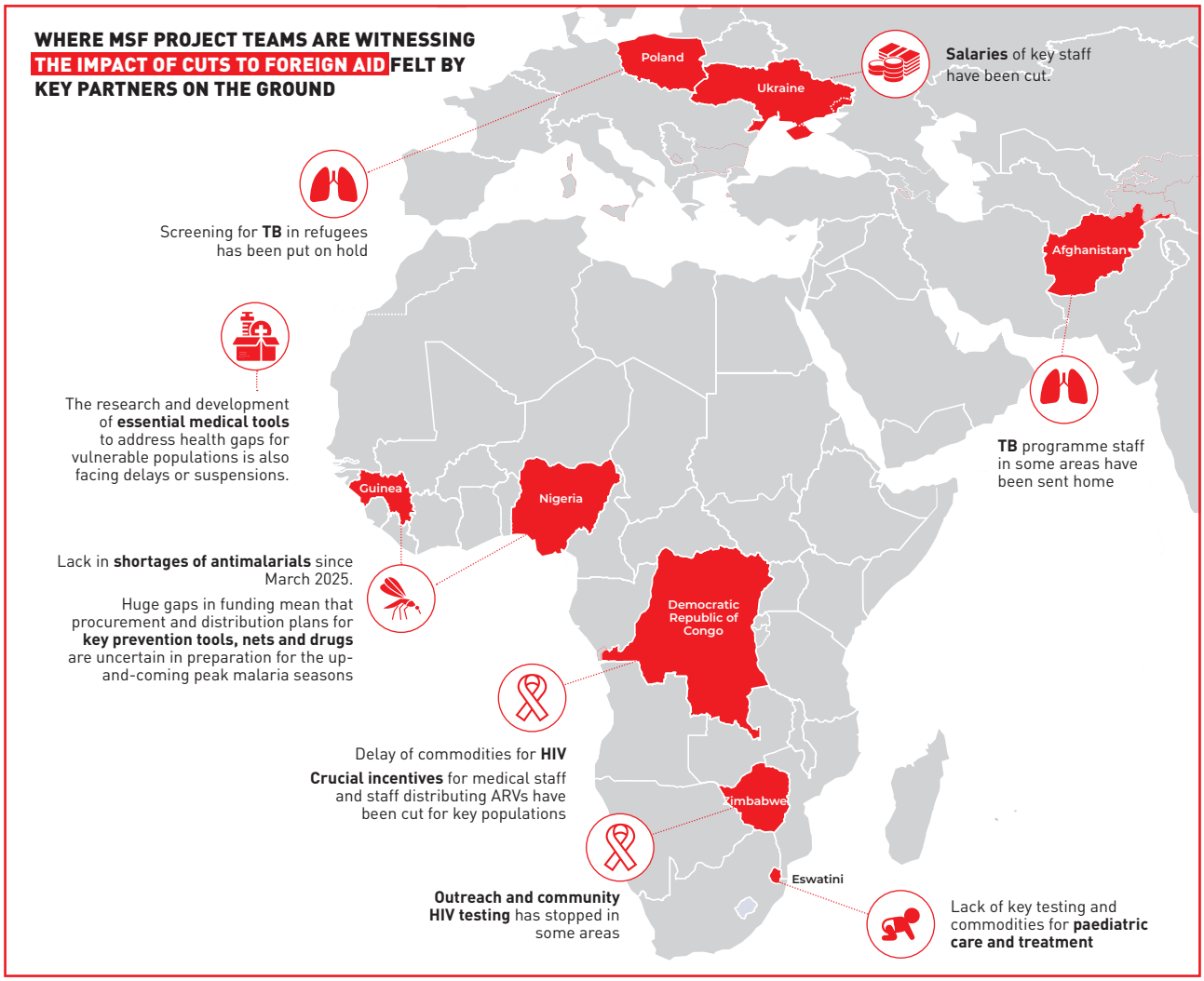
C. BILATERAL DONORS WILL NOT MEET DEFICITS FOR THE FUNDING OF HIV, TB AND MALARIA

The global health financing landscape is entering a period of acute uncertainty, with potentially devastating consequences for HIV, TB and malaria programmes. The most immediate and alarming threat comes from the US, where proposed budget cuts place PEPFAR, PMI and the TB bilateral program managed by USAID in jeopardy.

While the impacts and magnitude of the cuts to US foreign aid remain deeply uncertain, one thing is clear: a prolonged suspension or reduction of U.S. funding would cripple the availability of diagnostics and treatment for millions. Nowhere would this be more devastating than across Africa, especially the Sahel, where many national health programmes are sustained almost entirely through external financing from the Global Fund, PEPFAR, United States Agency for International Development (USAID) and PMI.

The future of PMI, PEPFAR and TB bilateral programme remains uncertain. It is not only the cuts themselves that are damaging; the uncertainty about what lies ahead, whether funding will continue, for how long, and at what scale, is already destabilising national responses. Programme planning has stalled, procurement cycles are in disarray, and governments and implementing partners are left unable to make critical decisions.

The sheer scale and reach of U.S. global health support means that no other donor is positioned to fill the gaps left by a retreat of this magnitude. The overnight dismantling of US foreign aid has the potential to disrupt and push fragile health systems to the brink, reversing decades of gains and triggering a humanitarian catastrophe.[14]



14 https://www.cgdev.org/blog/which-countries-are-most-exposed-us-aid-cuts-and-what-other-providers-can-do

The United Kingdom, co-hosting the Global Fund replenishment alongside South Africa, has added to the uncertainty. In February, the UK Prime Minister announced further reductions in aid spending, cutting the target from 0.5% of gross national income (GNI) to 0.3% by 2027 in favour of increased defence expenditures. [15]

Other European nations are following suit, retreating from their financial commitments to global health, with France making cuts to Overseas Development Aid (ODA) of 35%, the Netherlands of 25% and Belgium of 25%. This signals a broader shift in donor priorities, where global health is increasingly seen as a secondary concern rather than a shared responsibility. [16]

This fragility is compounded by a wider retreat from global solidarity. Previous commitments of fair financing to ODA and global health are being abandoned. Across donor governments, official development assistance (ODA) is being scaled back or redirected, and support for multilateralism is weakening. If these trends continue, the hard-won gains of the past two decades could unravel, driven not by the failure of tools or strategies, but by the erosion of the financing that sustains them.

15 The Budget Cuts Tracker. https://donortracker.org/publications/budget-cuts-tracker (last accessed on 24.4.2025)

16 Burden-shedding: the unravelling of the OECD aid consensus, DevPolicyBlog, Robin Davies, 7 March 2025. https://devpolicy.org/burden-shedding-the-unravelling-of-the-oecd-aid-consensus-20250307/

"The cuts to US foreign aid have thrown everything into disarray. Many health actors where MSF is working have been forced to reduce or close their activities. No one knows what the future holds, which makes it impossible to plan. It's complete chaos."

Ghazali Babiker, Head of Mission, MSF Philippines

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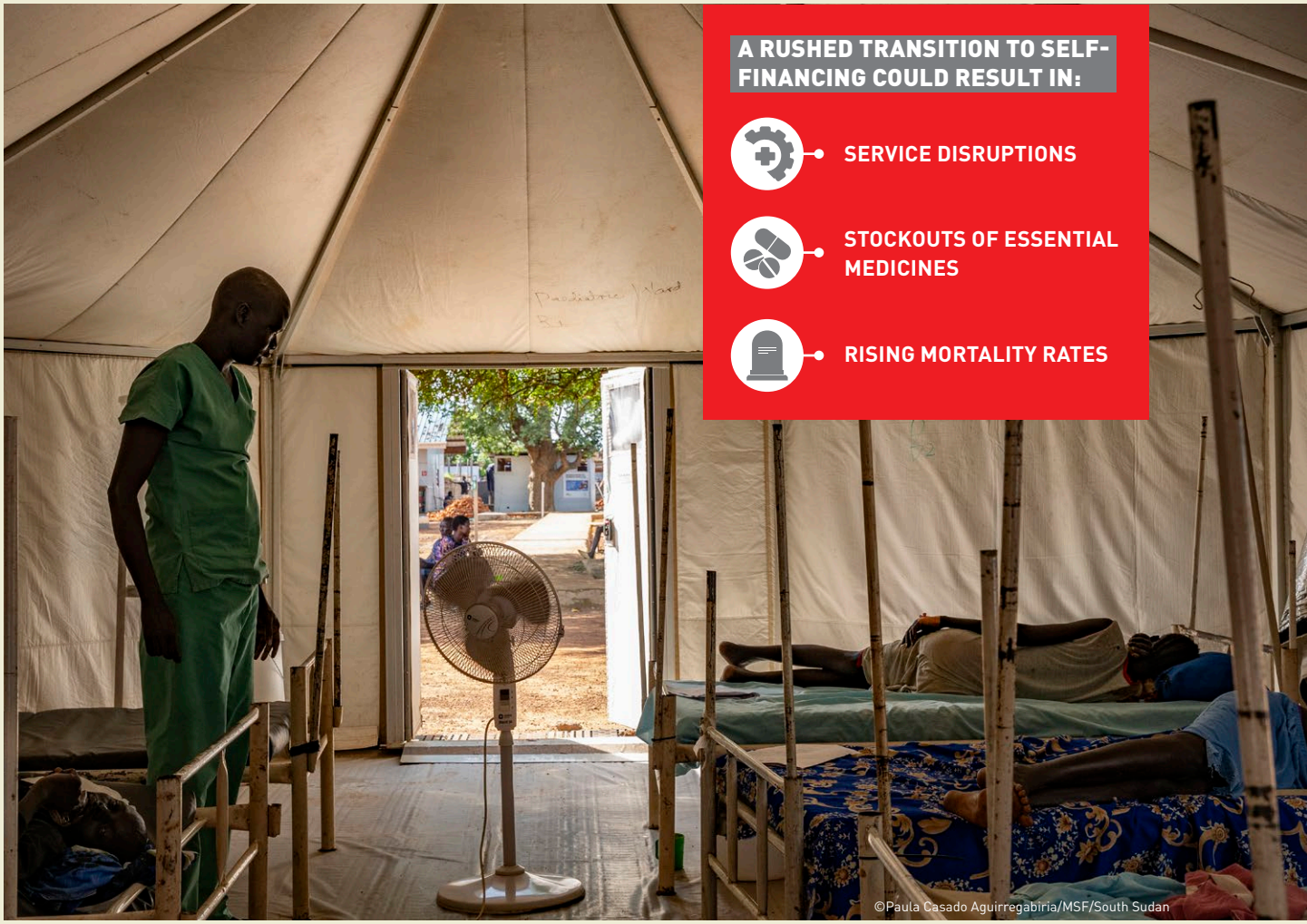

D. DOMESTIC RESOURCES WILL NOT MEET DEFICITS FOR THE FUNDING OF HIV, TB AND MALARIA

Already in the assumptions to determine the amount asked for in the investment case, the reliance on Domestic Resource Mobilisation (DRM) is unrealistically high. Within the investment case, financial sustainability scenarios and co-financing projections might be over-estimated. This high expectation will turn into a bigger gap than initially estimated.

Overall DRM for health is expected not to be increasing, mainly because of downward trend in economic growth and specific strains on the countries' economy, such as (a combination of) conflict, food and epidemic crises, drought, inflation and devaluation, and price hikes. Many LMICs already face weak tax bases, high debt burdens[17], and shrinking fiscal space. **The World Bank estimates that 41 countries face the prospect of lower real per capita government spending in 2027** than in 2019, while another **69** countries risk seeing stagnation in 2027 compared to 2019 levels.[18] Health expenditure is outcompeted by debt repayments in highly indebted countries.[19] Even countries classified as middle-income face shrinking budgets for public services and health. For instance, Pakistan allocates alarmingly low levels of government expenditure to health.[20] A country's classification as Low-, Middle-, or High Income is not adequately reflecting the fiscal space for health, the current health challenges, nor the population's poverty rates. [21]

17 The UNDP report *'Avoiding "Too Little Too Late" on International Debt Relief' (2022)* identifies 54 developing countries experiencing severe problems in meeting their debt obligations. Many countries spend more on external debt payments than on healthcare.

18 World Bank (2022) "From double shock to double recovery. Implications and Options for Health Financing in the Time of COVID-19. Technical update 2: Old scars, new wounds. https://openknowledge.worldbank.org/server/api/core/bitstreams/76d5786b-9501-5235-922a-caa71f99f0fc/content

19 https://blog.uantwerpen.be/iob/the-silent-debt-crisis/

20 World Bank Data. https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=PK (last accessed on 24.04.2025)

21 Equitable Access Initiative. https://archive.theglobalfund.org/media/1322/archive_equitable-access-initiative_report_en.pdf

Similarly, the ongoing cuts in bilateral donor funding will put higher demands on public domestic resources and these will be competing with needs in the HIV, TB, malaria response. Existing plans for DRM mostly fall short in replacing international funding or to increase the overall health expenditure needed. It is likely that countries might not be able to compensate for these donor cuts, creating extra gaps. **In South Sudan, each year MSF sections combined spend the equivalent of 50-60% of the entire Ministry of Health budget**, and the country is also extremely heavily reliant on US funding; the recent US cuts are therefore already having catastrophic effects[22] [21]

Greater domestic financing is often framed as a step towards country ownership. However, it is crucial that this is applied in proportion with the country capacity and resources. Realising ambitions in DRM through increased taxing of different kinds takes time, which is in sharp contrast with the speed by which donors are currently withdrawing funds. Many proposed so-called innovative financing solutions such as blended financing or debt swaps remain to be proven effective and will only mobilise limited amounts of DRM for health. In most contexts where MSF is present, increasing domestic financing risks devastating consequences because the health systems (assuming they are stable, while the reality is that there is an increase in fragile or conflict-affected states) are already overstretched. A rushed transition to self-financing could result in **service disruptions, stockouts of essential medicines, and rising mortality rates.**

In **Guinea**, for instance, **96%** of the jobs are in the informal sector and public revenues account for just **10%** of GDP, leaving little room for substantial domestic investment in health. In **DRC**, the Global Fund's allocation to the country was reduced by **12%** in the latest grant cycle, and the government has struggled to meet its co-financing commitments, delivering only **US$4 million** of the **US$20 million** pledged in the last cycle.[23] [22] As a consequence, planned government funding for ART did not materialise and created an additional gap in available HIV treatment. These examples underscore the need for continued international support and flexible co-financing arrangements that reflect economic realities, rather than unrealistic assumptions of domestic self-sufficiency.

Nowhere is the risk greater than in fragile and conflict-affected settings, where health systems depend almost entirely on external support. In countries facing conflict and mass displacement, whether in **Sudan**, or the **DRC**, **Mozambique** or **Ukraine**, governments struggle to sustain even the most basic health services. Forcing them to mobilise significantly more domestic resources under these conditions is not just unrealistic, it is dangerous. In these settings, **reducing donor support risks the total collapse of health services**. Co-financing plans for countries in conflict or affected by large epidemic outbreaks should be suspended, as additional demands on health expenditure arise and the health services need extra support to reach the most affected. For countries classified as 'fragile and conflict affected contexts' certainly adapted and more realistic DRM prospects should be planned, as public domestic funding promises are unlikely to be achieved and the health impact therefore will impose a high price on mortality and morbidity, with disproportional damage for the most vulnerable. The Global Fund cannot sacrifice urgent and short-term interventions because of long term (theoretical) aspirations of DRM.

MSF has consistently warned that shifting financial responsibility onto national governments without adequate safety nets will create additional and deeper gaps, deepening health inequities and leaving millions without care. HIV, TB, and malaria are not abstract policy challenges, they are diseases that devastate lives and communities when funding gaps emerge. The withdrawal of international support will not strengthen national health systems overnight. It will cause **treatment interruptions, increase mortality rates, and further entrench global health disparities**. Hence, the timing, speed and scale of DRM plans need to be adapted according to the current funding landscape, based on an updated and realistic assessment/analysis of the specific country's situation in terms of economy, health budget plans and health benefits at stake. Financial sustainability plans need to have built-in flexibility and caution. Such analysis should be made including inputs of civil society and patient organisations.


©MSF/Sudan

22 https://www.savethechildren.net/news/south-sudan-children-cholera-die-three-hour-walk-treatment-after-aid-cuts-shut-local-health

23 The Global Fund. Profiles – Democratic Republic of Congo https://www.theglobalfund.org/en/government/profiles/congo-democratic-republic/

E. PATIENTS SHOULD NOT PAY THE PRICE FOR THE FUNDING DEFICIT OF HIV, TB AND MALARIA


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While public DRM is often presented as a path to sustainability, it is important to recognise that in many countries, an increased burden shifted on "domestic resources" often comes with a hike in out-of-pocket (OoP) payments by people themselves. The proportion of OoPs in health expenditure has been consistently rising, especially in low-income countries, where OoP is the most important source of health financing.[24]

Efforts to expand care through public-private partnerships have shown mixed results. In **Pakistan**, the Global Fund has prioritised engagement with private providers for TB detection, as more than **80%** of patients first seek care in the private sector. However, these private facilities often lie outside the National TB Program's network and charge consultation fees, which limit access for poorer or rural patients. Without parallel investments in the public sector and clear accountability mechanisms, the expansion of private-sector engagement risks reinforcing existing inequalities in access and quality.

While accessing HIV, TB and malaria services free of charge has widely been evidenced and accepted to be essential to reach sufficient coverage and timely care under Global Fund funded interventions, MSF teams observe the persistence of important financial barriers to access, adherence and quality of care. This is the case in countries of **West and Central Africa** with poorer populations and worse health indicators, but nevertheless user fees are excluding, delaying and interrupting adequate prevention and treatment. This creates a paradoxical double burden for people: despite being poorer, they are expected to contribute more from their pocket to access healthcare[25]. The high user fees are considered to be one of the region's main barriers to access to healthcare[26]. User fees end up taxing the ill, increasing inequity and deteriorating health[27]. In **DRC 44%** of health costs are covered by private domestic spending, **37%** of which is through out-of-pocket (OoP) payments[28].

This high dependence on OoP spending creates barriers to accessing essential healthcare, particularly for the **73.5%** of the population who live below the poverty line.

©Alexis Huguet/Democratic Republic of Congo

24 Global Health Expenditure Database

25 Office of Inspector General. (2019) *https://www.theglobalfund.org/media/8493/oig_gf-oig-19-013_report_en.pdf* "Grant implementation in Western and Central Africa (WCA) Overcoming barriers and enhancing performance in a challenging region." The Global Fund

26 UNAIDS The Western and Central Africa catch-up plan.

27 https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2023. In 2023, results from national surveys were used to produce model-based estimates of the percentage of TB patients and their households facing catastrophic total costs in all 135 low and middle-income countries (LMICs) The model-based estimate for all LMICs was 55% (95% CI: 47–63%). Among the six WHO regions, the highest percentage was in the African Region: 68% (95% CI: 59–76%

28 https://apps.who.int/nha/database/ViewData/Indicators/en

Patient fees can also induce overprescription of drugs and tests and the promotion of certain (unnecessary) procedures to generate more revenue. These more expensive treatments can also distort the quality of care provided. Conversely, people with limited financial resources often receive inadequate, incomplete or sub-standard care.

In other instances, MSF observed in **Mozambique**[29] that patients with advanced HIV, upon admission to public facilities, faced inadequate infection prevention and control measures, along with critical gaps - exceeding **40%** in some cases - in access to essential antimicrobials necessary to treat bacterial and fungal co-infections associated with HIV and sepsis. When struck with antimicrobial shortfalls, patients were sometimes asked to purchase their own medications adding further financial burden. In **Sierra Leone**[30], MSF also observed suboptimal quality of care in primary care settings, noting that although HIV tests themselves are provided free of charge, patients are still required to pay for everything else involved in their diagnostic and treatment journey including basic infection prevention supplies like gloves, alcohol, and gauze, as well as essential medications such as antibiotics.

In several countries, inability to pay the fees leads to patients being detained by hospitals and undergoing abuse or other degrading treatment. Similar experiences were reported by MSF and others in **DRC, Kenya and Nigeria** among others[31]. Bodies of the deceased might also be withheld.

Financing by OoP is inherently regressive, disproportionately affecting the poorest and most vulnerable populations. As women are less able to access cash, they are exposed to exclusion and delays in seeking or obtaining care when user fees are required.

During outbreaks and other crises, patient payments hamper access to care and reduce coverage. WHO and World Bank surveys during the COVID-19 pandemic showed that financial barriers were the most common reason **(>40%)** for not receiving essential care[32]. Decreasing or abolishing user fees has been shown to be highly effective in increasing attendance rates for essential primary care and referral care, even when crises cause disruption of health services, such as during Ebola or other outbreaks.

When national health budgets are insufficient, and external funding decreases, the financial burden is pushed onto individuals - forcing them to pay for services, diagnostics, or medicines that should be freely accessible. Additionally, when medical supplies are falling short or out-of-stock in public services, people need to rely on paying OoP in private-for-profit outlets for their treatment, which are mostly more expensive and often of uncertain quality, in contexts where poverty is widespread. This results in delayed or foregone care, increased morbidity and mortality, impoverishment and deeper health inequities. A DRM approach that relies on inclusion of OoP spending is not sustainable, equitable or rights-based - it shifts the cost of care from governments to people, further entrenching barriers to access.


©Asim Hafeez/Pakistan

"We know that money is an enormous barrier to healthcare access. The healthcare system is supposed to provide care for free, however the people we see in MSF projects (where all is free) tell us they have to pay for malaria treatments in other facilities - including for appointments, purchase of supplies like syringes, gloves, and antipyretics (like paracetamol). It's not the health workers fault, it's a system issue. This is causing unintended harm and barriers to healthcare for patients."

Zakari Moluh, Project Coordinator, MSF project, Burundi

29 https://www.msf.org/broken-lens-antimicrobial-resistance-humanitarian-settings

30 https://www.msf.org/broken-lens-antimicrobial-resistance-humanitarian-settings

31 *WHO (2020) Ending hospital detention for non-payment of bills: legal and health financing policy options. Policy Brief. https://www.who.int/publications/i/item/9789240008830*

32 WHO & The World Bank (2023), *Tracking Universal Health Coverage. Global Monitoring Report 2023*.

F. PRESSURE ON GLOBAL FUND FINANCING

PAAR

There are already significant financing gaps in Global Fund funding for HIV, TB and malaria, leaving many critical interventions underfunded or entirely out of reach. Within the Global Fund's grant-making model, this reality is reflected in the structures of the Prioritized Above Allocation Request (PAAR) and Unfunded Quality Demand (UQD). The PAAR captures interventions that countries consider essential but cannot afford within their allocation, while the UQD confirms that these interventions meet technical standards but remain unfunded due to budget constraints. This system effectively institutionalises the exclusion of vital services, such as **diagnostics, community-based programming, and prevention tools**, not because they are unnecessary, but simply because there isn't enough money. Critical interventions are deprioritised due to lack of budget to be put in the PAAR/UQD.[33] For example in DRC the following have been placed in the PAAR the PMTCT services in nine provinces, the additional **10** units for AHD care (five are included in the grant), **20%** of the needs for microscopy inputs for TB, and the maintenance of existing GeneXpert machines. In **CAR**, the training of service providers for case management of Malaria in three Health Regions (RS1, RS2 and RS6) have been put in the UQD, although key to ensure quality of care. In Guinea, means for genotyping and the study on resistance of anti-TB drugs had to be put on the UQD considering the lack of space in the grant and in the **Philippines**, the current **US$225 million** PAAR request for 2024–2026.[34]

However, some gaps never make it into the PAAR or UQD registry: interventions removed during grant-making are often not resubmitted in updated PAAR lists for review, despite this being possible. The Global Fund should strengthen transparency by ensuring all unfunded priorities are reflected in the PAAR/UQD register. In **DRC** HIV testing is restricted to pregnant women, TB patients, index testing and key populations (including some strategies for adolescents) only in the Global Fund grant. This means provider-initiated counselling and testing (PICT), although critical intervention, as it targets people with symptoms, is not included in the grant for 2024-2026. Despite the possibility of putting PICT in the PAAR/UQD, it was not done, missing the opportunity to make these critical gaps visible. [35]

Another category of hidden shortfalls are the propositions that are excluded at the beginning or during the grant making process, deemed not to be fit within the country allocation envelope received as guidance from the Global Fund. Objectives might become less ambitious, and targets diminished. As many countries have no transparent and inclusive process for the Global Fund grant-making, certain important interventions might be abandoned, such as CSO support or community-led activities.

COVID-19 FUNDING (C19RM)

During the 7th replenishment (grant cycle 7 or GC7), some of these gaps were partially mitigated by emergency COVID-19 funding (C19RM; COVID-19 response mechanism), which allowed countries to reallocate resources and strengthen health systems through the Pandemic Fund and other temporary financing streams.[36] In **South Sudan** for example some key services, such as treatment for advanced HIV patients that had been allocated to the PAAR in the grant-making, were able to be funded through the C19RM funding. However, this money, due to being tied to the COVID-19 response and funding, now leaves an additional gap in the medium term as it will come to an end in 2025.

This additional Covid-19 support helped sustain core programmes, fund **diagnostic expansion, address antimicrobial resistance and address service disruptions** caused by the pandemic. Without sustained investment, countries face difficult choices in prioritising interventions, potentially leading to service reductions, stockouts and increased disease transmission. For countries that put those extra funds to use to support and protect health services, the end of this emergency COVID-era funding in the current replenishment cycle implies a sudden funding gap, and health systems would need to try to absorb these costs without a clear alternative source of financing.

The current situation of HIV, TB and malaria is far from ideal and besides the overall funding shortfall, further threats are to be anticipated, such as **conflict, displacement and climate change**. We have learned how fragile the progress is as shown by the COVID-19 crisis and further deterioration is possible without effective protection and mitigation efforts. To avoid further back-sliding and to prevent regression of the significant progress made through substantial investments over the last 20 years, the full Global Fund replenishment is the only hope to keep course in the current landscape.

33 cr_2023-2025-register-unfunded-quality-demand_tool_en

34 The Global Fund. Data explorer – Philippines https://data.theglobalfund.org/location/PHL/access-to-funding

35 The Global Fund. Data explorer – Philippines https://data.theglobalfund.org/location/PHL/access-to-funding

36 The Global Fund. COVID-19 Response Mechanism https://resources.theglobalfund.org/en/c19rm/

> *I don't know what is going to happen with the next [Global Fund] replenishment. Countries had some extra money in these past years because there was additional funding available for the COVID-19 response, which went towards health systems strengthening and other things. Now, with that money gone and donors cutting critical funding for critical lifesaving services and everything, the future of health financing looks bleak.*
>
> *Yusra Shariff, Advocacy Coordinator, all MSF sections, South Sudan*

2. CONSEQUENCES FOR PEOPLE AND POPULATIONS – AND POTENTIAL MITIGATION MEASURES

Following on from the previous section, the implications and the lives at risk from lack of funding are catastrophic. Outlined in the following section are the key challenges, but also potential areas to prioritise to mitigate the risks presented.

The consequences from not funding the replenishment, and prioritising these key mitigation measures, as highlighted in the insights from MSF projects in the below section, include:

- **PATIENTS MORE SERIOUSLY ILL, GREATER MORTALITY, MORE INTERRUPTION TO CARE, HIGHER VULNERABILITY**
- **MORE OUTBREAKS AND TRANSMISSION OF ALL THREE DISEASES**
- **HEALTH SYSTEMS OVERWHELMED**
- **INCREASED RESISTANCE TO MEDICINES**
- **BACK SLIDING IN RESPONSE – PANDEMIC THREAT RAISED**
- **LOSS OF PAST ACHIEVEMENTS AND INVESTMENTS**

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2.1. PEOPLE FACING EXTRA NEGLECT AND VULNERABILITY

A. PEOPLE AFFECTED BY CRISIS

Populations affected by **extreme weather events, conflict and displacement** remain among the most neglected in the global response to HIV, TB and malaria. In crisis-affected contexts, the collapse of health systems, destruction or abandonment of health facilities, and widespread insecurity make access to care nearly impossible. Ensuring continuity of treatment is a major challenge amid disruptions of services. To maintain key services and interventions for HIV, TB and malaria functioning in these circumstances, the mobilisation of rapid funding mobilisation is essential, responding to increased needs, worsened vulnerability and health service deficiencies. Adaptability to the changed and changing circumstances is of paramount importance, including through flexibility and process simplification of Global Fund grant modalities.

The situation in **Sudan** exemplifies this situation. WHO estimates that **70–80%** of health facilities in Sudan are not functioning in the most-affected conflict areas, leaving millions without access to basic medical care and, needing to look elsewhere for care and adding to one of the largest displacement crises in recent history.[37] The crisis is defined by widespread insecurity, looting of essential supplies, and destruction of healthcare facilities, devastating the health system's ability to function. In El Fasher alone, MSF-supported facilities were attacked more than **12** times between May and August 2024, with Al-Saudi Hospital targeted three additional times in December.[38] Key laboratory equipment necessary for diagnosing HIV, TB and/or malaria have been stolen and/or destroyed, severely limiting the capacity to provide timely and effective treatment. Health workers are in critically short supply, some having left the country, and there are many displaced due to insecurity, leaving affected communities without adequate health professionals. At the same time, bureaucratic barriers and lengthy importation processes have made it extremely difficult to get life-saving medical supplies into the country, and to move them where they are needed most, especially across conflict lines. This has delayed emergency interventions and further exacerbated the crisis. Beyond Sudan's borders, the crisis has placed enormous pressure on already fragile health systems in neighbouring countries.

In eastern **Chad**, the influx of Sudanese refugees underscores the need for a cross-border approach to healthcare. Displaced populations do not leave their health needs behind when they cross into a new country, yet too often, they remain outside the reach of national health programmes. Similarly, over one million people have crossed into South Sudan from **Sudan**, placing an additional strain on an already weak and unstable health system. For diseases such as HIV, TB and malaria, the disruption of care increases the **risk of transmission, treatment interruptions, and drug resistance**, turning a humanitarian emergency into a broader public health crisis. However, initiatives are failing to adapt sufficiently to the realities of protracted displacement, leaving gaps in the provision of care for the population and inconsistent access to prevention and treatment services. In the case of malaria, the consequences of conflict and displacement are equally devastating. Displaced populations, frequently residing in makeshift shelters or overcrowded camps, remain highly exposed to malaria vectors, particularly during seasonal peaks. Reduced immunity because of malnutrition and less malaria pressure in areas of origin create extra vulnerability. Yet, malaria prevention in these settings is rarely systematically addressed. Alongside Sudan, MSF sees similar patterns in other places facing acute conflict, such as in eastern **DRC**.

37 WHO (2024) Sudan surpasses 100 attacks on healthcare since 2023 armed conflict began. https://www.emro.who.int/media/news/in-sudan-there-have-been-more-than-100-attacks-on-health-care-since-the-armed-conflict-began.html

38 MSF. Attacks on hospitals and aid blockade in El Fasher jeopardises lives. https://www.msf.org/sudan-msf-outraged-and-alarmed-over-repeated-attacks-hospitals-el-fasher-and-blockade-urgently

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> ***Volatile contexts can change overnight, and in an emergency, agility is key. Resources need to be deployed rapidly without heavy bureaucracy stalling the process as there are often limited windows of opportunity to implement a lifesaving response for those most in need and wherever they are.***
>
> *Sonal Marwah, Intersectional Advocacy Coordinator, MSF, Sudan*

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DRC (beyond the volatile east of the country) presents an additional complexity due to numerous structural barriers, (financial, geographic, lack of healthcare workers and key commodities) where the provision of healthcare continues to be limited, risking populations health and lives. Such protracted humanitarian crises have ripple effects on antimicrobial resistance (AMR) among HIV patients, exacerbating a global health emergency already evident through high resistance rates to antibiotics, such as third-generation cephalosporins, fluoroquinolones, and increasingly carbapenems, documented among HIV patients in Bihar (India)[39], Kinshasa (DRC)[40], and Beira (Mozambique).[41] Many contexts where MSF have projects are facing the same type of challenges: **Guinea, CAR, Mozambique or South Sudan**.

The fast-tracking of additional resource mobilisation to respond to increased needs and to mitigate shocks in terms of the HIV, TB and malaria response might come under strain in the context of expected funding shortfalls. The Global Fund should allow shifts in specific allocations in existing grants. A stronger focus on ensuring essential medical supplies with buffer stocks and rapid response when there are threatened shortfalls is indicated, combined with direct support to frontline health and lay workers. Specific funding will be needed to ensure that patients are exempt from paying. Anticipation and mitigation of supply disruptions is needed, with the strengthening and filling of pipelines of essential medicines, a push for drug dispensing through community groups and patient autonomy, through which a continuity of services facilitates better withstanding of shocks.

An example of these needs where MSF is present is **Mozambique** which experiences one of the highest HIV burdens in the world, with an estimated **2.4 million** people living with HIV and an adult prevalence rate of **12.5%**. While some progress has been made toward the UNAIDS 95-95-95 targets, access to early testing, treatment, and care remains inconsistent, particularly in Cabo Delgado. Conflict-related displacement has disrupted treatment continuity, leading to gaps in ART adherence and high rates of AHD. In Palma, MSF projects last year saw averages of a minimal of **42%** (up to **86%** for the second quarter of 2024) of HIV abandoning ARV across 2024.

More broadly, in areas where the state is unable or unwilling to provide services, particularly those controlled by non-state actors, access to healthcare often depends entirely on non-governmental organisations (NGOs) and community-based organisations (CBOs). These actors frequently act as first responders and are uniquely positioned to deliver services in volatile or insecure settings. Their ability to scale up quickly, adapt to changing needs, and reach highly mobile or isolated populations is critical to maintaining life-saving care. The Global Fund grant structure is not always designed to accommodate the needs of populations in emergencies. Even when flexibility exists on paper, operationalising it remains a challenge on the ground. The Global Fund should prepare to facilitate shifts in funding channels to other implementing agencies (NGOs, CSOs and humanitarian actors).

39 https://pmc.ncbi.nlm.nih.gov/articles/PMC10759003/

40 https://scienceportal.msf.org/assets/8255

41 https://www.msf.org/broken-lens-antimicrobial-resistance-humanitarian-settings

©MSF/Democratic Republic of Congo

Given the increasing number of crises and emergencies witnessed by MSF across contexts, it is essential that the Global Fund further builds on and expands its Challenging Operating Environment (COE) policy within grants to ensure greater adaptability.[42] In protracted crisis settings such as **South Sudan** and **DRC** there needs to be robust analysis of the risks that could disrupt 'normal' implementation, such as conflict escalation or mass displacement, and concrete mechanisms to ensure continuity of care in these scenarios must be outlined. This analysis as well as a contingency plan, should part of the funding request that countries submit to Global Fund. This can then be considered for any grant-making process, ensuring clear appreciation and expectations of what the needs are, but also highlighting the risks, with upfront recognition that potential additional flexibility and unpredictable responses may need to factored in.

One COE context is **Mali**, where MSF sees increasing need for recognition of the volatile context demanding more support. In the region of **Douentza** MSF projects had an increase of **65% to 61,837** in 2024 versus **37,471** cases of malaria in 2023 (these numbers also reflect increased numbers of refugees and people moving due to conflict). Severe malaria cases doubled in these projects, with an increase of over **100% to 26,035** versus. **12,667**, in 2023 in line with the high rainfall recorded in 2024. This applies not only to traditionally recognised COE contexts, but also to settings that may appear stable at the time of grant development but are vulnerable to sudden instability. For example, **Mozambique**, where despite it not being a COE context, MSF has witnessed the impact, has increased needs due to conflict and cyclones. Greater integration of the COE policy into risk assessment, flexible grant architecture, and contingency planning is critical to maintaining access to HIV, TB, and malaria services in the face of escalating humanitarian challenges.

42 The Global Fund (2023). Conflicts, Crises and Displaced People. https://www.theglobalfund.org/media/11944/thematic_challengingoperatingenvironments_report_en.pdf

B. KEY POPULATIONS UNDER PRESSURE: EXCLUSION FROM CARE

Key populations, including **men who have sex with men, transgender people, sex workers and people who use drugs**, face disproportionately high HIV burdens compared to the general population. Globally, HIV prevalence is 11 times higher among men who have sex with men (MSM), 14 times higher among transgender people, four times higher among sex workers, and seven times higher among people who inject drugs. In many countries, these groups also face criminalisation, violence and entrenched stigma that significantly hinder access to essential services. External or international funding to local CSOs is critical in such hostile environments, where national governments often fail to prioritise, or actively obstruct services for these populations. As donor priorities change, influenced by domestic and political agendas, there is a growing risk that programmes supporting key populations could be deprioritised or defunded. There is also a risk that diplomatic pressure and policy influence could embolden some governments to roll back protections for key populations.

HIV prevention and care for key populations are already under strain due to fragmented services, supply gaps and restrictive policies. The gap in access to pre-exposure prophylaxis (PrEP), differentiated care models and mental health support disproportionately affects communities that are already marginalised. The Global Fund has played a critical role in supporting civil society and community-based organisations that provide non-discriminatory, peer-led services. These programmes often offer the only safe access points to care for people excluded from public health systems. However, many of these efforts remain underfunded, and the support they receive is increasingly fragile. As pressure mounts on bilateral donors to restrict funding for services deemed politically sensitive, the Global Fund must step in to maintain continuity and expand access, especially in prevention. **Key populations cannot be treated as optional in national strategies - they are essential to the success of the HIV response.** Without renewed investment, service interruptions will lead to increases in transmission, loss to follow-up (LTFU), and missed opportunities for testing, treatment, and prevention.


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In June 2024, DRC's minister of justice issued an order enforcing 'moral conduct'" which led to increased harassment of transgender people and MSM, causing a **30-40%** decrease in clinic attendance among these groups. Fear of discrimination and violence has also disrupted peer outreach programmes, further limiting access to essential health services. These measures create hostile environments where stigma and discrimination prevent vulnerable communities from seeking care, increasing disease transmission and worsening health outcomes.

Another example of the impacts of criminalisation of these populations can be found in **Kenya**, where MSF works with local CBOs in Mombasa to provide healthcare. Kenya's legal framework remains a major obstacle to healthcare access for LGBTQI+ communities and sex workers. Same-sex relationships are criminalised, and societal hostility toward these groups remains high. In 2023, a surge in anti-LGBTQ+ protests led to the closure of key partner CBOs, which disrupted service delivery and forced MSF to scale back activities at a time when these communities needed support the most.[43] High levels of stigma and discrimination in healthcare settings further deter key populations from seeking care. This is particularly concerning given recent shifts toward integrated models of care, moving away from standalone services such as drop-in centres, and towards mainstreaming care within the general health system. While this approach aims to expand access, the pervasive stigma among healthcare workers in Mombasa severely undermines its feasibility.

To address this, MSF has implemented targeted **anti-stigma interventions** in three sub-counties of **Mombasa** (Kisauni, Nyali, and Likoni), including healthcare worker sensitisation, facilitated dialogues between key populations and providers, and 'empathy exercises' such as privilege walks. Initial results from MSF projects in the first phase show measurable progress: LGBTQI+ stigma among healthcare workers dropped by **12%**, drug use stigma by **13%**, and sex work stigma by **3%**. While promising, these efforts currently reach only three out of over 300 facilities in Mombasa, underscoring the need for broader structural reform, political commitment, and national-scale investment in anti-stigma programming to ensure that key populations can access the care they need safely and without discrimination.[44]

MSF ANTI-STIGMA PROJECTS:

12%
DROP IN LGBTQI+ STIGMA AMONG HEALTHCARE WORKERS

13%
DROP IN DRUG USE STIGMA

3%
DROP IN SEX WORK STIGMA

Similarly, people in closed or criminalised settings, particularly prisoners, face significantly elevated risks of TB, including drug-resistant strains. Incarceration is a well-documented risk factor for TB due to overcrowding, poor ventilation, inadequate nutrition and limited access to healthcare. Transmission within prison settings also drives broader community-level transmission and development of resistance, making TB in prisons not just a human rights issue, but a public health one. MSF is working in prisons in different countries, where screening, diagnosis, and treatment of TB among detainees and staff have revealed significant health gaps. In **Tajikistan** (where MSF has projects), a recent study found the rate of TB in prison institutions to be **five times higher** than in the general population.[45] Symptomatic individuals that were part of the screening had a higher likelihood of TB diagnosis, and using chest X-rays significantly improved screening yield. These projects have also highlighted the need for adapted models of care that consider the mobility of detainees, pre-trial detention and the continuity of treatment after release. Yet most national programmes continue to overlook prisons and other high-risk institutional settings in TB control strategies.

With the threat of disappearance of US funding to programmes that support key populations, the Global Fund stands out as the sole remaining financing channel to ensure rights-based access to care among these groups and constitutes a crucial lifeline for CSOs and community- and peer-led approaches.

43 EFE (2023). Anti-LGBT demonstration in Kenya criticised by rights organisations. https://efe.com/en/latest-news/2023-10-06/anti-lgbt-demonstration-in-kenya-criticized-by-rights-organizations/

44 MSF (2023) The Mombasa Key Populations Study.

45 Yield of TB screening in prisons in Tajikistan: Ingenta Connect

C. CHILDREN STILL LEFT BEHIND IN HIV AND TB RESPONSE

Many service gaps are impacting children, and without additional resources for better tools and approaches, children's lives are at risk. Paediatric HIV remains one of the most persistently neglected areas in the global HIV response. In 2023, treatment coverage for children living with HIV was only **57%** globally and a shocking **37%** in West and Central Africa, leaving nearly **660,000** children without access to life-saving antiretroviral therapy. One in eight AIDS-related deaths last year was a child under the age of 15.[46]

While some regions have made progress in scaling up early infant diagnosis (EID), disparities remain stark: in West and Central Africa, only **27%** of HIV-exposed infants had access to timely EID, compared to **80%** in eastern and southern Africa.[47]

MSF project data from countries like the DRC and Guinea highlight how these gaps play out on the ground, where transmission from mother to child at national level report around **20%**, in contrast to MSF projects. In DRC in 2022, only **40%** of HIV positive pregnant women were put on ARV. **More than 3 million** pregnant women didn't get access to HIV test, and **20%** of those tested never received their results. In Guinea, **82%** of pregnant women had access to a HIV test during their ANC visit and around **85%** of the HIV positive ones were put on ARV. However, challenges persist for PMTCT and paediatric care, namely the access to EID (transport of samples, transport of results and delay to obtain results), availability of HIV testing and the stockout of Pediatric post-natal prophylaxy (NVP syrup).

The PMTCT program supported by MSF in Conakry is showing very impressive results, with only **1%** of transmission* when the mothers are tested and put on treatment on due time, during the ANC visits and have a close follow-up until the end of the program. The global vertical transmission is at **5%**, as shown in the graph.

In many sites, stockouts of dried blood spot (DBS) cartridges for EID, lack of laboratory equipment, and delayed result return, sometimes taking months, undermine the potential impact of PMTCT services. Paediatric HIV care is further constrained by weak health systems, limited community follow-up, and barriers to care faced by mothers, such as stigma or limited access to healthcare.

While there has been welcome progress in the development and registration of child-friendly antiretroviral formulations, challenges persist. Paediatric postnatal prophylaxis (PNP) regimens remain outdated, and children's access to newer, safer, and easier-to-administer formulations is limited by fragmented supply chains and high prices. GeneXpert-based early diagnostic testing, though essential, is still unaffordable or unavailable in many settings, and the lack of paediatric-friendly point-of-care options further delays diagnosis and treatment.

46 UNAIDS (2024) Global AIDS Update. https://www.unaids.org/en/resources/documents/2024/global-aids-update-2024

47 Ibid.

©Peter Caton/South Sudan


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PAEDIATRIC TB

Despite growing recognition of the devastating impact of TB on children, paediatric TB care remains alarmingly inadequate. In MSF projects in **Malakal, South Sudan**, where MSF serves a catchment population of **164,000**, over **500 new TB cases** were diagnosed and treatment initiated in 2024. Disturbingly, **36%** of these cases were among children, highlighting a severe public health crisis. WHO estimates that **1.25 million children** develop TB each year, yet only half are diagnosed and reported to national TB programmes.[48] This stark gap in finding the children with TB means that hundreds of thousands of children each year are left untreated. It is estimated that **96%** of deaths in children from TB were among children never put on treatment, consequently suffering severe illness or death from a curable disease.[49]

The 2022 WHO guidelines introduced shorter antibiotic regimens for children with non-severe drug-susceptible TB (DS-TB), significantly reducing the treatment burden on children and caregivers[50]. However, MSF's 2024 TACTiC (Test, Avoid, Cure TB in Children) survey, covering **14** high TB-burden countries[51] revealed stark gaps between WHO guidance and national paediatric TB policies and practices.[52] While **10** of the **14** countries surveyed by MSF include this policy, globally less than **50%** of countries report this updated policy in their guidelines. Child friendly formulations for TB treatment were available in only 10 of the14 countries surveyed by MSF.[53]

In addition, WHO recommend clinical decision algorithms to address the under-diagnosis of TB in children; however, among the countries surveyed by MSF, only **5 out of 14** countries have adopted this tool. WHO also recommend using alternative samples to sputum, which is hard to collect in children, and although **10** countries include stool-based testing using Xpert Ultra in their policy, just eight have national programme-level support materials to ensure its rollout. The key reasons identified for these gaps in care were urgent investment and technical support. As a result, many children with TB remain undiagnosed, missing the opportunity for early treatment and facing a much higher risk of severe disease and death.

48 WHO (2024). Global Tuberculosis Report. https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2024

49 Reference Dodd PJ, Yuen CM, Sismanidis C, Seddon JA, Jenkins HE. The global burden of tuberculosis mortality in children: a mathematical modelling study. Lancet Glob Health. 2017 Sep;5(9):e898-e906. doi: 10.1016/S2214-109X(17)30289-9. PMID: 28807188; PMCID: PMC5556253.

50 WHO (2022). Consolidated Guidelines on Tuberculosis. https://www.who.int/publications/i/item/9789240048126

51 Afghanistan, Central African Republic, Democratic Republic of Congo, Guinea, India, Mozambique, Niger, Nigeria, Pakistan, Philippines, Sierra Leone, Somalia, South Sudan, Uganda

52 MSF (2024). TACTiC: Test, avoid, cure TB in children - a survey of paediatric TB policies. https://www.msf.org/tactic-test-avoid-cure-tb-children

53 https://www.stoptb.org/sites/default/files/documents/25103_UNOPS_SUFT2024_v04_JM_HQ.pdf

Preventive treatment (TPT) is a critical tool for stopping the progression of TB infection to active disease, particularly for children living with HIV and those in close contact with TB patients. Shorter one to three-month TB preventive treatment (TPT) regimens are now recommended by WHO. MSF's 2024 TACTiC survey noted that all countries have updated policies for children under five years in close contact with TB patients, but only **11 of the 14** surveyed countries have these for children and adolescents living with HIV. There are large gaps in TPT policy for children over five years and adolescents exposed to TB in their households. However, implementation of TPT remains weak in many contexts even if policies are updated, and there are limited resources and money to support implementation, resulting in very few children receiving preventive treatment; as children are at higher risk of developing TB and of death from TB, this gap is deadly. WHO reports that in 2023 only **43%** of under 5-year-olds eligible received TPT[54]. Challenges to scale up are linked to the lack of resources needed for household visits, community follow-up and the exclusion of active TB.

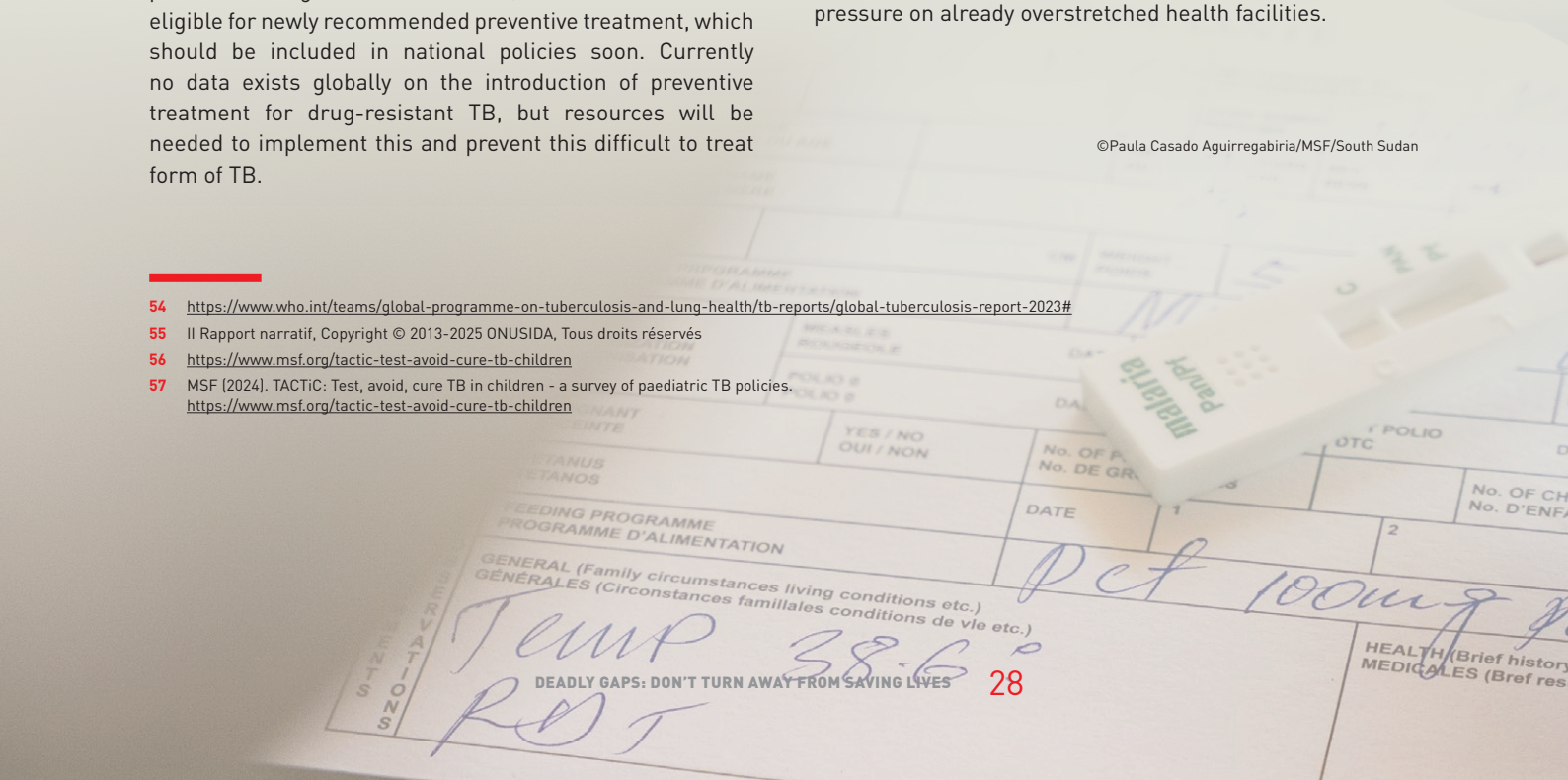
In Guinea, **19.7%** of PLHIV newly enrolled on ART (1,552/7,884) and **19.7%** those already on ART (19,492/98,998) started TPT in 2024[55]. TPT coverage remains low, despite its key role in reducing the risk of active TB. No data are available for age groups (<5 years, 5-15 years, 15+), which limits the analysis of priority populations. In the MSF project, **66%** of the patients were on TPT in 2024. In **Keamari district, Pakistan**, MSF observed poor follow-up tracing and inadequate household contact screening, where only **10%** of household contacts were screened in 2023, and no TPT initiation occurred. However, by providing these resources for community activities in an MSF project in an urban slum in **Manila, Philippines** where the prevalence of active TB among the population is **5%**, MSF was able to achieve **75%** investigation of children under five years old and **76%** TPT acceptance.

In an MSF project in **Gujranwala, Pakistan**, household contact investigation is done and of **1186** household contact persons of drug-resistant TB cases, **1041** would have been eligible for newly recommended preventive treatment, which should be included in national policies soon. Currently no data exists globally on the introduction of preventive treatment for drug-resistant TB, but resources will be needed to implement this and prevent this difficult to treat form of TB.

For drug-resistant TB (DR-TB), while many countries have adopted policies allowing the use of newer medicines such as bedaquiline and delamanid for children of all ages, implementation remains slow, and in some countries, young children are still being left behind. (Out of the 14 countries surveyed for the MSF 2024 TACTiC survey only three countries had procured bedaquiline and delamanid).[56] The failure to rapidly introduce child-friendly formulations of these newer regimens means that many children continue to be subjected to outdated and painful treatments, despite clear evidence that better options exist.[57] Children are at risk of infection in the household. Identifying TB among those households living with a person affected by drug-resistant TB is resource intensive as it requires supplementary testing, clinical assessments and engaging with the households in the community. MSF project in Gujranwala has significantly increased the number of children diagnosed with DR-TB by correctly resourcing outreach activities in 2024. The proportion of children put on treatment for DR-TB went from **2%** and **6%** in 2022 and 2023, respectively to **20%** in 2024.

MALARIA

Intermittent preventive treatment (IPT) strategies, which have the potential to reduce malaria cases among at-risk populations, remain poorly implemented. Intermittent preventive treatment in pregnancy (IPTp), which is crucial for protecting pregnant women and their unborn children from malaria-related complications, is often underutilised due to gaps in coverage and access. In several contexts, such as **Burundi, DRC, CAR and Mali**, MSF has observed that the proportion of pregnant women receiving the recommended three or more doses of IPTp falls far below national and global targets, leaving many unprotected. Similarly, IPT for infants and school-aged children - both of which have demonstrated effectiveness in reducing malaria incidence - are either absent from national strategies or not scaled up to reach those who would benefit most. The failure to implement these preventive measures not only leads to higher disease burden but also contributes to increased pressure on already overstretched health facilities.



©Paula Casado Aguirregabiria/MSF/South Sudan

54 https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2023#

55 II Rapport narratif, Copyright © 2013-2025 ONUSIDA, Tous droits réservés

56 https://www.msf.org/tactic-test-avoid-cure-tb-children

57 MSF (2024). TACTiC: Test, avoid, cure TB in children - a survey of paediatric TB policies. https://www.msf.org/tactic-test-avoid-cure-tb-children

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D. MISSED AND LATE: GAPS IN CARE FOR SEVERE DIAGNOSES, PREVENTION AND TREATMENTS

The persistent neglect of advanced HIV disease (AHD) remains a critical gap in the HIV response, with HIV-related deaths stagnating at 630,000 per year for several years.[58] **A significant proportion of people living with HIV are diagnosed at late stages**, many due to (late) disengagement from care after treatment initiation, when their immune systems are already severely compromised. Without appropriate detection and management, they are at high risk of rapidly dying from opportunistic infections such as tuberculosis, cryptococcal meningitis, and severe bacterial infections.

Despite the existence of WHO-recommended AHD packages - including screening tools like CD4, TB LAM and CrAg, and essential prevention and treatment medicines like fluconazole and cotrimoxazole - implementation remains weak. Services are often fragmented, rarely decentralised to the primary health care (PHC) level, and constrained by chronic stockouts and underfunded supply chains. In many settings, rapid diagnostic tools that can be used at primary health care level are available but not deployed at scale, due to policy and operational inertia. Late detection leads to worsened outcomes and premature death.

Underinvestment is a key barrier: in Guinea, just US$150,000 was allocated to AHD services in the Global Fund grant 2024-2026, and in DRC, only five hospitals offer comprehensive AHD care, another 10 have been put on the UQD list that has no assurance to be fund - an effort vastly inadequate for the scale of need. 2024 MSF data from South Sudan reveals alarmingly high rates of advanced disease: in **Abyei, South Sudan, 2023/2024, 47% patients had advanced HIV among those tested** (47 out of 101). In addition Ulang, **54% presented with WHO stage 3 or 4 illness.** These figures correlate with high HIV & TB related mortality rates experiences in our projects – for instant at another MSF's inpatient facility in Malakal in the same state of Upper Nile, total deaths attributed to HIV/TB coinfection was around **16%**. Though the program observed some remarkable programmatic progress in addressing the retention rate after decentralisation of HIV care to the rural PHCCs, for instant in **Ulang, MSF recorded the retention rate of 77% (at 12 months) in 2024 compared to just 39% retention rate (at 12 months) in 2022.** In Conakry, Guinea, where MSF is supporting eight PHC facilities, the screening of AHD is done systematically for people tested HIV positive. **In 2024, among the 2210 people tested positive, 2033 (92%) had a CD4 test; 38% (768) had a CD4 <200.**

One of the root causes of these outcomes is the lack of decentralised HIV services and in particular HIV diagnostics and detection tools of alarm signs and complications. Most AHD care is concentrated in urban referral centres, while PHC centres often lack screening, diagnosis, and treatment capacity. In Guinea, MSF's rapid mixed study done at the Donka AHD unit, December 2024 and January 2025 has shown how people navigate long, complex pathways before reaching a facility, often arriving extremely sick.[59] It included a retrospective quantitative analysis of patient dossiers and a semi-structured interviews with Health staff and focus interview with patients and accompanying people.

58 https://www.unaids.org/en/resources/fact-sheet

59 https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0281425&type=printable

In 2024, **997** people were admitted in **Donka** from which **44%** came from MSF supported cohort and **56%** from other health facilities. **65%** of the patients transited by one or several health facilities before reaching Donka.

Patients admitted at an advanced stage are highly vulnerable. Referrals to medical centres not equipped for AHD without prompt referral to the Donka USFR prolong diagnostic and treatment times and compromise the survival of patients with advanced stages.

Lack of information and stigma hinder adherence: **16%** (11 out of 69) of PLHIV surveyed said they had no knowledge of HIV before their testing.

"I didn't have any information; I received it here in Matam."

61% (42 out of 69) of PLHIV surveyed said they first seek treatment from a healer. If the results are not satisfactory, they go to a health facility.

"Back home, the hospital is very far away and there's no money. The healer is very skilled; he treats many illnesses free of charge."

72% (50 out of 69) of PLHIV surveyed said they have experienced stigma and discrimination in their community.

"When I cook, no one eats because I have HIV."

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In **South Sudan**, weak referral systems and geographic barriers contribute to massive loss to follow-up (LTFU): over the last few years, MSF recorded just **39%** retention at **12 months** among ART patients in Ulang, and **50%** in Malakal.

Closing the AHD gap requires urgent investment in decentralised screening and treatment at the PHC level, stronger referral systems for complex cases, and consistent supply of essential diagnostics and medicines. Without these, avoidable deaths will continue to undermine global efforts to reduce HIV mortality.

Despite major scientific advances in the treatment of drug-resistant TB (DR-TB), including the roll-out of shorter, all-oral regimens (such as the six-month BPaLM (Bedaquiline, Pretomanid, Linezolid and Moxifloxacin) and nine-month MDR-TB regimens), access remains highly uneven across countries. At the end of 2023, only **58** countries had introduced the six-month BPaLM/BPaL (Bedaquiline, Pretomanid and Linezolid) regimen, and just **100** were using the nine-month all-oral approach.[60] For people in fragile, conflict-affected, or decentralised settings, these newer regimens remain largely inaccessible due to supply shortages, weak procurement systems, and limited training of health personnel.

Severe malaria remains a leading cause of death in children under five in high-burden countries, with **40,000** estimated malaria deaths in DRC alone in 2023. Despite global efforts to scale up vector control and chemoprevention, many people still present to health facilities in critical condition, often due to late diagnosis, weak referral systems, and lack of access to early treatment at the community level.

In MSF projects across South Sudan, DRC, and Burundi, teams have recorded alarming spikes in severe malaria cases and associated mortality. **In Aweil, South Sudan, MSF documented a 300% increase in malaria-related deaths** (all ages) between August and September 2024 compared to the same period the previous year. Contributing factors included stockouts of basic malaria commodities in primary care facilities, delays in seeking care due to distance, flooding, cost or insecurity, and gaps in seasonal malaria chemoprevention (SMC) program where some highly populated health zones as well as 'last mile' areas are not yet targeted by this preventive activity.

Facilities treating severe malaria cases frequently face shortages of essential supplies such as artesunate, blood transfusion kits and oxygen. In many rural districts, blood transfusion capacity is non-existent or unsafe due to a lack of screening reagents and consumables. MSF has often had to intervene by reinforcing blood banks, providing logistics support for stock transport, and covering referral costs for critically ill patients.

60 https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2023#

©Giuseppe La Rosa/MSF/Massakori

2. 2. KEY EFFECTIVE APPROACHES UNDERMINED BY FUNDING SHORTFALLS

A. POOR DECENTRALISATION AND INSUFFICIENT ACCESS TO QUALITY CARE FOR HIV, TB AND MALARIA

Alongside recurring stockouts of essential medicines and diagnostics, access to care for HIV, TB and malaria continues to be critically undermined by the poor quality and centralisation of diagnostic and treatment services. In many contexts where MSF works, care remains heavily concentrated in urban hospitals or referral centres, requiring people—especially those in rural, conflict-affected, or underserved areas—to travel long distances across insecure or impassable terrain. These journeys delay diagnosis and treatment, increase LTFU, and result in preventable deaths.

Decentralisation of services remains weak, despite years of policy commitments and technical guidance. For TB, this failure is particularly stark. In **Mozambique's Cabo Delgado** province, for example, sputum samples from the MSF project in Macomia district have to travel more than **100 km** for analysis in Pemba due to the absence of functioning laboratories nearby. The same is happening in **Mocimba Do Praia district** where sputum samples are sent to Palma. Both locations being situated in a conflict zone, road movement are sometimes blocked due to insecurity, delaying even more the capacity to test.

Another specific issue is related to the treatment initiation that remains restricted to district hospitals. As a result, people are routinely lost between testing and treatment initiation. While global policy and procurement advances—such as shorter, all-oral regimens for multidrug-resistant TB (BPaLM/BPaL)—offer hope, they remain out of reach for many due to the persistent lack of decentralised treatment capacity, weak provider awareness, and irregular drug supply.

For HIV, decentralisation and differentiated models of care have proven highly effective in improving patient retention and health outcomes. Approaches like **community ART groups, fast-track refills, and multi-month dispensing** significantly reduce patient burden and facility congestion. Yet, despite national policy endorsement of six-months dispensing in countries like Guinea, uptake remains low. In practice, many people must still return to health centres every month for ART refills, often queuing for hours, missing work or school, and risking disengagement from care. These models remain inconsistently implemented due to inadequate investment, limited health worker training, and a failure to incorporate them into national service delivery frameworks.

For malaria poor translation of national treatment guidelines into clinical practice exacerbates the challenges. Community health workers (CHWs), in **Burundi** who should be at the frontline of decentralised health delivery, are too often unsupported - lacking the tools, training, remuneration, and supervision necessary to fulfil their roles effectively. This failure to operationalise quality at the point of care leaves large segments of the population without timely or appropriate treatment.

B. SIDELINED AND UNDERFUNDED: THE CRITICAL ROLE OF CIVIL SOCIETY AND COMMUNITY-BASED ORGANISATIONS

Civil society organisations (CSOs) and community-based organisations (CBOs) are at the heart of effective health responses. They are deeply embedded in the communities they serve, but they also have the flexibility, trust and local knowledge to deliver services in areas that governments and large institutions often struggle to reach. In many countries, particularly those with fragile health systems, they play an indispensable role in ensuring that people affected by HIV, TB and malaria receive timely, life-saving care. CBOs, grassroots groups, informal associations, and peer-led networks form the backbone of HIV, TB and malaria service delivery for many of the most marginalised communities.

These organisations, whether officially registered or not, often work with extraordinary dedication and impact, particularly in areas where the public health system is absent, distrusted or inaccessible. Many operate without formal recognition or sufficient funding, despite being deeply embedded in local communities and able to reach people most affected by stigma, discrimination and exclusion.

Beyond direct service delivery, these organisations also play a vital role in monitoring, particularly in tracking the availability of commodities, user fees and discrimination. Through community-led monitoring, CSOs and CBOs provide real-time data on supply chain gaps, barriers to access, and service disruptions; insights that are often missing from official reports.

CBOs play a critical role in providing stigma-free, peer-led services for key populations. Peer counsellors, drawn from these same communities, are an essential cadre in this response, supporting testing, prevention, behaviour change communication, linkage to care, adherence support, community-led monitoring, and mental health care. Their trust and proximity to the populations they serve make them indispensable, particularly in contexts where legal or social barriers prevent people from seeking services in public facilities.

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> ***"The work of CBOs is so important. They have the trust of their communities; they are strong advocates and they reach people that would likely be excluded from care in the regular health system. I'm really concerned, particularly for those working with key populations, that they are no longer going to be able to operate, as it might be harder for them to get funding as we see increasing anti-LGBTQI+ agendas at play."***
>
> *Alexandre Ventura MSF Head of Mission, México and Central America/América Central*

In **Honduras, in San Pedro Sula**, there are various civil society organisations that the Global Fund is supporting, which provide crucial testing and engagement with key populations. The CSO leaders are crucial to highlighting the key challenges, as observed by the MSF clinic (working with sex workers and/or the LGBTQI+ population.) The MSF project in San Pedro Sula, opened in 2022 has seen an increase in new patients each year, providing tests, care and treatment for HIV. (The project provided **1,144** consultants in 2022, **1,838** consultations in 2023 and **2,235** consultations in 2024). The MSF team works with key civil society leaders who report that sometimes assumptions are made linking key populations to HIV and a lack of confidentiality and discrimination in health facilities is a significant barrier in contrast to the availability of facilities.

Yet this crucial workforce is heavily reliant on external donor support, particularly from the Global Fund and PEPFAR. The increasing emphasis from the Global Fund and other donors on domestic resource mobilisation risks further deprioritising community-led initiatives, as government budgets rarely allocate sufficient funds for grassroots organisations.

In **North Macedonia**, the CBOs that MSF work with continue to play a vital role in sustaining HIV prevention efforts amid ongoing budgetary constraints. CBOs are responsible for delivering the majority of HIV prevention services, yet for the first quarter of 2025, only two organisations were able to maintain operations, with others suspended until public procurement processes are finalised. As HIV funding is expected to shift further toward domestic responsibility, the ability of CBOs to remain active will be critical in preventing service collapse.

The Global Fund and other donors must ensure that funding mechanisms remain accessible to these organisations and that their role in delivering services, advocating for people and holding health systems accountable is fully recognised and supported.

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C. INSUFFICIENT INVESTMENT IN HUMAN RESOURCES FOR HEALTH (HRH)

A critical shortage of health workers, compounded by chronic salary delays and lack of training and supervision, is crippling healthcare delivery in many contexts. This has been further exacerbated by the recent US funding cuts, impacting on healthcare staff for all three diseases supported by the Global Fund.[61] In **South Sudan**, it is a common occurrence for the last few years that public sector health workers have gone four to five months without pay, a crisis that forces many to abandon their posts or turn to informal cost-recovery mechanisms to survive. People who should receive free treatment instead face out-of-pocket fees for consultations, medicines, and diagnostic tests.

Perverse financing structures can distort care delivery. In **Burundi**, for instance, performance-based financing (PBF) mechanisms have unintentionally incentivised the use of thick blood smears over rapid diagnostic tests (RDTs) for malaria, due to the way in which indicators are measured and rewarded. These preferences may appear minor, but they create financial barriers, inefficiencies, delay treatment and undermine the use of more appropriate and timely diagnostics in peripheral facilities. Moreover, PBF has introduced competition between health centres and CHWs, particularly over indicator-linked resources. This often leads to stockouts at the community level, where CHWs are unable to provide services and must refer people to higher-level facilities, defeating the core purpose of decentralised care.

The HRH crises disproportionately affect certain contexts more than others. CAR is among the five countries facing a critical shortage of Health workforce, with a density at less than **0.5 per 1000 population** (while WHO recommendation to provide adequate coverage with primary health care is 2,5). Density of physician is **0,07 per 1000 population**, nurses and midwives **0,26 per 1000 population** and community health workers **0,02**.[62] The health workforce is not evenly distributed in all regions and districts. Bangui has proportionally more health workers than the wider health care structure.

Domestic budget shortfalls limit governments' ability to recruit and retain sufficient health workers, and international donors remain reluctant to fund recurrent costs, such as salaries and living conditions for frontline health workers. In **Guinea**, about half of the staff in health facilities are not on the government payroll, forcing them to rely on informal user fees to sustain themselves. During a supervision mission leaded by CNLS and including all partners involved in HIV conducted in Boké in November 2024, it was noted that of the **18** health centres visited, only three had a permanent PMTCT officer, the others being occupied by interns. Some have held these positions precariously for more than 15 years, such as at the CSU of Boffa or the CS of Kassapo and the CS of Sareboido, where an intern has been working for 20 years. This situation results in paid services that can be a barrier for pregnant women to attend an ANC, or even to attend follow-up appointments. The absence of a robust HRH strategy and sustained investment undermines the health system's ability to provide consistent, equitable care, and severely limits access to essential services for the population.

61 TB: https://www.who.int/news/item/05-03-2025-funding-cuts-to-tuberculosis-programmes-endanger-millions-of-lives
Tuberculosis Resurgent as Trump Funding Cut Disrupts Treatment Globally - The New York Times
Malaria: https://apnews.com/article/usaid-cuts-africa-malaria-health-trump-22252b138d6eeaa143cc892731aec227
HIV: https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250307_South-Africa_fs

62 [1] 9789290234555-eng.pdf

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THE IMPORTANCE OF COMMUNITY HEALTH WORKERS FOR HEALTH SERVICE DELIVERY

Community health workers (CHWs), and by extension CSO and CBO activities, are an essential part of the healthcare system, playing a critical role in expanding service coverage, particularly in hard-to-reach areas. They are often the first point of contact for healthcare, providing preventive care, treatment and public health information. A stronger commitment to effective support for CHWs, through a structured approach that ensures community representation and participation, proper training and adequate compensation, is essential. While CHWs cannot replace trained medical professionals, task shifting has proven to be an effective strategy for improving access to healthcare, yet reluctance to embrace it continues to hinder progress.

Despite their crucial role, CHWs are often treated as cheap or unpaid labour, making retention and service quality unfeasible. When budgets tighten, community health services are among the first to be deprioritised, despite their importance in delivering care to underserved populations. Supply-chain failures hit CHWs particularly hard; when medicines and medical supplies are in short supply, community-based services are often the first to be cut off, forcing people to travel long distances to overstretched health facilities where they may face even greater financial barriers. Underpaid CHWs may be left with no choice but to sell medical supplies that should be free of charge, further hampering access to essential healthcare.

CHWs, who are crucial in bridging access gaps, frequently lack the resources, training, and support needed to carry out these interventions effectively. In many cases, essential medicines and diagnostic tools fail to reach them due to supply-chain bottlenecks, leaving people with no option but to seek care at distant facilities.

D. INSUFFICIENT ACCESS TO PREVENTIVE TOOLS


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Access to preventive products remains a major challenge across multiple disease areas, limiting the ability to reduce new infections and break transmission chains for HIV, TB and malaria. Despite the availability of effective prevention tools, gaps in awareness, supply, affordability and health system implementation exclude many at-risk populations from benefiting from these interventions. These challenges highlight the critical role of the Global Fund in shaping markets and ensuring that life-saving preventive commodities are accessible and affordable, especially in low-income and crisis settings.

With prevention failing, the transmission and incidence of the three diseases will rise and put further pressure on health services, with the real risk of overwhelming health systems due to the increased need for treatment and care.

PREP AND PEP

In the case of HIV prevention, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) remain underutilised due to a combination of policy, supply chain and awareness barriers. In **Honduras**, PrEP was only recently introduced, with the national policy launched at the end of 2022. However, implementation challenges persist, including gaps in healthcare worker training, inconsistent stock availability and limited public awareness. MSF provides PrEP for LGBTQI+ individuals and sex workers, yet access beyond MSF facilities remains limited, and mainly dependent on international funding. Similarly, PEP remains difficult to access for victims of sexual violence due to insufficient funding and unclear protocols in hospitals and health centres.

A similar situation can be found in **Malawi**, where MSF is working alongside community-based organisations led by and for sex workers to provide sexual and reproductive health services, including HIV prevention, mental health support, and peer-led capacity building. Sex workers in Malawi face disproportionately high risks of HIV infection, with prevalence among this group reaching nearly **60%**.[63] This is over **13 times higher** than the general population, reflecting the systemic barriers and vulnerabilities they face. One of the major challenges in HIV prevention among sex workers is the low acceptance of oral PrEP, largely due to stigma and concerns about daily pill burden. Many fear being mistakenly identified as HIV-positive simply for taking PrEP, which discourages uptake. For sex workers, many of whom are unable to negotiate condom use with clients, the need for discreet, long-acting prevention methods is critical. In response, MSF has committed to providing injectable PrEP (Cabotegravir) in two towns this year, offering an alternative that reduces the need for daily adherence and helps overcome stigma-related barriers. However, national scale-up efforts have stalled due to reduced US funding, leaving many sex workers without access to this essential prevention tool. Without equitable access to injectable PrEP, those at highest risk remain dangerously exposed to HIV infection.

63 https://www.unaids.org/en/20190402_country_focus_Malawi#:~:text=Sex%20workers%2C%20with%20an%20HIV,an%20HIV%20prevalence%20of%2017.3%25

MALARIA PREVENTION

Preventive interventions for malaria, particularly **insecticide treated bed nets (ITN) and chemoprevention**, are critical pillars of malaria control, yet their implementation remains inconsistent across many endemic countries (South Sudan, DRC, Mali are all examples provided throughout this report). Perennial malaria chemoprevention (PMC), which involves giving a single dose of sulfadoxine-pyrimethamine (SP) to infants in high-burden areas, has been part of WHO guidance since 2014. Yet few countries have adopted it. **58%** of pregnant women are still not benefiting from this protective intervention even though it is low-cost and highly effective.[64] Similarly, intermittent preventive treatment during pregnancy (IPTp) remains poorly scaled in many regions, leaving pregnant women without protection during one of the most vulnerable periods. For example, in DRC which experiences perennial malaria transmission, preventive tools are chronically underfunded and deprioritised. Unlike countries with seasonal malaria peaks, the constant burden in DRC fails to trigger emergency responses. As a result, there is minimal investment in SMC, PMC or IPTp, even though these interventions could significantly reduce repeated infections, severe anaemia in children, complications in pregnancy, and preventable deaths. A recent outbreak of a 'mysterious' disease with high fatality in Equateur province proved to be malaria, left untreated, illustrating the high death toll of what should be a preventable and easily treatable illness[65].

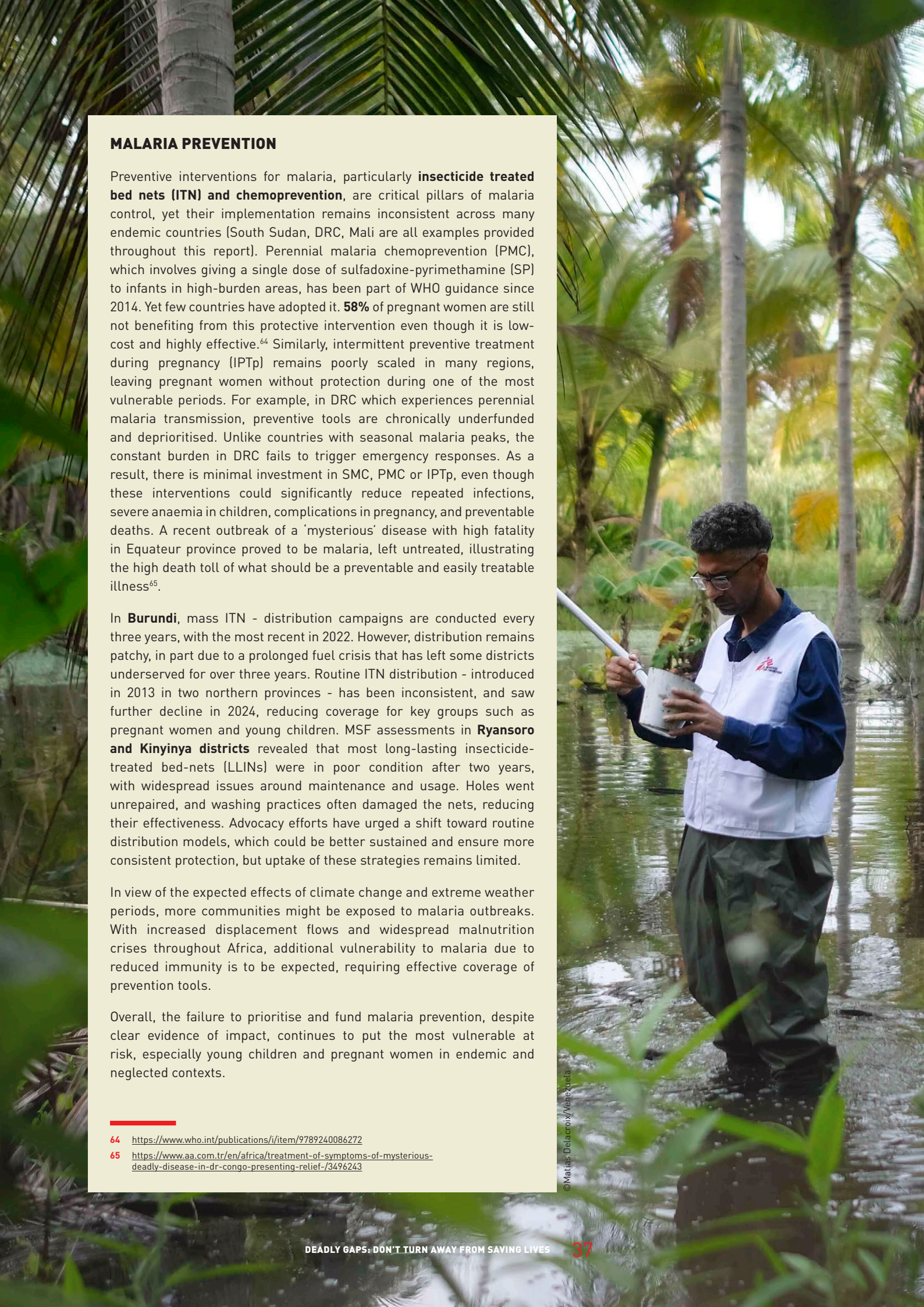
In **Burundi**, mass ITN - distribution campaigns are conducted every three years, with the most recent in 2022. However, distribution remains patchy, in part due to a prolonged fuel crisis that has left some districts underserved for over three years. Routine ITN distribution - introduced in 2013 in two northern provinces - has been inconsistent, and saw further decline in 2024, reducing coverage for key groups such as pregnant women and young children. MSF assessments in **Ryansoro and Kinyinya districts** revealed that most long-lasting insecticide-treated bed-nets (LLINs) were in poor condition after two years, with widespread issues around maintenance and usage. Holes went unrepaired, and washing practices often damaged the nets, reducing their effectiveness. Advocacy efforts have urged a shift toward routine distribution models, which could be better sustained and ensure more consistent protection, but uptake of these strategies remains limited.

In view of the expected effects of climate change and extreme weather periods, more communities might be exposed to malaria outbreaks. With increased displacement flows and widespread malnutrition crises throughout Africa, additional vulnerability to malaria due to reduced immunity is to be expected, requiring effective coverage of prevention tools.

Overall, the failure to prioritise and fund malaria prevention, despite clear evidence of impact, continues to put the most vulnerable at risk, especially young children and pregnant women in endemic and neglected contexts.

64 https://www.who.int/publications/i/item/9789240086272

65 https://www.aa.com.tr/en/africa/treatment-of-symptoms-of-mysterious-deadly-disease-in-dr-congo-presenting-relief-/3496243



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2.3. ESSENTIAL MEDICAL SUPPLIES MISSING

The effectiveness of the HIV, TB and malaria response is inherently tied to the strength of the health system in which it operates. Weaknesses in any health system are exacerbated in humanitarian contexts, where systems are often fragile or collapsing; major gaps persist, severely limiting the population's access to healthcare. It is crucial that these complexities of these contexts are recognised to prevent further risks to the effectiveness of the HIV, TB and malaria response.

A. REPEATED STOCKOUTS, SUPPLY CHAIN DISRUPTIONS AND COMMODITIES NOT REACHING THE LAST MILE

Supply chain breakdowns and recurring stockouts have a direct and distressing impact on people, undermining the reliability of health services and pushing care further out of reach for those who need it most. When essential medicines or diagnostic tools are missing, people are often forced to return to health centres multiple times - frequently travelling long distances at great personal cost. These repeated disruptions not only delay treatment and increase the risk of severe illness or death, but they also erode trust in the health system and discourage people from seeking care altogether.

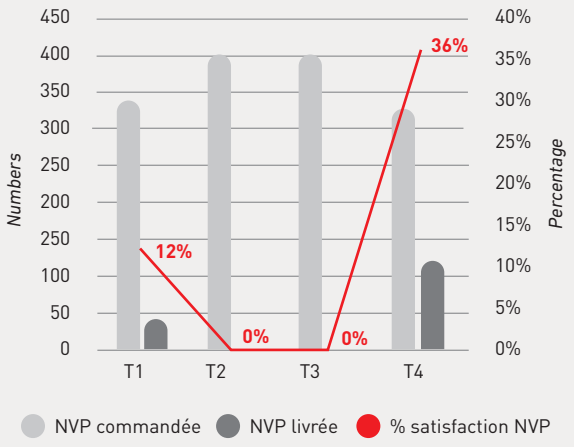
Supply-chain breakdowns compound low availability of essential supplies. Despite the arrival of life-saving medicines and diagnostic tools in-country, MSF teams repeatedly encounter situations where these commodities fail to reach the facilities and communities that need them. This reflects systemic weaknesses in last-mile delivery, decentralisation and supply-chain accountability. Health centres frequently run out of key medicines, diagnostics and preventive tools due to poor quantification of needs, fragmented procurement processes, bureaucratic bottlenecks and weak transportation infrastructure. Products often arrive in lower quantities than needed, or even out of date. Health facilities are passively supplied based on preset allocations rather than actual consumption - not considering seasonal changes in consumption or the emergence of outbreaks. The lack of buffer stocks exacerbates these problems. Often the system has no response to stocks running low and fails to avoid anticipated stock-outs. In under-resourced health systems with limited data capacity, this lack of flexibility consistently fails to respond to real needs.

©SMarco Doneda/MSF/ Democratic Republic of Congo

The consequences of these gaps are stark. Between August and September 2024, **MSF's hospital in Aweil, South Sudan recorded a 190% increase in malaria admissions and a 300% increase in malaria-related deaths compared to the same period in 2023.** Paediatric blood transfusions tripled. Investigations by MSF teams in surrounding health centres revealed widespread stockouts of malaria rapid diagnostic tests (RDTs)and antimalarials. Deprived of early diagnosis or treatment, people arrived in critical condition. In discussions with the Global Fund, it was revealed that essential malaria commodities were sitting in the capital, **Juba**, but had not been distributed to peripheral health facilities - a failure that MSF has documented repeatedly across multiple countries.

In 2024, the MSF teams in **Conakry** noted recurrent rupture of Nevirapine syrup, rapid screening tests, rifampicin–isoniazid–pyrazinamide–ethambutol (RHZE) and rifampicin and isoniazid (RH) for adults and rifampicin, isoniazid and pyrazinamide (RHZ) for children. The overall satisfaction rate for ARV's order at the Central Pharmacy of Guinea was **62,75%**. The paediatric items are the ones the most in stockout, as shown by the graphic below related to the prophylaxis for exposed newborns:

Satisfaction rates of NVP sirup orders in the eight MSF supported facilities, 2024

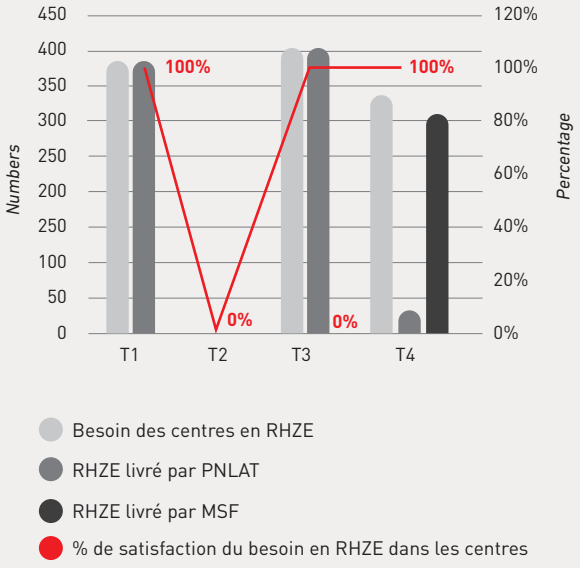


It's really heartbreaking to see a transmission from a mother to her child couldn't be avoided by lack of tests for the mother and her child or the lack of drugs for the newborn, when you know that the commodities that could avoid this transmission are unavailable due to late shipping of commodities, lack of good monitoring of supplies and under evaluation of needs. It is unacceptable to think that due to this situation a child will have to grow with HIV in a Congolese context where the access and the availability of those commodities are still a huge challenge. If nothing changes, this child and its parents will have to grow with this additional fear of tomorrow.

Lara de Jacquier, MSF Project Coordinator, and Isabela Salim MSF Advocacy Manager, both in DRC.

For TB as well, the low satisfaction rate of orders pushed MSF to cover the gaps:

Gap coverage for RHZE in the Health facilities supported by MSF in 2024



In **Guinea**, inefficient procurement strategies compound the problem. Instead of using Wambo.org, the Global Fund's pooled procurement platform which offers negotiated lower prices, the government procures their share of medical supplies for the three diseases from local distributors at sometimes higher prices. This reduces the quantity of medicines that can be purchased and delay its delivery, as the acquisition procedures are very heavy and involve different Ministries, increasing the frequency and severity of stockouts, and directly impacts access to care for people in need.

Peripheral, rural, and conflict-affected areas suffer the most. MSF has often had to step in to ensure last-mile delivery by covering emergency transport costs in contexts where national systems have broken down, such as in **Upper Nile (South Sudan), Maniema (DRC), and Cabo Delgado (Mozambique)**. Even where diagnostic tools are technically available, care often falters in implementation. In Mozambique, growing resistance to dolutegravir is a looming threat, with recent studies showing resistance rates as high as **89.5%** in **Maputo** and **34.7%** in **Beira**. Yet the country lacks robust resistance surveillance systems, particularly at decentralised levels, undermining its ability to detect and respond to treatment failure in real time. Similarly, in MSF-supported sites across conflict-affected regions, including **Macomia**, **Palma**, and **Mocimboa da Praia**, there are recurrent stockouts of critical commodities—from paediatric ART and second-line TB drugs to TB-LAM and CrAg tests for AHD. Weak quantification, supply chain fragmentation and delays in last-mile delivery continue to create chronic gaps in care.

Essential antimicrobials needed to treat TB, and bacterial co-infections are also facing shortages in various contexts, subsequently impacting patients living with HIV and TB. The Global Fund plays a critical role in improving the reliability and quality of antibiotic supply for opportunistic infections[66], as demonstrated by the provision of metronidazole in **DRC**.[67] Increasing resistance rates and stockouts among antimicrobials for opportunistic infections necessitate expanding the portfolio of antimicrobials covered by the GF in its pooled procurement and supply management activities.

66 https://globalfundadvocatesnetwork.org/resource/technical-and-advocacy-brief-on-amr-and-hiv-tb-and-malaria/

67 https://www.theglobalfund.org/media/2663/oig_gf-oig-16-022_report_en.pdf


©Paula Casado Aguirregabiria/MSF/South Sudan

2.4. PRICES OF MEDICAL TOOLS TOO EXPENSIVE AND UNAFFORDABLE: AMBITIOUS APPROACH TO MARKET SHAPING VITAL – INCLUDING NEW PRODUCTS

The Global Fund has played a pivotal role in market shaping, helping to drive down costs and increase access to life-saving medicines, diagnostics, and preventive tools. By leveraging pooled procurement and volume-based price negotiations, it has helped to make essential health commodities more affordable and accessible, particularly in low-income countries where fragmented supply chains, small population size and high drug prices have historically been major barriers.

There is an opportunity for the Global Fund to build on these successes and address the urgent gaps in access to critical commodities that remain prohibitively expensive or entirely out of reach for many ministries of health. In too many cases, cost remains a decisive factor in determining whether life-saving treatments and prevention tools are included in national guidelines or made available at scale.

Second-line malaria treatments, such as dihydroartemisinin-piperaquine (DHA-PQ), remain unaffordable in many countries and have yet to be incorporated into national treatment protocols despite their critical role in managing drug-resistant strains. The same applies to **new HIV prevention technologies**. Long-acting injectable PrEP could dramatically improve adherence and uptake, particularly among key populations who struggle with daily pill regimens, yet its high price keeps it out of reach for most health systems. Ministries of health cannot simply absorb these costs, and without active Global Fund intervention, access will remain limited to the wealthiest countries and donor-funded pilot programmes. Scale up of highly effective tools will thus remain out of reach for most and those most in need of it.

It is crucial in the current context of reduced funding that **The Global Fund embraces the opportunity and is ambitious and systematic in its approach to price negotiation to ensure that cost does not remain a barrier to equitable access.** This includes negotiating lower prices for second-line malaria treatments, pushing for the rapid introduction of new HIV prevention tools into national programmes, and actively working to prevent the monopolisation of essential health commodities by a handful of pharmaceutical companies. Without stronger market-shaping interventions, the Global Fund is missing a clear opportunity to decrease inequities and to secure better value for money in giving access to essential tools to a broader group of people in need.

THE GLOBAL FUND'S ROLE IN ENSURING FAIR AND TRANSPARENT PRICES OF GENEXPERT CARTRIDGES AND IN BOOSTING COMPETITION

GeneXpert diagnostic tests, produced by Cepheid, a subsidiary of US conglomerate Danaher, play a crucial role in diagnosing tuberculosis (TB), HIV, hepatitis, sexually transmitted infections (STIs), Ebola, and other diseases in low- and middle-income countries (LMICs). Yet the prohibitively high cost of these tests has severely restricted access, leaving millions without timely diagnosis and treatment.

In 2019, MSF research estimated that each GeneXpert test could be sold at a sustainable profit for just US$5, given the high sales volumes achieved by Cepheid and Danaher. However, **despite receiving $252 million in public funding to develop the technology, Cepheid continued to charge $10 per TB test (until September 2023)**, and between $15 and $20 for tests used to diagnose drug-resistant TB, HIV, hepatitis, and other diseases - markups of 200% to 400% above estimated production costs.

The Global Fund, as one of the largest financers of procurement of GeneXpert cartridges, has a critical role in shaping the market for diagnostics by using its purchasing power to leverage price concessions with Cepheid, or by working with partners to take the legal and regulatory steps needed to secure new manufacturers. In response to sustained advocacy from the 'Time for $5' coalition and TB activists, Danaher announced in September 2023 that it would lower the price of the TB test from $10 to $8. According to the Global Fund, this price reduction is expected to generate $32 million in annual savings - enough to procure an additional 3.6 million TB tests per year.

However, this price reduction remains incomplete, as the cost of other critical diagnostic tests remains excessively high. The Global Fund has the leverage to push for further reductions. It must use its purchasing power to demand fair pricing across all GeneXpert tests, ensuring that essential diagnostics are affordable and accessible. Danaher also committed in 2023 to an independent third-party audit of its production costs, yet a year later, it has provided no transparency on the audit process or whether the findings will be made public.

Equally, the Global Fund must play an important role in introducing competition to a monopolistic supply system, encouraging procurement of new and innovative competitor products, which will eventually enable a sustainable, fair price in the global market.

The Global Fund's market-shaping role must go beyond incremental price cuts—sustained pressure is needed to drive costs down while encouraging manufacturers to provide fair and transparent pricing.[68]

68 MSF (2019). Time for $5: GeneXpert Diagnostic Tests. https://msfaccess.org/time-for-5-brief

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3. CONCLUSION

This report highlights the growing disconnect between global health ambitions and the realities on the ground in many countries affected by HIV, TB and malaria. Despite notable gains in recent decades, progress is stalling or reversing in numerous contexts, driven by inconsistent funding, shifting donor commitments, widening emergencies and continued weaknesses within health systems.

Essential interventions, including for key populations, people with advanced HIV disease, children and those living in conflict settings, remain under-supported. Community-based and civil society organisations continue to operate at the margins of funding structures, despite their critical role in reaching populations excluded from formal systems. The growing imposition of out-of-pocket payments, stockouts of key commodities, and limited decentralisation of diagnostic and treatment services further constrain access to care, particularly for people in remote or insecure areas.

The current international funding cuts cast a long dark shadow on the ability to contain and suppress the three major pandemics of HIV, TB and malaria. Already today, important funding gaps undermine life-saving interventions. Without the necessary financial commitments, these gaps will deepen and widen further, with increased mortality, ill health and epidemic spread as consequence.

MSF teams see in their daily work the consequences for people and populations. This report highlights the gaps in essential services and interventions that funding shortfalls create in many countries and communities, including the poorest and most vulnerable.

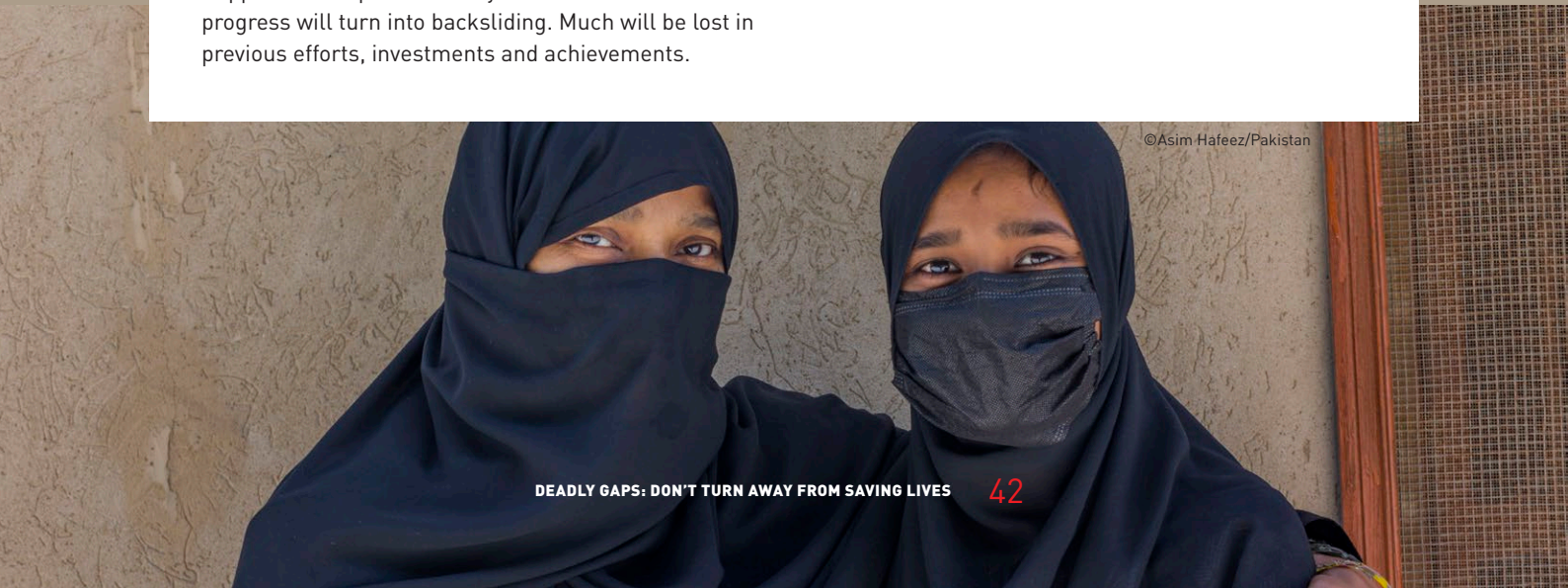
Urgent mitigation measures are needed. Without these, we will see an increase in mortality, morbidity, medical complications, new infections and outbreaks, bringing the response to HIV, TB and malaria further off-track. Health systems will once again be overwhelmed by severely ill patients, and communities crippled and impoverished by ill health and death. Past progress will turn into backsliding. Much will be lost in previous efforts, investments and achievements.

The Global Fund remains one of the few mechanisms capable of supporting large-scale, inclusive responses to these three diseases. Its full replenishment is critical to protect and preserve past achievements and avoid slide-back in the world's response.

There are few alternatives, whatever the popular narratives imply. The existing funding gaps, combined with unrealistic expectations around domestic resource mobilisation will undermine effective responses. Limitations in grant flexibility — especially in fragile or rapidly evolving contexts — risk undermining the potential impact of GF grants.

The catastrophic reversal of the extraordinary progress of the last 20 years is a real threat. If there is a reduction in the highly effective strategies (and often game changes) that the Global Fund has consolidated and expanded over the last 20 years, there will be a regression to HIV, TB and malaria pandemics. Insufficient funding threatens the key foundations that are in place to address the pandemics of these three diseases. These key foundations, outlined in this report, and identified in MSF projects are reliant on the Global Fund's vital support. To name a few these include community-led approaches and differentiated delivery strategies, CSO involvement in planning, implementation and monitoring, focus on vulnerable people and communities, protection of patient and human rights, adoption of innovative tools and strategies, flexibility of allocation and risk mechanisms in COE and swift reactions to outbreaks and other crises that are on the rise.

The coming replenishment offers a unique chance to preserve the response to HIV, TB, and malaria at a time of growing global uncertainty. Optimal use of available resources should ensure that people and communities most in need are reached in priority. A focus on existing supply and service gaps combined with prioritising the most effective strategies will be essential in order to avoid further erosion of progress and to support equitable access to care.



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KEY RECOMMENDATIONS

Our recommendations in full to mitigate and avoid further deadly gaps in essential interventions to contain the human costs of HIV, TB and malaria are as follows:

1. Full replenishment of the Global Fund

The investment case proposed for the 8th replenishment, by the Global Funds own admission is requesting less than the minimum to meet all needs in addressing HIV, TB and malaria.

The reliance on Domestic Resource Mobilization is significantly overestimated, leading to unrealistic expectations and potentially larger funding gaps. Many lower and middle-income countries (LMICs) face economic constraints, weak tax bases, high debt burdens, and limited fiscal space, which hinder their ability to mobilize domestic resources for health adequately. Concurrently, cuts in bilateral donor funding amplify the pressure on domestic resources, further jeopardizing the sustainability of healthcare systems.

Fragile and conflict-affected settings face the greatest risks, as their health systems rely heavily on external support, and donor withdrawal could lead to the collapse of essential services. Rapid transitions to self-financing in such contexts may result in severe consequences, including service disruptions, rising mortality rates, and increased financial barriers for patients. Innovative financing solutions, while promising, remain unproven and insufficient to offset international funding cuts.

Maintaining external financing remains the core pillar of the response against HIV, TB and malaria. DRM ambitions must be balanced with the urgent need to prevent treatment interruptions and health inequities, with an emphasis on protecting vulnerable populations. Financial sustainability strategies should be cautious, flexible, and developed in collaboration with civil society and patient organisations to ensure equitable and effective health outcomes. Prioritising immediate, tangible health interventions over long-term theoretical aspirations is critical to minimizing the devastating consequences of funding gaps.

Additional pressure on the Global Fund must be prevented to ensure that the financial burden for essential care on countries unable to increase public health budgets is not increased and certainly costs must not be shifted to people through OoP payments or user fees.

2. Priority for funding: start with reality, the existing gaps impacting on people now

Analysing the key gaps and unmet needs in current Global Fund grants should start with a review of the updated UQD and PAAR registers. In these, the unfunded high-quality interventions that were dropped during grant-making are reflected. This allows visibility to be given to the gaps in programming. Additional shortfalls that remain under the radar should be highlighted during the grant-making process, to prevent countries from limiting ambitions and important interventions because they exceed the limitations of the allocation envelope provided.

Meaningful involvement of civil society in grant making needs to be guaranteed, preventing loss of important CSO and CBO interventions that risk is not included plans and funding requests, that are at risk of being dismissed by governments.

The financial shortfalls in ensuring sufficient availability of supplies for diagnostics and treatment at health facility and patient level should be prioritised. Direct medical consequences of shortages in essential medical supplies include interruption of treatment, delays in starting adequate care, and sub-standard quality of care, leading to death, more complications, induction of treatment failure and resistance, and reduced coverage of preventive measures. Stock outs in public services also force people to forego treatment or to pay high prices out-of-pocket in private outlets for medicines of often doubtful quality.


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3. Focus on interventions supporting most vulnerable people

People facing specific and worse vulnerability are most at risk of service gaps and interruption of interventions. These include **key populations, people in crisis** including **refugees** and **displaced people**, those most at risk of dying rapidly due to severe illness, and **children**. Funding should focus on concrete, effective support to reduce mortality and morbidity risks, to protect them from exclusion from care, neglect and abuse.

Support for key population-led and peer-delivered models of care should be expanded, particularly in contexts where key populations are criminalised. Due to the high risk of infection and transmission, effective protection depends also on sufficient availability of prevention tools and interventions. The Global Fund's support for patient protection and human rights approaches should be strengthened.

People affected by crisis, such as conflict, displacement, epidemic outbreaks or natural disasters face significant and immediate life-threatening risks due to interruption of treatment, increased obstacles to accessing timely care, living conditions and additional health needs. Mitigation measures such as buffer stocks, patient autonomy and rapid response mechanisms to threatening stock outs are lacking. Currently, aid during such crises is slow and often ill-adapted. The Global Fund's policy on COE contains the intent for more adaptability, but wider implementation should be applied to more contexts. More flexibility is needed, and administrative hurdles should rapidly be resolved. In view of the volatility in many countries, grant planning should include clear contingency plans to respond to increased health needs and difficult circumstances, including reprioritisation to direct life-saving interventions and possibly other grant holders. Existing Global Fund grants should be able to shift to additional resource mobilisation and to more adapted responses in crisis situations, including funding for CSOs, NGOs and other non-state actors with expertise in emergencies.

Rolling out the detection and treatment package for patients with AHD is urgent, as they face severe medical complications and high risk of imminent death. At primary health care early detection and reference depends on access to CD4 count, LAM and CrAg diagnostic tools. Treatment for key opportunistic infections, including cryptococcal meningitis, Kaposi sarcoma and others, is now restricted to too few hospitals, hampered by insufficient funding for key medical supplies.

Children are at particular risk of death from HIV, TB and malaria, especially as child-adapted diagnosis and treatment is lacking in many places because of funding gaps. A roll out of decentralised and innovative models of care (such as self-management, community-based approaches etc) should gain speed. Improved surveillance of treatment failure and drug resistance in children is also needed. For HIV there is an urgent need to scale up early infant diagnosis (EID) and to improve postnatal prophylaxis. Financing child-friendly treatment formulations against HIV and TB can improve coverage and outcomes. Due to funding shortfalls in the malaria response, gaps in ACT therapy, availability and preventive chemoprophylaxis are observed, which constitutes a high mortality risk for children, in highly endemic regions and areas hit by outbreaks and malnutrition.


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4. Protect the strategies of value

In times of funding cuts or shortfalls, key strategies might suffer a loss of financial support, undermining effectiveness, coverage and efficiency reaching the needed results. This must be avoided at all costs, as it threatens the most effective use of available funding and will further risk the derailing of achievements and progress of the response against HIV, TB and malaria. Lessons learned from evidence and experience should inspire prioritisation of protecting and promoting the strategies that made and will make the response more effective in saving lives and reaching those most in need.

Support to civil society and community-based organisations - At the heart of effective health responses, CSOs and CBOs play a crucial role in ensuring timely, life-saving care for people affected by HIV, TB, and malaria. Without these networks the backbone of the most effective service delivery is at risk, for the most neglected or marginalised communities. Without community-led monitoring, independent real-time data on supply gaps, barriers to access, and service disruptions will be missing, as often these are lacking in official reports. Their inclusion in planning and grant making processes ensures that the response reflects the in-country reality of unmet needs and not only government preferences. Despite their critical role, CSOs and CBOs are often underfunded and sidelined. Rarely supported by their national governments and deprioritised in government dominated donor requests, many struggle to secure financing. As most depend on the Global Fund to fulfil their role in delivering services, advocating for patients and holding health systems accountable, continued priority should be given to protect and enhance these direct funding streams. Grant application and reporting processes should be simplified and facilitated to make them more accessible to CSOs and CBOs to support them in this vital role.

Roll out community approaches, decentralised care and differentiated service delivery models - It remains a huge challenge to bring medical supplies and services closer to people who need them. Funding decentralised models of care, including community-led or patient-based services, has shown to be key to improving coverage, timely access and continuity of adequate care. This includes ensuring sufficient availability of tools for early diagnosis and detection at primary health care level (GeneXpert, malaria RDTs, PIMA, CrAg, etc.). More support is also needed to scale up existing and innovative differentiated service delivery models to reach more people; examples are community ART groups, multi-month dispensing, family-based TB care and integrated community malaria interventions.

Safeguard and roll out effective access to prevention tools - Malaria prevention tools such as SMC, PMC, LLINs, and indoor residual spraying (IRS), should be rolled out, including new tools such as malaria vaccination and innovative vector control methods, with particular attention to high-burden and crisis-affected areas, to malaria outbreaks and where people are more exposed to its risks, such as during periods of malnutrition, displacement or experiencing effects of climate change. As a gamechanger in HIV prevention, countries need to be fully able to scale up oral and injectable PrEP and PEP, including offering it during routine and community-based services for adolescents and key populations. Where PMTCT coverage remains limited, extra efforts are needed. Ensuring better access to TPT is a key element in TB control.

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5. Sufficient funding focused on patient and service benefits

Health systems funding should prioritise those interventions that have a direct impact on patient and health benefits, protecting them from disruptions in treatment, care and prevention. This includes sufficient availability of essential medical supplies, provided free of charge to people. This implies support to ensure adequately trained, motivated and remunerated frontline health workers (including community and lay workers), to avoid essential medicines going missing or becoming unaffordable for people.

Uninterrupted and sufficient availability of essential medical supplies - With increased risks of funding shortfall and weakening of supply lines, it is important to invest consistently in better forecasting and tracking of drug orders in line with consumption trends, provide more support to means and mechanisms for effective last-mile delivery, finance larger buffer stocks, and strengthen capacity for emergency procurement and early gap-filling responses. Independent monitoring through community-led initiatives can allow the prevention and mitigation of stockout threats.

Any support to systems for health should focus on bringing more resources to remunerate, motivate and support frontline health workers, to ensure free of charge care to people and reduce the financial burden on households, and to support community-led and patient-centred approaches. Interventions supported under the general umbrella of 'health systems strengthening' should be reviewed - and possibly paused- on the basis of their direct contribution to improved results at patient and community level.

6. Price reductions for medicines through negotiation and market shaping

With health budgets under strain, obtaining lower prices for essential products will be key, and the Global Fund should increase its role in negotiation and market-shaping.

To put available funds to best use in purchasing medical supplies, price negotiations and market-shaping efforts must be prioritised. In addition to obtaining more value for money overall in terms of essential medicines and thus providing treatment for more people, specific attention should be paid to reducing the price of currently unaffordable products, such as GeneXpert tests, paediatric ARVs, long-acting PrEP, and second-line malaria drugs. As the Global Fund is increasing its proportion in medical purchase for HIV, TB and malaria, the importance of its role increases in the negotiation of more affordable prices, pooled procurement and securing of quality supplies. A combination of increased efforts in market shaping is needed to increase access to life-saving tools to more people in need.

DEADLY GAPS: DON'T TURN AWAY FROM SAVING LIVES
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