GFAN ASIA-PACIFIC

DECEMBER 2021

ACCELERATING TO THE FINISH:

Increasing Sustainable Financing for HIV, Tuberculosis and Malaria Responses in Asia-Pacific to Achieve the 2030 Targets

CONTENTS

ACRONYMS

ART	Anti-Retroviral Therapy
C19RM	COVID-19 Response Mechanism of the Global Fund
CBO	Community-Based Organisation
CCM	Country Coordinating Mechanism
COVID-19	Coronavirus Disease 2019
CRG	Community, Rights and Gender
CSO	Civil Society Organisation
CSEM	Civil Society Engagement Mechanism for Universal Health Coverage by 2030
CSS	Community Systems Strengthening
GDP	Gross Domestic Product
GFAN AP	Global Fund Advocates Network – Asia Pacific
GLOBAL FUND	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
IWG	India Working Group on Health Advocacy
KP	Key Population
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
MSM	Men Who Have Sex With Men
ODA	Official Development Assistance
OOP	Out-of-Pocket
OSF	Open Society Foundations
NSP	National Strategic Plan
PLHIV	People Living with HIV
PWUD	People Who Use Drugs
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable Development Goal
STC	Sustainability, Transition and Co-Financing (Global Fund policy)
TB	Tuberculosis
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
USD	United States Dollar
WHO	World Health Organisation

ACKNOWLEDGMENTS

Global Fund Advocates Network Asia-Pacific (GFAN AP) would like to extend our sincere appreciation to the National Coalition of People Living with HIV India (NCPI+), the India Working Group for Health Advocacy (IWG); Yayasan Spiritia (Spiritia Foundation), DAST; and Centre for Supporting Community Development Initiatives (SCDI), for their tremendous efforts in compiling the in-country investment cases in India, Indonesia, Sri Lanka and Vietnam respectively. Special thanks are extended to all the consultants who have led the in-country investment case development processes including conducting focus group discussions, key informant interviews, desk reviews, financial analyses, and drafting. Special appreciation is extended to all members of communities and civil society and government officials who participated in focus group discussions and key informant interviews.

GFAN AP extends a very special acknowledgment to all the communities and civil society living with, affected by and vulnerable to HIV, TB and malaria; community and civil society advocates; civil society, community-based and -led and key population organisations for their remarkable courage and perseverance in fighting the three diseases and advocating for the protection of human rights, equality and non-discrimination for key and vulnerable populations.

GFAN AP expresses appreciation to Trisuli Plus, the country partner in Nepal who is currently developing a communities and civil society-led investment case for the three diseases in Nepal, and will be supporting the development of an investment case for the three disease responses in the Pacifics in 2022.

“Accelerating to the Finish” was written by Niluka Perera, Advocacy, Programmes and Coordination Officer of GFAN AP with review and editorial support from Lorina McAdam and Rachel Ong, Regional Coordinator of GFAN AP; with thanks to Nicolette Mallari for providing layout and design support.

AT A GLANCE

The COVID-19 pandemic exacerbated existing concerns about the Asia-Pacific region's ability to achieve an ambitious series of objectives by 2030: disease-specific targets for HIV, TB and malaria, the related Sustainable Development Goal (SDG) 3.3, "By 2030, end the epidemics of AIDS, tuberculosis (TB), malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases," and a commitment to achieving universal health coverage (UHC), which is enshrined in SDG 3.8, "Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". The ultimate commitment of the SDG to "Leave no one behind", has been further threatened by the COVID-19 pandemic, especially for communities and civil society vulnerable to HIV, TB and malaria including key populations for HIV, migrants, internally displaced persons, indigenous people, the poor, and other vulnerable groups and individuals.

Global Fund Advocates Network Asia-Pacific (GFAN AP) therefore commissioned five countries – India, Indonesia, Nepal, Sri Lanka and Vietnam – to undertake research and analysis to understand the current situation, barriers and challenges, and the investments needed within the HIV, TB and malaria national responses to reach these goals. This research was done using a combination of desk reviews, key informant interviews, and focus group discussions, followed by analysis, with each study documented in a country investment case. This document presents the overall findings and proposes a series of recommendations for the region, which are summarised here.

1. DESPITE SOME PROGRESS AGAINST HIV, TB AND MALARIA, COUNTRIES IN THE ASIA-PACIFIC ARE NOT ON TRACK TO ACHIEVE TARGETS FOR THE THREE DISEASES, NOR UNIVERSAL HEALTH COVERAGE. In 2019, only 75% of people living with HIV in Asia-Pacific were aware of their status, short of the 90% goal. Many high TB burden countries were not on track to reach the 2020 milestones of the End TB Strategy, and will therefore not reach the 2030 targets on their current trajectory. Malaria decline over the past two decades has slowed and the decrease of cases in 2019 was four percent lower than 2000, making malaria elimination by 2030 less likely. Beyond the three diseases, the Asia-Pacific region is also a long way from achieving universal health coverage as defined by the World Health Organisation in terms of all individuals and communities receiving the health services they need without suffering financial hardship.

2. CURRENT HEALTH FUNDING IS INSUFFICIENT TO ACHIEVE DISEASE-SPECIFIC TARGETS, AND ITS SUSTAINABILITY IS THREATENED BY DECREASING OR STAGNATING DOMESTIC FINANCING. In 2019, financing for the global AIDS response fell more than USD 7 billion short of the USD 26.2 billion that UNAIDS estimated was needed. Funding gaps of close to USD 5 billion annually impede progress in the overall TB response globally. Total available funding for malaria reached only USD 3 billion against a global target of USD 5.6 billion in 2019. Furthermore, at 2.1% of GDP, public spending on health in the WHO South-East Asia region is the second lowest across all WHO regions and far below the UHC benchmark of 5% of GDP. Many health programmes are dependent on external support, jeopardising their predictability and sustainability.

3. HIGH AND INCREASING OUT-OF-POCKET EXPENDITURE FOR HEALTH CARE THREATENS THE HEALTH OUTCOMES OF KEY AND VULNERABLE POPULATIONS IN THE REGION. As a result of low government investment in health care, almost half of health spending comes from out-of-pocket payments by households in lower-middle and low-income countries in the Asia-Pacific region. This averaged 47.4% in 2017, a slight decrease in percentage, but a real increase from 2010. These costs may be manageable by middle- and upper-income households in the region, but it creates a financial barrier for the most vulnerable and marginalised individuals, deterring people from seeking care, or limiting the services they can access, resulting in worse health outcomes for those already falling behind.

4. THE GLOBAL FUND HAS PLAYED A SIGNIFICANT ROLE IN SUPPORTING THE THREE RESPONSES IN ASIA-PACIFIC COUNTRIES AND BUILDING EFFECTIVE COMMUNITY SYSTEMS. The Global Fund has invested 16% of its total contributions to countries in the Asia-Pacific region. This investment helped put 2.4 million people living with HIV on anti-retroviral treatment, treated 3.1 million people with TB, and distributed 9.6 million mosquito nets. Furthermore, the Global Fund has been the key supporter of community, rights, and gender-based approaches, and improved the enabling environment for community and civil society engagement through ensuring participation in country coordinating mechanisms. The community systems the Global Fund helped strengthen over the years contributed to a strong community-led COVID-19 response in many countries, ensuring that key and vulnerable populations retained access to HIV, TB and malaria services throughout the pandemic, which helped protect gains against the three diseases.

5. IMPROVING ACCESS TO HEALTH CARE BY VULNERABLE AND MARGINALISED COMMUNITIES REQUIRES ADDRESSING SYSTEMIC, HUMAN RIGHTS, AND SOCIO-ECONOMIC BARRIERS. Many Asia-Pacific countries retain laws and policies that criminalise or disadvantage some key and vulnerable populations. This situation was exacerbated by COVID-19 control measures, where police powers have been used to harass, harm, and arrest vulnerable groups, such as sex workers, people who use drugs, people living with HIV, and LGBTQI people. The pandemic has also worsened gender gaps, putting further strain on people already disadvantaged by structural inequalities.

6. DOMESTIC FINANCIAL AND POLITICAL RESOURCES ARE NOT PRIORITISING THE TWO KEY SOLUTIONS TO ENSURING THAT VULNERABLE AND MARGINALISED GROUPS ARE NOT LEFT BEHIND: COMMUNITY SYSTEMS STRENGTHENING, AND A RIGHTS-BASED APPROACH. Interventions including outreach to marginalised communities, addressing human-rights barriers to accessing health services, and community systems strengthening including community-based and -led monitoring interventions are heavily reliant on external financing and are poorly or not funded by domestic resources.

THESE FINDINGS HAVE LED TO THE FOLLOWING RECOMMENDATIONS:

1. URGENTLY INCREASE DOMESTIC RESOURCE MOBILISATION:
Governments need to increase their spending on health care, with guidance from civil society on the most appropriate investments for sustainable investments in health and UHC.

2. INCREASE THE FISCAL SPACE FOR HEALTH:
Donors and technical partners need to work with governments to provide additional resources and hold them accountable to improving health outcomes.

3. PROTECT HUMAN RIGHTS, COMMUNITY ENGAGEMENT, AND CIVIC SPACE:
Laws and policies must change to remove barriers to accessing health care for the most marginalised communities.

4. SUPPORT COMMUNITY SYSTEM STRENGTHENING:
Invest in what works, whereby the COVID-19 pandemic demonstrated that with the right support, communities are effective responders.

While this document presents regional-level analysis, country-level summaries are presented at the end of this document, providing additional context on the realities of the four countries which developed their Investment Case.

1.

THE NEED:

The Why, What, and How of this Report

THE WHY

The Global Fund Advocates Network Asia-Pacific (GFAN AP) is an advocacy platform of HIV, Tuberculosis (TB) and malaria community and civil society organisations in the Asia-Pacific region. GFAN AP supports advocacy for a fully resourced Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); increased and sustainable domestic resource mobilisation for health; and equitable, people-centred, human rights-based and gender-transformative inclusion of HIV, TB and malaria responses within universal health coverage (UHC). GFAN AP envisions that all people in the Asia-Pacific living with, affected by and/or vulnerable to HIV, TB and malaria can access quality and equitable health care and services as part of UHC. In achieving this vision, GFAN AP supports the coordination, convening, and mobilisation of community and civil society organisations to advocate for a fully resourced Global Fund that ensures access to quality and equitable healthcare as part of UHC for all people-living with, and affected by, and/or vulnerable to HIV, TB and malaria.

GFAN AP has been observing the mixed progress against the three diseases with concern, which was further compounded by the COVID-19 pandemic. It was therefore increasingly urgent to understand what the biggest needs and resource gaps are, so that they can be filled. We also wanted to identify best practices and success stories in the Asia-Pacific region we could learn from and which could be replicated in order to accelerate progress in the three diseases for UHC.

Therefore, this regional report aims to provide:

- **An overview of investments (both financial and other resources) required to achieve the targets set for the three diseases to achieve UHC in Asia-Pacific; and**

- **Recommendations for moving forward, including in areas of community, rights and gender, and community systems strengthening (CSS) for sustainable national responses in Asia-Pacific.**

THE WHAT

GFAN AP commissioned a series of investment case reports in India, Indonesia, Nepal, Sri Lanka, and Vietnam to gather evidence on the situation, the needs, and resource gaps that exist, in order to identify the support necessary to meet these targets from the perspectives of communities and civil society.

This report provides an overview of the current situation in the region in terms of progress (or lack thereof) against targets and commitments, and presents key findings from the analysis and research and makes the case for further investments, and what investments would be most impactful. The report ends with conclusions and recommendations for taking these findings forward.

THE HOW

This report is a synthesis of the key findings and recommendations of four in-country, community-led investment cases supported by GFAN AP. The investment cases were developed in India, Indonesia, Sri Lanka and Vietnam by the India Working Group For Health Advocacy (IWG) and National Coalition of People Living with HIV in India (NCPI Plus); Spiritia Foundation, DAST, and the Centre for Supporting Community Development Initiatives (SCDI) respectively.[1] The country investment cases were developed through information gathered via focus group discussions, key informant interviews, desk reviews, and financial analyses. At the point of writing, only the investment case for Indonesia has been finalized and disseminated. The Indonesia Investment Case can be found here. Other countries are in the process of finalising their reports for publication and dissemination.

The background information for this regional synthesis was gathered through a desk review of key reports and political commitments including, but not limited to: the Political Declaration of the High-level Meeting on UHC "Universal health coverage: moving together to build a healthier world"; Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030;[2] Political Declaration of the UN General-Assembly High-Level Meeting on the Fight Against Tuberculosis;[3] Global AIDS Strategy 2021-2026 – End Inequalities. End AIDS;[4] the Rome Declaration adopted at the Global Health Summit;[5] Joint United Nations Programme on HIV/AIDS (UNAIDS) annual updates; World Health Organisation (WHO) annual reports on TB and malaria; United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) reports on the Sustainable Development Goals (SDGs); the Sustainable Development Report 2021;[6] publications of the Global Fund including Results Reports; and World Bank reports and data. In addition, reports developed by communities and civil society networks and organisations including APCASO, Civil Society Engagement Mechanism for universal health coverage by 2030 (CSEM), Youth Voices Count, Youth Lead, DAST, and Spiritia Foundation were also included in the literature review.

Key thematic areas were identified across all four in-country investment cases including but not limited to: progress or failure in the national three disease responses; domestic resources allocation and interventions for health in general and in achieving UHC, and HIV, TB, malaria responses in particular; investment and impact of the Global Fund; community, rights and gender realities; COVID-19 impact; and examples of best practices contributing to progress. These thematic areas were used to compose the regional synthesis. The recommendations have been arrived at through synthesising individual recommendations from country investment cases.

2.

THE SCENE:

Better is Still Not Good Enough

THE THREE DISEASES

Even prior to the COVID-19 pandemic, national and global HIV, TB and malaria investments and responses were not on track to achieve 2030 targets, which can be at least partly explained by the lack of resources available to invest in them:[7]

- Resources for HIV responses in low- and middle-income countries decreased by 7% between 2017 and 2019.[8]
- There is an expected funding gap of USD 15 billion for 2020-2022 for TB prevention and care in the 86 countries eligible for Global Fund support.[9]
- Funding for global malaria control and elimination efforts decreased by 15% between 2017 and 2018, from USD 3.2 billion to USD 2.7 billion.[10]

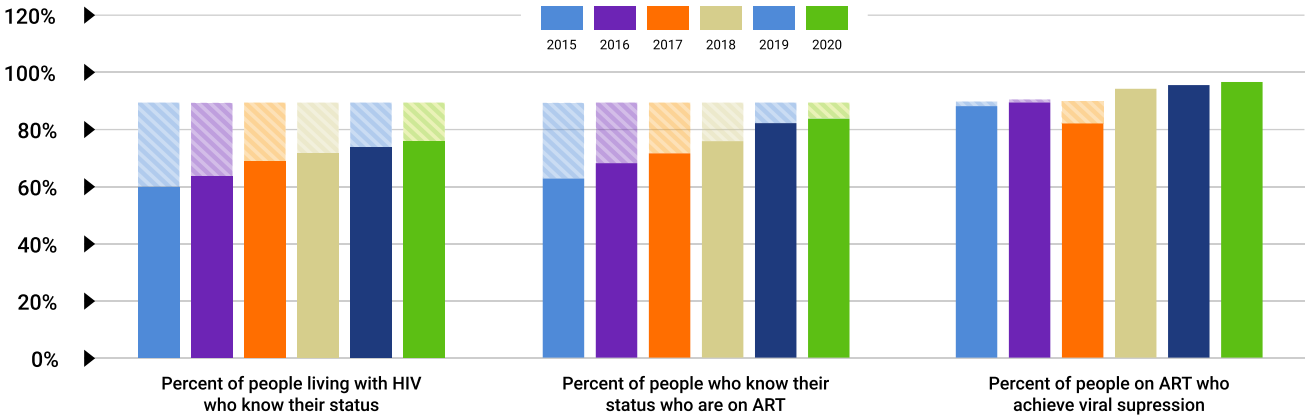
The pandemic exacerbated the situation by diverting limited resources, and disrupted the access to and provision of health services across the world, threatening to reverse the hard-earned gains achieved against the three diseases. For example, between April and September 2020, compared to the same six-month period in 2019, HIV testing fell by 41%; TB referrals declined by 59%; and malaria diagnoses fell by 31%.

From 2015 to 2020, there were 3.5 million more HIV infections and 820,000 more AIDS-related deaths than the 2020 targets[11] – a direct result of the collective failure to invest sufficiently in comprehensive, rights-based HIV responses.[12] Globally, an estimated 10 million people fell ill with TB in 2019, a number that has been declining very slowly in recent years and most WHO regions and many high TB burden countries were not on track to reach the 2020 milestones of the WHO End TB Strategy 2016 – 2035.[13] For malaria, even though a decrease in cases was observed, the decline over the past two decades has slowed, and there were an estimated 229 million malaria cases in 2019 in 87 malaria endemic countries, declining by less than four percent from 238 million in 2000.[14]

In 2020, HIV infections in the Asia-Pacific declined slightly, with reductions in Cambodia, Myanmar, Thailand, and Vietnam offset by sharp increases in Pakistan and the Philippines.[15] Key populations (KPs, see box)[16] and their partners accounted for an estimated 98% of new HIV infections, and more than one quarter of new HIV infections were among young people. Rising numbers of new infections among men who have sex with men (MSM)

are a major concern. An overall slowing in reductions in new HIV infections coincides with a decline in political and programmatic commitment, alongside punitive laws and policies, and rising stigma and discrimination that block effective AIDS responses.[17]

PROGRESS TOWARDS 90-90-90 TARGETS FOR HIV IN ASIA-PACIFIC



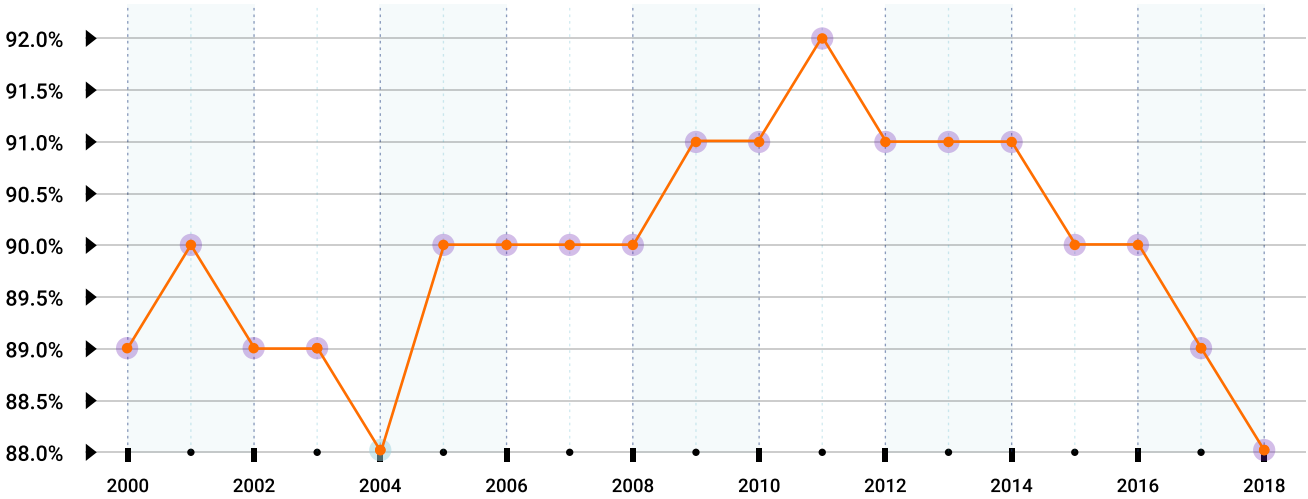
SOURCE: UNAIDS Data hub, https://aphub.unaids.org.

WHO ARE KEY POPULATIONS?

According to the Global Fund, key populations (KPs) for HIV include gay, bisexual and other men who have sex with men; women, men and transgender people who inject drugs, and/or who are sex workers; as well as all transgender people. They are socially marginalised, often criminalised and face a range of human rights abuses that increase their vulnerability to HIV.

Among people who developed TB in 2019, 44% were in the WHO region of South-East Asia – the highest rate among all WHO regions. Among the eight countries that accounted for two-thirds of the global TB burden, six were in the Asia-Pacific: India (26%), Indonesia (8.5%), China (8.4%), the Philippines (6.0%), Pakistan (4.4%), and Bangladesh (3.6%).[18]

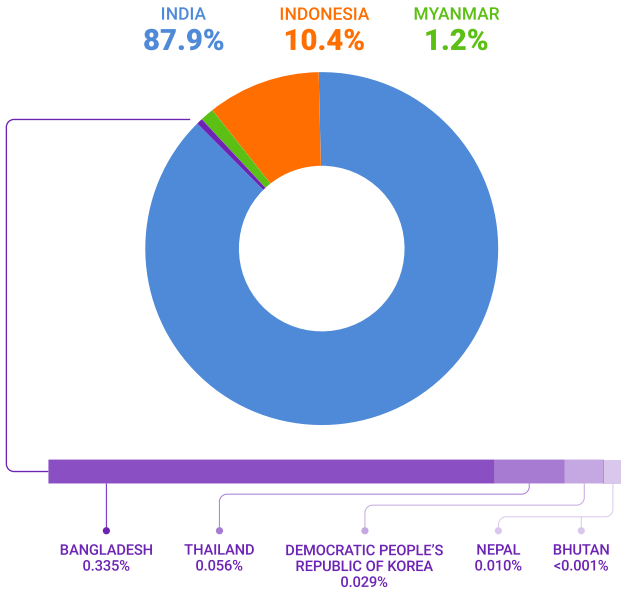
TUBERCULOSIS TREATMENT SUCCESS RATE (% OF NEW CASES) - EAST ASIA AND THE PACIFIC



SOURCE: The World Bank, https://data.worldbank.org/indicator/SH.TBS.CURE.ZS?end=2018&locations=4E&start=2000&view=chart.

The WHO South-East Asia Region accounted for approximately 3% of the burden of malaria cases globally and India accounted for about 86% of all malaria deaths in the region.[19] The Greater Mekong Sub-region is a recurrent epicentre of insecticide and antimalarial drug resistance in *Plasmodium falciparum* malaria, representing a serious threat to malaria control efforts in the region – particularly India – and beyond[20] and is of great concern.

SHARE OF ESTIMATED MALARIA CASES IN 2019 IN WHO SOUTH EAST ASIA REGION



SOURCE: WHO, World Malaria Report 2020.

KEY AND VULNERABLE POPULATIONS

The second round of a WHO "pulse survey" published in April 2021, revealed that over one year into the COVID-19 pandemic, substantial disruptions persist. About 90% of countries are still reporting one or more disruptions to essential health services, marking no substantial global change since the first survey was conducted in the mid of 2020. While this is partly due to COVID-19 control measures such as lockdowns, this is also a result of the diversion of resources from essential health services to fight COVID-19.[21] Many communities – particularly young KPs – are severely affected by COVID-related disruptions to prevention, testing, treatment, support and care services for the three diseases, and sexual and reproductive health.[22]

It is estimated that a total disruption of antiretroviral therapy (ART) for six months could lead to more than 500,000 additional deaths from AIDS-related illnesses (including TB), mainly in sub-Saharan Africa in 2020–2021.[23] Modelling suggests that the number of people developing TB could increase by more than one million per year between 2020–2025. The impact on livelihoods resulting from lost income or unemployment could also increase the percentage of people with TB and their households facing catastrophic costs.[24] History has provided repeated examples of rapid malaria resurgence when control or elimination efforts are eased, resulting in lives lost, economic hardship and declining productivity, and wasted decades of effort and investment.[25]

Human rights infringements, gender-based violence, inequalities, and stigma and discrimination faced by KPs for all three diseases have heightened in the context of COVID-19 with lockdowns and increased mobility restrictions. The increasing militarisation of COVID-19 responses across the Asia-Pacific region on the pretext of "Global Health Security" risks pushing the already bleak realities of key populations further behind.[26] Some governments have introduced emergency measures that increase their powers, limit freedom of speech,[27] and threaten the human rights of marginalised groups.[28] There have been alarming reports of police powers being used to harass, harm and arrest vulnerable and criminalised groups, such as sex workers, people who use drugs (PWUD), people living with HIV (PLHIV), and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people.[29]

A major reason the world has not achieved the 2020 HIV goals is due to the legal and policy environment. Criminalisation, stigma, and discrimination against PLHIV, KPs, gender-based violence against women and girls, and other vulnerable populations create very real barriers to people accessing HIV prevention and treatment services. The Global AIDS Strategy 2021-2025 sets new 10-10-10 targets on the removal of punitive laws that criminalise key populations and expansion of supportive laws and policies to fight stigma, discrimination, gender-based violence, and gender inequity. UNAIDS estimates that achieving these targets will prevent 2.5 million new HIV infections and 1.7 million AIDS-related deaths by 2030.[30]

The pandemic has also worsened gender gaps, putting further strain on people already affected by structural inequalities. Globally, women lost more jobs and sources of income than men, and therefore face more financial challenges, even in high-income countries. By 2021, around 435 million women and girls will be living on less

than USD 1.90 a day, including 47 million pushed into poverty as a result of COVID-19.[31] It is also estimated that the 5% global drop in gross domestic product (GDP) in 2020 will push an additional 177 million people into poverty worldwide, two-thirds of whom are in South Asia.[32] According to a COVID-19 Rapid Assessment conducted by DAST among key populations in Sri Lanka, many respondents reported having lost their jobs or income sources due to COVID-19, as many are employed in the informal sector. The impact on sex workers is profound.[33] This is a reality among many key population members across the region including communities vulnerable to TB and malaria, such as miners, farmers, migrants, and indigenous people who are heavily reliant on informal income generation sources.[34]

These significant socio-economic impacts of COVID-19 on communities living with, affected by, and vulnerable to the three diseases impedes the achievement of the HIV, TB and malaria 2030 targets established in SDG 3.3 on Good Health and Wellbeing, and ultimately UHC and the 2030 agenda. Yet it should also be noted that data specifically on key and vulnerable populations can be limited and delayed, meaning that many of these impacts are not adequately measured, captured, and taken in to account during policy, investment, and decision-making.

HEALTH FINANCING AND COVID-19

The SDGs are now even more threatened, despite progress in East and South Asia regions since adoption of the goals in 2015. Similarly, while the Pacific sub-region made some progress against SDG 3 (particularly in maternal health), it is not on track to achieve any of the 17 Goals by 2030, and some aspects of the health goal – particularly TB – have shown no improvement for two decades.[35] The pandemic has increased the incidence of extreme income poverty in low- and middle-income countries,[36] while further impairing long-term financing for sustainable development, especially in the poorest countries. National revenue, international public and private resource flows have all fallen.[37] The dual challenge of managing the spread of the virus and sustaining other health services, has tested all national health systems' ability to reach everyone with quality essential health services without financial burden. Despite years of investments in health systems strengthening (HSS), the COVID-19 pandemic and lack of attention to pandemic preparedness exposed the failure of the existing global health infrastructure when it was needed most, with devastating human and economic consequences.[38] It has also revealed government neglect or failure to invest adequately in health, social safety nets, and emergency preparedness to protect its populations – particularly its most vulnerable.[39] The extreme pressure on health systems across the world underscores the urgent need

CRIMINALISATION OF KEY AND VULNERABLE POPULATIONS

In the Asia-Pacific region:

- *18 countries criminalise sexual activities among consenting same-sex adults in some form;* [i]
- *5 countries criminalise gender identity/expression of transgender people;* [ii]
- *All countries criminalise sex work or certain activities associated with sex work, except New Zealand and New South Wales (Australia);* [iii]
- *11 countries have HIV criminalisation laws;* [iv]
- *14 countries have the death penalty for drug offences.*[v]

Despite 147 national constitutions in the world offering protection against discrimination, key and vulnerable populations to TB, such as mobile and migrant populations, people living with HIV, people who use drugs, prisoners, and women, who are often stigmatised because of their social or legal status are driven away from accessing TB services as result of discrimination.

Migrant populations and internally displaced populations very often lack access to timely diagnosis and treatment for TB due to a host of factors, including their immigration or legal status, language and cultural barriers, policies requiring identity documents to access services, and fear of law enforcement.[vi] *Similar barriers face mobile and migrant populations in accessing timely malaria services, which can be exacerbated if they are involved in activities such illegal as logging or mining.*

SOURCES:

i. https://www.humandignitytrust.org/lgbt-the-law/map-of-criminalisation/.
ii. https://www.humandignitytrust.org/lgbt-the-law/map-of-criminalisation/.
iii. https://www.aidsdatahub.org/sites/default/files/resource/sex-work-and-law-asia-pacific.pdf.
iv. https://www.aidsmap.com/about-hiv/hiv-criminalisation-laws-around-world.
v. https://www.hri.global/death-penalty-2020.
vi. B. Citro, 2020, Activating a Human Rights-Based Tuberculosis Response: A Technical Brief for Policymakers and Program Implementers, Global Coalition of TB Activists, Stop TB Partnership.

to accelerate efforts towards achieving UHC, ensuring that all people – especially the most vulnerable and marginalised – can access the highest possible standards of health and well-being.

International health financing institutions such as the Global Fund, have stepped up to support countries to fight COVID-19 and protect the progress achieved against HIV, TB and malaria. By November 2021, the Global Fund had approved USD 4.1 billion to support COVID-19 responses in 107 countries and 20 multicounty grants through its Grant Flexibilities and COVID-19 Response Mechanism (C19RM). These investments aim to reinforce the COVID-19 response, pandemic-related adaptation of HIV, TB and malaria programmes, and strengthen health and community systems.[40] The Global Fund mobilised nearly USD 3.75 billion (as of November 2021) of its USD 10 billion target. It is also a founding partner of Access to COVID-19 Tools Accelerator (ACT-Accelerator), a global collaboration of leading public health agencies working with governments, civil society, and industry to accelerate the development and equitable distribution of tests, treatments and vaccines and the strengthening of health systems to fight COVID-19. Such initiatives are critical to ensure that HIV, TB and malaria responses achieve 2030 targets.

However, bilateral and multilateral donors, such as the Global Fund, plan to transition out of low- and middle-income countries as their income levels rise. As economies grow, it is assumed that countries will increase spending on health, progressively moving away from donor financing towards domestically-funded health systems. According to the Sustainability, Transition and Co-financing (STC) Policy of the Global Fund,[41] more than 15 countries in Asia-Pacific are classified as upper middle-income countries or as lower middle-income countries, or as countries with "Not High Disease Burden" indicated for one or more of the three diseases. Both of these categories infer readiness to transition out of Global Fund support.[42] A case study commissioned by the Open Society Foundation in three Eastern European countries revealed that withdrawal of funds by the Global Fund has resulted in difficulties sustaining service delivery to KPs, and ensuring civil society inclusion in the development of sustainable systems for national HIV response.[43] Asia-Pacific countries may also face the same challenge with all testing, treatment, prevention and community engagement activities focused on key populations – including advocacy – either being underfunded or unfunded entirely. In addition, even though the Global Fund has put in place mechanisms and policies to support countries during the transition process, it is anticipated that the large dent on health and financial systems of countries from COVID-19 will further hamper domestic resource mobilisation.

Official development assistance (ODA) and domestic public resources are two of the most important sources of long-term sustainable financing for health responses, especially in low- and middle-income countries. However, the data show that even prior to the pandemic, increases in domestic public resources had failed to materialise and were insufficient to meet needs.[44] This implies that the external resources channelled via ODA to countries in Asia-Pacific and in other regions is stagnant or decreasing. In the first seven months of 2020, bilateral commitments – ODA and other official flows – were 11% lower than the same period in 2019. ODA alone has fallen by 5%.[45] However, commitments from international financial institutions increased by 31%, compared with the same period in 2019. The overwhelming impact of COVID-19 on the three responses, combined with the fact that they were already off track to achieve 2030 targets prior to the pandemic, indicates that ground-shifting financial and political commitments – nationally and globally – are required to achieve 2030 targets.[46]

GLOBAL FUND COVID-19 RESPONSE MECHANISM AND 5% GRANT FLEXIBILITIES SUPPORT TO ASIA-PACIFIC

C19RM

In 2020, the Global Fund provided USD 102.67 million to 11 countries and as of 26 November 2021, another USD 583.12 million to 19 countries in Asia-Pacific region to:

- *Reinforce national COVID-19 responses;*
- *Mitigate COVID-19 impact on HIV, TB and malaria programs;*
- *Make urgent improvements to health and community systems to help fight COVID-19.*

5% Grant Flexibilities

As of 6 September 2021, under 5% Grant Flexibilities, the Global Fund has provided USD 65.23 million to 21 countries in Asia-pacific to combat COVID-19 and protect progress against the three diseases.

SOURCE: https://www.theglobalfund.org/en/our-covid-19-response/.

3.

THE FINDINGS:

Lessons Learned Reveal the Most Promising Path

BEFORE THE PANDEMIC, SOME REASONS FOR OPTIMISM

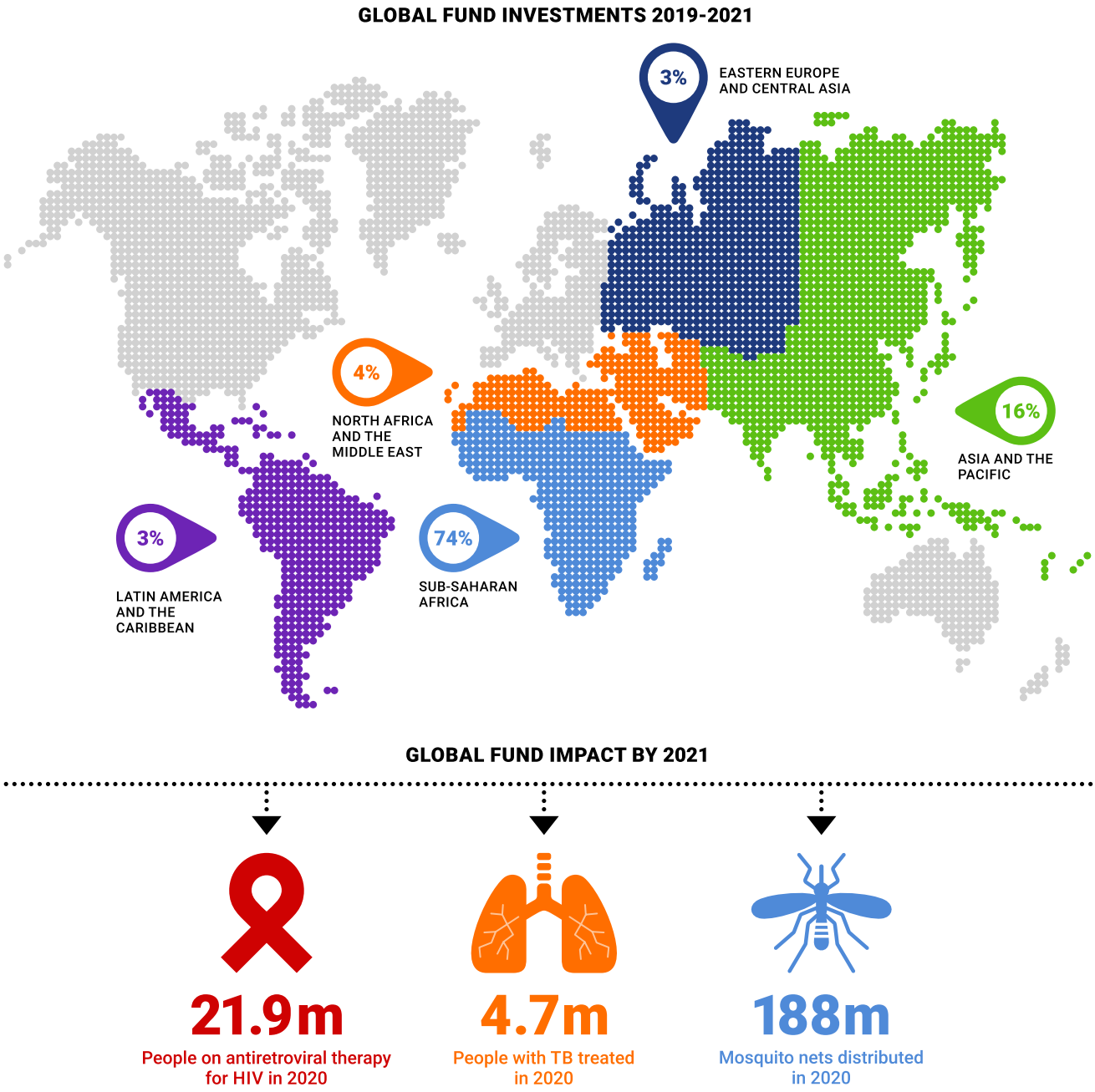
Despite major challenges the Asia-Pacific region has seen achievements and progress in HIV, TB and malaria. In 2019, 75% of PLHIV in Asia-Pacific were aware of their status. Among those diagnosed with HIV, 80% were on treatment, of which 91% were virally suppressed.[47] This represents only a slight increase of PLHIV who knew their status since 2016, however, the percentages of PLHIV on treatment and virally suppressed have seen phenomenal progress, from 71%, 47%, and 39% respectively.[48] HIV funding from domestic sources also increased by 87% between 2010 and 2019.

There were large drops in the reported number of people diagnosed with TB between January and June 2020 in India, Indonesia, the Philippines and South Africa; four countries that account for 44% of global TB cases. Compared with the same six-month period in 2019, overall reductions in India, Indonesia and the Philippines ranged between 25–30%.[49] High-quality TB services have expanded, many cases are treated, and the treatment success rate for new TB cases reached more than 80% in most Asia-Pacific countries in 2017.[50]

Malaria case incidence in WHO South-East Asia region reduced by 78%, from around 18 cases per 1,000 population at risk in 2000, to about four cases in 2019.[51] India contributed the largest absolute reductions in the region, from around 20 million cases in 2000 to about 5.6 million in 2019. Sri Lanka was certified malaria free in 2015, and Timor-Leste reported zero malaria cases in 2018 and 2019.[52] In the WHO South-East Asia region, malaria deaths reduced by 74%, from about 35,000 in 2000 to 9,000 in 2019.[53]

THE IMPORTANT IMPACT OF THE GLOBAL FUND

The Global Fund has contributed significantly to HIV, TB and malaria responses in the region. Between 2019 and June 2021, 16% of the Global Fund's total investment was in the Asia-Pacific. As per its 2021 Results Report, the Global Fund has put 21.9 million PLHIV on treatment, 4.7 million people have been treated for TB, and 188 million mosquito nets have been distributed.[54]



SOURCE: Global Fund Results Report 2021.

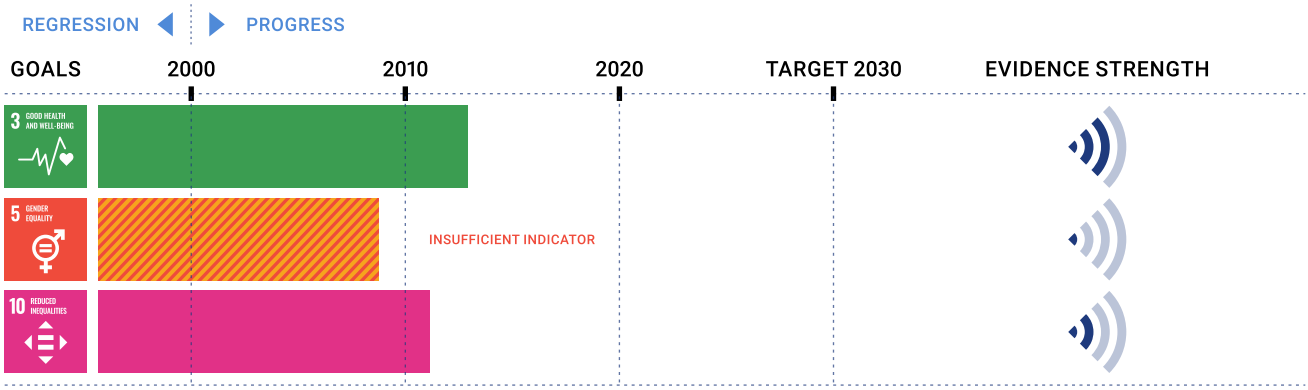
Global Fund investments have catalysed increased testing and treatment for all three diseases in the region. In Indonesia, Global Fund-supported programmes have bridged the gap between outreach and testing, and deepened the collaboration between health facilities and civil society organisations resulting in noteworthy increases of HIV testing.[55] In India, with the support of the Global Fund, 1.8 million people were treated for TB in 2017.[56] In the same year, 2.74 million TB cases were detected in India. With the support of the Global Fund, Sri Lanka eliminated malaria in 2015, and Vietnam is entering the malaria pre-elimination phase. Between 2013-2017, confirmed malaria cases decreased from 17,128 to 4,548 in Vietnam and in 2017, there were only six deaths due to malaria in the country. Drugs to treat the disease are widely available. With the support of the Global Fund since 2018, the government of Vietnam is also funding methadone treatment for people who inject drugs in all 63 provinces, covering a total of 52,000 patients.[57] In 2020, Vietnam took a critical step in harm reduction by rolling out the take-home Opioid Substitution Therapy programme.[58] Global Fund support also helped to ensure that the malaria response is supported by a strong network of community health workers in Vietnam.[59]

CONCERNING LACK OF PROGRESS TOWARDS THE SUSTAINABLE DEVELOPMENT GOALS

Despite these impressive gains, however, available data indicate that countries in the Asia-Pacific are not on track to achieve the SDGs. The region has fallen behind in terms of the progress needed by 2020 to reach SDG targets by 2030, and on its current trajectory, the region may achieve less than 10% of the goals.[60] Despite moderate improvements against three targets under SDG 3 (good health and well-being), including in malaria prevention, the SDG Dashboard shows that major challenges exist across most SDGs, including the remaining ten targets under SDG 3, SDG 5 (gender equality), and SDG 10 (reduced inequalities).[61] Specific indicators show that TB incidence is stagnating, and UHC was only moderately improving.[62] Progress continues to be uneven across the region, demonstrating the diversity of commitment and challenges.

According to the 2021 Sustainable Development Report, Indonesia is ranked 97 of 193 countries with a score of 66.3 – a one point and four-position rise since 2020. Vietnam has made significant progress and is now ranked 51, with an SDG Index Score of 72.8. With an overall SDG index score of 60.1 in 2021, India slipped three places in the SDG rankings of the UN from 117 in 2019 to 120 in 2020[63] and remained there in 2021. Sri Lanka showed progress in the relative ranking, moving from 94 in 2020 to 87 in 2021. Analysis suggests that the key challenges are a combination of under-investment, variable political will, and the need for policy changes.[64]

PROGRESS OF SELECTED SDGs IN ASIA-PACIFIC: SDG 3, SDG 5, SDG 10



SOURCE: UNESCAP, Asia and the Pacific SDG Progress Report 2021.

PROGRESS IN SELECTED SDGs IN INDIA, INDONESIA, SRI LANKA AND VIETNAM

COUNTRY	SUSTAINABLE DEVELOPMENT GOAL		
	3 GOOD HEALTH AND WELL-BEING	5 GENDER EQUALITY	10 REDUCED INEQUALITIES
INDIA	● ↗	● →	● ✕
INDONESIA	● ↗	● ↗	● ✕
SRI LANKA	● ↗	● →	● ✕
VIETNAM	● ↗	● ↗	● ✕

● Significant Challenges Remain ● Major Challenges Remain ↗ Moderately Improving → Stagnating ✕ Information Unavailable

SOURCE: SDG Dashboard and Trends - 2021-11-30.

DOMESTIC RESOURCE MOBILISATION IS STILL INADEQUATE

Securing and sustaining the resources necessary to facilitate sustainable development remains a major challenge in the region. Domestic resources for health remain significantly low. The percentage of GDP spent on health in lower-middle and low-income countries in Asia-Pacific did not change between 2010-17 at 4% of GDP.[65] In the region, almost half of health spending comes from out-of-pocket (OOP) payments by households in lower-middle and low-income countries,[66] averaging 47.4% in 2017, a slight decrease in the percentage share but a real increase from 2010.[67]

Total government health expenditure as a percentage of GDP in some countries in the region with high HIV, TB and malaria disease burdens either decreased or remained stagnant in the 2015-2020 period. In India, total health expenditure as a proportion of GDP declined from around 4% to 3.5%, with India's public health expenditure remaining at 1.1% of GDP in 2020-21, despite COVID-19.[68] In Indonesia, healthcare spending as a percentage of GDP was only 2.9% in 2019, which is similar to 2017 and 2018, but a reduction from 2016.[69] In 2018, government health expenditure in Vietnam accounted for 2.7% of Vietnam's GDP, which has been stagnant over the past several years.[70] Sri Lanka's government health spending as a share of GDP is relatively low by regional standards and is currently constrained by a very low level of overall government revenue.[71]

MAJOR GAPS REMAIN IN THE FINANCIAL RESOURCES REQUIRED TO ACHIEVE NATIONAL TARGETS FOR HIV, TB AND MALARIA IN INDIA, INDONESIA, SRI LANKA AND VIETNAM

Despite Global Fund allocations, countries in the Asia-Pacific region will not have enough resources to meet their HIV epidemiological targets. Prevention funding is particularly vulnerable and requires greater domestic leadership and coordination. Bilateral donors are still crucially important in the response to HIV throughout the Asia-Pacific region.[72] Funding gaps and persistent health system challenges threaten further progress in malaria responses in Asia-Pacific. Achieving the regional goal of malaria elimination by 2030 will require an intensification of efforts and a plan for sustainable financing.[73] Many aspects of the TB response, including developing and delivering new drugs, vaccines, and diagnostics required to end the TB pandemic, are underfunded.[74]

By 2021, India saw a massive 42% shortfall in the investments needed to support the HIV National Strategic Plan for 2017-2024.[75] Sri Lanka's HIV Response needs approximately USD 28 million of additional financing over the next eight years to reach the national 2030 targets of 95:95:95 and to ensure UHC of key population communities.[76] In Indonesia, the estimated funding shortfall for the HIV response amounts to USD 55.2 million for the period of 2022 – 2023, and USD 58.4 million in 2024.[77] The amount of budget requested for India's National TB Elimination Program has seen a sharp decline during 2019-20. For the national TB response in Indonesia, the estimated funding gap for community participation amounts to USD 123.7 million for the period of 2022 – 2023. It was projected that external funding would drastically reduce from year 2024 in Vietnam for all three diseases responses, while OOP payments would continue to increase by almost 40% from USD 11.9 million in 2021 to USD 16.6 million in 2030.[78]

DOMESTIC RESOURCES FOR COMMUNITY, RIGHTS AND GENDER ASPECTS OF THE THREE DISEASE RESPONSES ARE SIGNIFICANTLY LOW

Initiatives and interventions aimed to promote and protect human rights, gender equality, and ensure meaningful community engagement in general, and in HIV, TB and malaria responses in particular, are underfunded across the region. Insufficient support services, notably shelters, provision of legal aid or psychological support – especially for key and vulnerable populations including women and girls – have been noted across most countries of the region.[79] Government funding for gender equality is still inadequate.[80] There continues to be a lack of clarity among stakeholders of the three disease responses nationally regarding the vital role that communities can play in designing, delivering and evaluating impactful programming to ensure systems for health are resilient and sustainable.[81]

Around 72% of the funding gap within the HIV response in Indonesia for 2022-2023 relates to activities for which the Government of Indonesia is either ill-prepared or unwilling to address on its own. Reasons for this include reluctance

to support outreach to marginalised communities, including some key populations, addressing human-rights barriers to accessing HIV services, and community systems strengthening (CSS), including community-based and -led monitoring.

The resource gap for addressing CRG issues and CSS alone amounts to USD 23.7 million, which is 43% of the funding gap. In Indonesia's national TB response, the estimated funding gap for community participation amounts to USD 123.7 million for 2022-2023. The largest funding gap for community and civil society engagement and activities is within the malaria programme with an estimated USD 87.6 million needed for 2021-2023, including USD 37.1 million for 2023 alone. Sri Lanka requires significant resources to ensure the community, rights and gender (CRG) response within the HIV response is on track to achieve 2025 and 2030 targets and is estimated at approximately USD 2.3 million for the next eight years. Even though India and Vietnam do not have financial analyses for investments required for CRG interventions, it is clear that significant financial gaps remain.

COVID-19 HAS WORSENED THE SITUATION FOR HIV, TB AND MALARIA

COVID-19 has contributed significantly to existing challenges, and the impact on the fight against HIV, TB and malaria worldwide has been devastating. Between 2019 and 2020, the number of people treated for multidrug-resistant TB (MDR-TB) in the countries where the Global Fund invests, dropped by 19%, with those on treatment for MDR-TB registering an even bigger drop of 37%. Compared with 2019, people reached with HIV prevention programs and services declined by 11%, and 12% for young people. Interventions to combat malaria appear to have been less disrupted by COVID-19, however, suspected cases of malaria tested fell by 4.3% compared with 2019, potentially due to a reduction in treatment seeking.[82] In addition, COVID-19 related disruption of procurement and transportation of medicines and laboratory consumables has also made a significant impact on the three responses.[83] The Global Fund, anticipating a stock-out of HIV, TB and malaria drugs, diagnostics and other commodities, took immediate steps to address this threat by collaborating with suppliers and supporting supply and procurement channels.[84] In some countries and contexts, civil society participated in advocacy efforts with the same goal.

COVID-19 IMPACT ON THE THREE RESPONSES IN THE COUNTRIES SUPPORTED BY THE GLOBAL FUND

21.9m
People on antiretroviral therapy for HIV – an 8.8% increase compared to 2019 despite COVID-19.

104m
People tested for HIV – a 22% decrease compared to 2019 due to COVID-19.

8.7m
People reached with HIV prevention services – an 11% decrease from 2019 due to COVID-19.

4.7m
People treated for TB – an 18% decrease compared to 2019 due to COVID-19.

101,000
People on treatment for drug-resistant TB – a 19% decrease compared to 2019 due to COVID-19.

194,000
Children in contact with TB patients received preventative therapy – a 13% increase compared to 2019 despite COVID-19.

271,000
HIV-positive patients on antiretrovial therapy during TB treatment in 2020 – a 16% decrease compared to 2019 due to COVID-19.

188m
Mosquito nets distributed to protect families from malaria – a 17% increase compared to 2019 despite COVID-19.

259m
People were tested for malaria – a 4.3% decrease compared to 2019 due to COVID-19.

11.5m
Pregnant women received preventative therapy – nearly the same as in 2019.

9.4m
Structures covered by indoor residual spraying in 2020 – a 2.9% increase compared to 2019 despite COVID-19.

SOURCE: Global Fund Results Report 2021.

In Indonesia, the closure of *puskesmas* (government-mandated community health clinics) interrupted integrated health services, such as family planning, maternal and child health services, and HIV prevention of mother-to-child transmission, with access to *puskesmas* dropping from 94% to 64% during the pandemic. The Indian government's TB notification system, *Nikshay*, reported a 70% drop between the tenth and fifteenth weeks of 2020, which would have had a commensurate impact on morbidity, access to treatment, and TB-related mortality.

COVID-19 has severely disrupted community systems and community-led service delivery channels. In Vietnam, the rising costs of treatment, postage, internet and telephone bills etc., are borne by peer educators or community-based organisations (CBOs) with no additional resources allocated for such expenses by the national programme budgets.[85] As in many other countries in the region, in Indonesia, movement restrictions implemented to curtail COVID-19 transmission resulted in closure of places frequented by key populations, and where they can be reached by outreach workers. There was also a lack of funding to provide adequate protection to fieldworkers of civil society organisations (CSOs), including access to COVID-19 vaccination for frontline workers, who have been forced to limit HIV, TB and malaria support activities.

Apart from the devastating impact on the testing, treatment and prevention targets of the three diseases, COVID-19 also impacted the human rights situation of the communities and civil society living with, affected by, and vulnerable to the three diseases in the Asia-Pacific region, which was already unsatisfactory.[86] A baseline study by the Global Fund on the human rights situation of key and vulnerable populations in Indonesia observed that the punitive environment for key populations has increased. The assessment concluded that stigma and discrimination, punitive laws, policies and practices, gender inequality, and gender-based violence continued to affect HIV, TB and malaria-affected communities.

In Vietnam and Sri Lanka, COVID-19 has increased the need for psychological support amidst social distancing and/or lockdown measures, and also saw increased reported cases of domestic violence and abuses. COVID-19 also created more rights-based barriers to UHC for key populations in Vietnam. Qualitative interviews conducted for the Vietnam country investment case revealed increasing shunning of healthcare facilities by community members due to fear of COVID-19, compounded by the lack of information on COVID-19 control and transmission. The lack of information on routine HIV, TB and malaria services during COVID-19 also created more barriers to achieving UHC goals for key populations.[87] In India, COVID-19 and its preventive measures such as lockdowns increased domestic violence, compromised access to sexual and reproductive health services, and affected livelihoods through a massive reduction in labour force participation, particularly for women.[88]

IN INDIA, INDONESIA, SRI LANKA AND VIETNAM, DUE TO COVID-19:

HIV, TB and Malaria testing, treatment and prevention for key and vulnerable populations were
significantly affected.

Community systems and community service delivery channels were
significantly disrupted.

Human rights situation of the communities living with, affected by and vulnerable to HIV, TB and malaria channels were
significantly worsened.

The unmet need for mental health support was
significantly increased.

Domestic violence faced by key and vulnerable populations was
significantly exacerbated.

Despite the challenges, community systems have been instrumental during the height of COVID-19 waves in many countries to cushion the impact on HIV, TB and malaria responses and to support key and vulnerable populations. In Vietnam and Sri Lanka, peer educators and CBOs have been shouldering the extra responsibility of ensuring that those who are living with and affected by the three diseases have access to treatment, testing and other support services despite lockdowns. In India, PLHIV networks have not only ensured distribution of ART to PLHIV but have also worked with government agencies to ensure ART delivery to PLHIV who have been distanced from their regular clinics due to mass migration across the country due to COVID-19.

THE RISKS OF GLOBAL FUND TRANSITION

Transitioning out of Global Fund support is expected to further threaten reaching testing, treatment, prevention, and CRG-related targets for key and vulnerable populations in the Asia-Pacific region. Given Global Fund eligibility requirements related to economic growth and reduction of disease burden, India faces the possibility of Global Fund transitioning out its support, despite the continued acute need for external funding as well as technical support, especially in light of the COVID-19 pandemic.[89] In Vietnam, funds for priority public health programmes such as for HIV, TB and malaria have been transitioning from being heavily dependent on external assistance to domestic financial sources, further putting pressure on individuals as this translates to increased OOP expenditure. The majority of prevention interventions for key populations, especially CSS in Sri Lanka, rely on the Global Fund. The potential transitioning of the Global Fund from Sri Lanka in 2025 will therefore have a major impact on communities and civil society partners in the country.[90] Global Fund transitioning out of middle-income countries in the region in the context of COVID-19 and while the domestic resources for health are not at an adequate level, will jeopardise HIV, TB and malaria national responses, which risk leaving key and vulnerable populations even further behind.

Even though the STC Policy of the Global Fund lays out innovative financing mechanisms to support countries in achieving sustainable responses in the three diseases, many of the financing tools and mechanisms fail to meaningfully involve and engage communities and civil society in decision-making, and it is unclear how broad-based country coordinating mechanisms (CCMs) will continue and/or engage in health responses without accountability to the Global Fund.

4.

THE CASE:

More, Smarter Investment, Now

THE REGION IS OFF-TRACK TO REACH THE SUSTAINABLE DEVELOPMENT GOALS BY 2030

HIV, TB and malaria responses have been off track to reach 2030 global and national targets even before the COVID-19 pandemic exploded. Despite the global and national political commitments made in the UN Political Declarations on TB (2019), UHC (2019), and HIV (2021), the SDGs and targets set in national strategic plans, the three disease responses were not on track to reach testing, treatment and prevention targets. At both global and national levels, financing targets for the three responses were significantly underachieved.

A drastic reduction of 90% in new infections is needed to meet incidence and mortality goals of the HIV response where large gaps remain in key prevention programmes. The global TB response is off track to meet END TB targets[91] on incidence and mortality, and gaps remain in MDR-TB detection and treatment outcomes. While there has been global progress in malaria burden and mortality reduction due to increased resources to expand coverage of effective interventions, the malaria response is off track to meet 2030 Global Technical Strategy morbidity and mortality targets. As concluded by UNESCAP in its 2020 report, the Asia-Pacific region is not on track to achieve any of the 17 SDGs. These failures are thought to be primarily associated with a lack of political commitment and financing for the three responses and SDGs – both nationally and globally.

COVID-19 SET BACK PROGRESS…

The COVID-19 pandemic and ensuing impacts on the three disease responses served as a stark reminder of the fragility of our health systems. This is unsurprising given that domestic health financing has not met the required levels and that global financing for health has not sufficiently improved. Global Fund data collected from April to September 2020 indicate that HIV referrals fell 37% in Q2/Q3 of 2020 relative to the same period in 2019, and HIV testing fell by 41%. TB referrals dropped 70% in 2020 in comparison with 2019, and drug-sensitive TB diagnosis and screening services decreased by 52%. The number of patients enrolled in treatment fell by 46%, and testing for HIV in TB patients declined by 48%, with urban areas more affected than rural areas. In surveyed facilities in seven Asian countries, malaria diagnoses fell

56%, and malaria treatment services plummeted by 59% with all levels of facilities severely affected.[92] As reported in the Global Fund Results Report 2021, compared to 2019, there was a 22% decrease in people tested for HIV and 19% decrease in people on treatment for drug-resistant TB. Impact on malaria appears minimal, with only a 4.3% decrease in people tested for malaria in 2020 compared to 2019, however this can be critical in both high-burden and elimination settings.

… BUT THE PANDEMIC ALSO DEMONSTRATED WHAT IS POSSIBLE

These losses occurred despite global and local response efforts. Global health financing institutions such as the Global Fund, reacted decisively to the COVID-19 pandemic in attempt to protect the gains achieved against the three diseases, and to support the countries where Global Fund invests to fight COVID-19. The 5% Grant Flexibilities and C19RM initiatives established by the Global Fund for COVID-19 mitigation activities, approved USD 4 billion as of 21 October 2021, which have supported 107 countries and 19 multicounty programmes.

Furthermore, communities living with, affected by and vulnerable to three diseases and civil society rose to the challenge across the world to ensure continuity of services for communities in accessing lifesaving testing, treatment, and prevention services and commodities. Despite myriad challenges, including limited access to emergency financial resources, policy and legal barriers, lack of access to personal protective equipment and technical support, communities-led and -based organisations and CSOs delivered essential goods during country-wide lockdowns and curfews, providing support to survivors of human rights violations, gender-based violence, and other abuses spurred by the pandemic and its subsequent realities.

The community systems supported by the Global Fund over the years have played a crucial role in ensuring that communities and civil society are meaningfully engaged in decision-making on the use of emergency funds made available by the Global Fund to combat COVID-19 and protect progress against the three diseases. The engagement of communities and civil society through country CCMs in developing funding requests for C19RM ensured that community needs amidst the COVID-19 pandemic were also integrated into the funding proposals. These included the provision of digital communication infrastructure, ad-hoc modalities for delivering ART, and TB and malaria treatment, increased travel allowances for peer educators, and emergency human rights focused interventions for key populations. The community COVID-19 response demonstrates that strong, sustainable and adequately-funded community systems with supportive and safe environments to enable engagement can contribute significantly to building resilient and sustainable systems for health, ensuring equitable access to health for all – even during a crisis.

COMMUNITY RESPONSES TO COVID-19

*In **INDIA**, communities and civil society engaged with the National AIDS Control Program and state health authorities to ensure the continuation of ART supply to PLHIV amidst mass internal migration due to COVID-19.*

*Similarly, in **SRI LANKA**, PLHIV community organisations shouldered the burdened of ART delivery to those who could not visit clinics due to lockdowns.*

***INDONESIAN** communities and civil society conducted surveys to gather information on the impact of COVID-19 on those affected by TB and used the findings to shape requests to the C19RM funding mechanism.*

*Community-led and -based organisations in **VIETNAM** not only provided essential goods and services to marginalised and vulnerable communities, but also bore the additional expenses of delivering testing, treatment and prevention services to communities amidst COVID-19.*

SOURCE: Country case studies.

ACHIEVING THE SDGS REQUIRES MOBILISATION, INCLUSION, AND A COLLABORATIVE EFFORT

National responses for the three diseases need significant support to build infrastructure; purchase health commodities for testing, treatment and prevention; and maintain, increase and strengthen the health workforce to build strong health systems to achieve UHC. While national governments may be more inclined to finance health system strengthening (HSS) components domestically, there is a real threat of a lack of domestic investment in programmes specifically focused on key populations, as evidenced in several countries in the region where Global Fund is transitioning. CSS is a key component, along with HSS in developing resilient and sustainable systems for health. Despite proving their effectiveness – especially in the COVID-19 context – CSS interventions across the world that contribute to ensuring meaningful community engagement in the three responses are only marginally, or not financed domestically, and are dependent on external financing.

Rights-based, people-centred, equity-focused and gender transformative health responses for the three diseases are imperative to achieve 2030 targets and UHC across the Asia-Pacific region. Such responses can address underlying inequities that continue to weaken health systems. Human rights barriers including criminalisation of sexual orientation or gender identities, occupations, gender-based violence, and abuse, stigma and discrimination, is clearly linked to driving HIV vulnerability among key populations.[93] Approaches to fighting TB still remain largely biomedical, research and public health-based, essentially ignoring the underlying social, economic, and structural factors driving the epidemic and drug resistance. At the same time the highest TB burdens exist where vulnerability and marginalisation increase the risk of infection and disease, while also erecting barriers to accessing testing and treatment services.[94] Malaria continues to most affect those who experience social, economic, legal and human rights barriers. Because of the unofficial status of many of the populations vulnerable to malaria, they are not only often hard to reach but may not readily avail themselves of health services provided by governments.[95]

Increased and accelerated financial investments through domestic public resources and ODA – both bilateral and through international financial institutions – for HIV, TB and malaria responses nationally and globally are critical to ensure that the three responses are on track to achieve 2030 targets. It is crucial that flexible financing and the technical support needed to strengthen the capacity and domestic financing of national health systems are prioritised through supporting governments, especially in low- and middle-income countries, to increase investment in sustainable and resilient health systems.[96] International financial institutions and development finance institutions play an increasingly important role as providers of development finance and by channelling bilateral ODA resources, it is important they strengthen their focus on the poorest, most vulnerable and marginalised.[97] It is equally important to ensure that international financial institutions, such as the Global Fund, are fully resourced to support national governments and communities to fight the three diseases, protect and promote human rights and gender equality, and strengthen resilient and sustainable systems for health to achieve UHC, leaving no one behind.

Achieving the 2030 targets in the remaining eight years will only be possible by addressing the legal, policy, and human rights barriers, and the socio-economic impediments that prevent communities living with, affected by and vulnerable to the three diseases from accessing health services. This can be done through mobilising increased global and domestic investment and political commitment, with a focus on engaging all stakeholders – communities, civil society, political leaders, public services, the private sector, and technical experts – to identify and implement solutions that permanently remove the barriers facing key and vulnerable populations. It will only be when the most vulnerable and marginalised individuals have unfettered access to the care they need, that health coverage can be considered truly universal, and only then, will the 2030 Sustainable Development Goals be realised.

5.

THE RECOMMENDATIONS

We All Have a Role to Play

1. INCREASE EFFECTIVE GLOBAL AND DOMESTIC INVESTMENT IN HEALTH

The evidence demonstrates that insufficient investment in health is curtailing progress against all global and national health targets: the TB, HIV and UHC declarations, the SDGs themselves, and national plans for the three diseases, and national health insurance. Investment in health is needed both in quantity and quality, to ensure that resources contribute directly to achieving targets in a way that key and vulnerable populations are the first to benefit, not the last. We therefore call on all stakeholders to work together to achieve this as follows:

RECOMMENDATIONS FOR NATIONAL GOVERNMENTS:

1. Commit to and achieve the target of at least **5% of GDP allocated to health** and achieving UHC, with a priority on achieving 2030 HIV, TB and malaria goals.
2. Mobilise **the political will and leadership to treat HIV, TB and malaria with the same urgency as COVID-19**, and allocate the necessary political and financial resources to end the three diseases as epidemics by 2030. This requires re-calculating national targets and re-estimating financial needs in the context of COVID-19 and losses experienced, then create or utilise effective fiscal mechanisms to mobilise the resources required.
3. Be bold in exploring **domestic financing options,** including progressive taxation, taxes on consumer items harmful to health, and negotiating debt-for-health agreements to increase resources available for investment in health.
4. Develop/strengthen national **health insurance schemes** that provide at least basic health care for all citizens and migrants in the country, with particular attention to meeting the needs of key populations to significantly reduce out-of-pocket expenses, especially for socially, economically and legally vulnerable communities and populations.
5. Develop clear, **unified plans and messaging** to mobilise a whole-of-government approach to directing and channelling national efforts and international assistance to achieving health targets.
6. Actively engage and **listen to representatives of affected key and vulnerable populations** in determining how resources should be used, and assign a portion of the budget for directly supporting community- and civil society-led initiatives.

RECOMMENDATIONS FOR BI-LATERAL DONORS

1. Meet the commitment of allocating **0.7% of GDP to ODA** to support low-income economies achieve faster, equitable growth; and hold each other accountable to meeting this commitment.
2. **Prioritise achieving global health targets** in international development plans, and integrate consistent support for health goals in all trade and other investments with the Asia-Pacific.
3. Use influence with Asia-Pacific governments to **hold them accountable** to investing new wealth into achieving SDGs 3.3 and 3.8.
4. In addition to bilateral assistance, **contribute to global health financing** facilities to ensure a fully resourced Global Fund, as well as increased commitments to Unitaid, and GAVI/COVAX.
5. Pursue mechanisms such as **debt relief to expand fiscal**[98] space in low-income countries, on the condition that debt repayments are invested in health.
6. Provide **technical assistance** to not only ensure that investments in health adopt and adapt proven global best practices, but to also strengthen domestic resource mobilisation efforts to invest in sustainable and resilient health systems and national health insurance schemes.
7. Increase meaningful efforts among donors to **coordinate investments** to support government priorities in a way that avoids duplication and omissions, and minimises administrative and transactional costs and time.

RECOMMENDATIONS FOR THE GLOBAL FUND

1. Continually broaden the scope for **budget flexibility** to respond to learnings and emergencies, with a focus on achieving global health targets, including UHC.
2. Ensure that at least 25% of country allocations is directed towards **community and civil society-led initiatives**.
3. Conduct and disseminate **research demonstrating the return on investment** for supporting community- and civil society-led efforts, and engaging representatives of key and vulnerable populations in decision-making processes.
4. Engage and **listen to national civil society in reviewing criteria to trigger transition planning**, to consider the needs of key and vulnerable populations before decisions are made to draw down investments.
   Ensure that groups and activities that are often neglected by domestic budgets remain supported.
5. Continue to ensure that civil society are well represented and influential on **country coordinating mechanisms**, and that civil society coordinating mechanisms receive adequate financial and technical assistance to ensure their effectiveness on the CCM.

RECOMMENDATIONS FOR TECHNICAL PARTNERS

1. Provide **technical assistance** to national governments to seek new and effective ways of mobilising domestic resources, based on experienced in other countries, while respecting government leadership.
2. Ensure that national plans are well grounded in **global best practices**, and well adapted to the needs of each specific country, and the different key and vulnerable populations within it.
3. Invest in strengthening the capacity of national partners not only to understand but to lead conversations regarding health planning and investments, and advocate in the international community for **national leadership**.
4. **Partner with local communities and civil society on research and evaluation efforts** to strengthen local capacity, ensure a local perspective, and to ultimately build community confidence and ownership over the decisions resulting from research and evaluations.

RECOMMENDATIONS FOR PRIVATE FOUNDATIONS

1. Contribute to, and use influence to advocate for more **investment in global health financing facilities**, particularly to ensure a fully resourced Global Fund.
2. Engage civil society in low- and middle-income countries to identify how additional resources can **complement the efforts of institutional donors** to fill gaps, and ensure that key and vulnerable communities are supported and heard in health responses.
3. Participate in donor coordination mechanisms and ensure that investments are complementary, while also **increasing the donor community's risk appetite** by being willing to provide assistance to mitigate risks.

RECOMMENDATIONS FOR THE PRIVATE SECTOR

1. Within the context of the business, **seek opportunities to influence financing decisions** in countries of operation or markets, and leverage supply chains, workforces, products, and communications to support national health agendas, in addition to providing financial assistance where possible.
2. Ensure that **workers in the Asia-Pacific have access to quality health care** in line with national standards, either through direct provision, or supporting national health insurance schemes. This includes ensuring that all migrant workers receive adequate health coverage.
3. Seek **public-private-community partnerships** with national governments and civil society to develop mutually beneficial health initiatives that contribute to lowering the cost of health care or improving health outcomes.

RECOMMENDATIONS FOR NATIONAL CIVIL SOCIETY

1. Work together to **strengthen our capacity and coordination** to effectively influence investment decisions, by presenting a united front with clear messages around how to achieve health targets in our country.
2. **Build our evidence base** to help guide investment decisions to ensure that our governments and donors are aware of how new investments can be best utilised to achieve targets from the perspective of the affected communities.
3. **Bring the voice of key and vulnerable populations** to the decision-makers to ensure that new investments take into account the human implications of these decisions.

RECOMMENDATIONS FOR GLOBAL CIVIL SOCIETY

1. **Lobby donor governments** to increase ODA contributions to meet the 0.7% of GDP commitment with a focus on investing more in health, and/or advocate for debt-for-health swaps.
2. **Hold donors and recipients mutually accountable** for achieving targets for the three-diseases, and UHC, by raising public awareness and creating sustained visibility and pressure.
3. **Support civil society** in low- and middle-income countries to advocate for a fully resourced Global Fund.
4. **Work in solidarity with communities and civil society** in low- and middle-income countries to amplify their voices in global forums, and strengthen their access and capacity to advocate for increased health financing at the global level.

2. STEP UP THE FOCUS ON EQUITY, HUMAN RIGHTS, AND GENDER TRANSFORMATION

All health responses, especially for communities and civil society living with, affected by and vulnerable to HIV, TB and malaria, should be human rights-based, people-centred, equity-focused, and gender transformative. For too long, legal or policy barriers, stigma and discrimination have created insurmountable barriers to health and well-being – particularly for the most vulnerable. We call on all stakeholders to work together to address national governments, donor countries and private sector and foundations in the following way:

RECOMMENDATIONS FOR NATIONAL GOVERNMENTS

1. **Decriminalise and reform all laws, policies and practices that impede access** – directly or indirectly – to HIV, TB and malaria health services of individuals and communities living with, affected by and vulnerable to three diseases, or civil society working on these issues.
2. Enact enabling laws and policies to **protect the right to health of key and marginalised communities** by facilitating open and transparent law and policy reform processes. Engage communities and civil society living with, affected by and vulnerable to three diseases throughout this process, and be willing to listen to them, and be held accountable to them.
3. **Address stigma and discrimination** against key and vulnerable populations throughout the health system – from policy makers to health care providers – to remove a key barrier to accessing quality care. This may start with policy, but must also include communication, training, and consequences for those found in violation. This can be leveraged as an entry point to addressing stigma and discrimination in the wider community, particularly by engaging local leaders and influencers.
4. **Review gender-based barriers to achieving UHC**, and work with civil society to address these barriers through both policy and practical measures.

RECOMMENDATIONS FOR DONORS

1. Advocate and provide financial assistance to national governments of the Asia-Pacific to **prioritise achievement of the UNAIDS 10-10-10 targets** as a mechanism for accelerating achievement of health targets.
2. **Provide technical assistance** to support the removal of punitive laws that criminalise key populations, and the expansion of supportive laws and policies to fight stigma, discrimination, gender-based violence, and gender inequity.
3. Consider **accepting national commitments** to removing legal or other non-financial barriers facing key populations in accessing quality health care, as government contributions/co-financing.
4. **Coordinate** among all donors to ensure consistent expectations in terms of respecting human rights and gender transformation, and demand accountability from national governments against indicators of progress towards equity.

RECOMMENDATIONS FOR THE GLOBAL FUND AND MULTILATERAL PARTNERS

1. Fulfil the **commitments to human rights and gender** enshrined in the new Global Fund Strategy 2023-2028.
2. Ensure that country allocation **budgets dedicate the resources required** to implement appropriate interventions to contribute to rights-based and gender-transformative processes and outcomes.
3. Provide **technical assistance** to ensure that governments and implementing partners have the necessary capacity to design, implement, monitor and evaluate the rights and gender aspects of their plans.
4. **Hold national governments and implementing partners accountable** to their rights and gender-related targets.

RECOMMENDATIONS FOR NATIONAL CIVIL SOCIETY

1. **Bring the voices of the key populations together** to demonstrate the impact of discriminatory policies and practices as part of advocacy for the reform of all laws and policies that criminalise or discriminate against vulnerable or marginalised individuals in a way that impedes their access to health care.
2. Engage with policy makers to **advise on appropriate policy**, and bring evidence to ensure that new policies are driven by data, and strengthen civil society's capacity to hold our governments accountable to implementing improved policies.
3. **Support the rollout** of new policies at the community level, including ensuring widespread awareness among community leaders, health care workers, and key and vulnerable individuals themselves.

3. PRIORITISE COMMUNITY SYSTEMS STRENGTHENING

Recognising the vital role played by communities and civil society across the world in responding to COVID-19 reveals an opportunity for accelerating progress towards health goals. Community systems must be sustainably supported in order to be strengthened as a key element of sustainable and resilient systems for health. The public and private sectors alone cannot meet all needs – particularly those of key and vulnerable populations, and the community is best positioned to provide appropriate, consistent, and quality services, while also ensuring that public and private services are held accountable to the community itself. This includes ensuring that the community is organised, that civil society is thriving, and that key activities, such as community-led monitoring, are supported. Civil society needs to have the legal protection and assistance to meaningfully engage in health responses as service users, service providers, decision makers and collaborators as an inherent aspect of effective health responses. We therefore call on diverse stakeholders as follows:

RECOMMENDATIONS FOR NATIONAL GOVERNMENTS

1. Recognise the unique role of communities and civil society as partners, advisors, and service providers, in the three disease responses, and **provide the platform, respect and time they deserve as equal partners** in achieving shared health goals. This includes working with civil society to research, design, implement, evaluate, and communicate on health programming.
2. Create/improve and facilitate legal, policy and fiscal mechanisms to sustain and increase **community-led health services delivery** – including, but not limited to community health workers – and community-led monitoring of health services within national health responses for the three diseases.

3. **Protect and promote civic spaces, and enabling supportive environments** for civil society engagement and inclusion in health responses including for key and vulnerable communities.
4. **Encourage local governments to support community system strengthening** efforts and establish and support community-level partnerships. This includes ensuring that community-level dialogue, information sharing, and feedback is taking place over local efforts to achieve national health targets.

RECOMMENDATIONS FOR BILATERAL DONORS

1. Increase investment in new and expanded financing channels specifically for civil society, community-based, and community-led organisations to strengthen community systems. This should include **supporting networking and capacity building** for networks of communities and key populations to develop and implement community-based and community-led HIV, TB and malaria interventions, as well as assistance for capacity building, evidence gathering, partnerships and advocacy, as well as providing institutional and operational support.
2. Ensure that some **resources are allocated directly to civil society** to engage and directly support affected key and vulnerable populations.
3. Leverage influence to **support governments and civil society to work together** at the regional and national level to develop and implement specific activities into national strategic plans for the three responses and efforts towards UHC.

RECOMMENDATIONS FOR THE GLOBAL FUND AND MULTILATERAL PARTNERS

1. Fulfil the commitments "to **maximise the engagement and leadership of affected communities**, to ensure that no one is left behind, and that services are designed to respond to the needs of those most at risk," including full engagement of civil society, as expressed in the new Global Fund Strategy 2023-2028.[99]
2. Ensure that country allocation **budgets dedicate the resources required** to adopt community-engagement approaches and community systems strengthening.
3. **Coordinate** across all donors to ensure a shared commitment to the centrality of community leadership and strengthening, making the necessary political, technical and financial resources available.
4. Ensure that national and regional civil society organisations and networks have access to **institutional support**, the opportunity to continue strengthening their technical and operational capacity, and the forums to meet and to share and learn from each other.
5. **Hold national governments and implementing partners accountable** to their committments to participation and inclusion.

RECOMMENDATIONS FOR CIVIL SOCIETY

1. Ensure that we are consistently working with **competence and integrity** to demonstrate the effectiveness of strong community systems. This includes working together in the spirit of cooperation in the best interests of the communities and populations we serve and represent.
2. Strive to continually **strengthen our knowledge** on the three diseases and UHC, and our skills to analyse and advocate, and bring effective and creative solutions to the table in the service of those we represent.
3. Continually **gather and disseminate evidence**, our successes and lessons learned to advocate for further investment in CSS, and to support the learning of other communities.

PARTING WORDS

The research undertaken in India, Indonesia, Sri Lanka and Vietnam represent four snapshots from a diverse region of how the Asia-Pacific is falling behind in achieving critical health targets. While COVID-19 has reversed gains and stalled progress, it is also clear that the challenges to overcome go beyond a pandemic, but relate to the legal environment, discriminatory attitudes, political will, cooperation between sectors, and most importantly – financing.

While the goals that our governments have committed to are ambitious, and while there have been setbacks, this document has attempted to spur us on in the spirit of partnership and with a sense of urgency to reflect on where we are, where we are going, and what we need to get there. This research will inform GFAN AP's continued efforts to advocate for a fully resourced Global Fund, and to ensure that the Global Fund and other donors work in partnership alongside implementing country governments, communities that are affected by and/or vulnerable to the three diseases, civil society, and the private sector. It will only be with a clear and shared vision of the increased investment needed, and how those additional resources must be directed, that will be able to get the region back on track to achieving the three disease targets, and working towards a UHC that leaves no one behind.

INDIA COUNTRY SNAPSHOT

POPULATION	**2020:** 1.38 Billion
PER CAPITA INCOME	**2019:** USD 2,100 (World Bank) **2020:** USD 1,900 (World Bank)
GDP INVESTMENT IN HEALTH	**2018:** 0.9% of GDP **2019:** 1.2% of GDP **2020:** 1.1% of GDP[1]
OUT-OF-POCKET COSTS	62.6% of health expenditure in 2018[2]
SDG INDEX SCORE	**2019:** 61.10 **2020:** 61.92 **2021:** 60.07
SDG PROGRESS	
RESOURCE GAPS FOR NATIONAL HIV, TB AND MALARIA RESPONSES	• In 2021, India had a 42% shortfall in the investments needed to support the HIV National Strategic Plan for 2017-2024. • Despite the India Joint Monitoring Mission of Revised National Tuberculosis Program recommending increased funding in 2019, the National Tuberculosis Elimination Program's budget decreased sharply in 2019-20. An estimated USD 4.46 billion (INR 24,092 crores) will be required from 2021 to 2023-2024. • While the budget allocation to the National Vector Borne Disease Control Programme recently increased, there remains a budget gap to meet the Malaria National Strategic Plan (NSP) requirement for 2017-2022 of USD 1.97 billion (INR 10,653 Crores).
HIV	An intermediate goal of the HIV NSP (2017-2024) was a 75% reduction in new HIV infections by 2020, along achieving the 90-90-90 targets. However, in 2019, out of the 2.35 million people living with HIV in India, only 76% were aware of their HIV status, 63% were on Antiretroviral Therapy (ART) and 53% were virally suppressed.
TB	With an estimated incidence of 2.69 million cases in 2019 and the highest-ever notification of 2.4 million cases in 2019-2020,[3] India recorded the biggest contribution to the global increase in TB in 2020. India's case notification has been consistently improving since 2017-2018. While the 12% annual increase over the last three years is encouraging, India is 50% short of achieving the NSP's TB notification target of 3.6 million new notifications by 2020.
MALARIA	India accounted for 88% of malaria cases and 86% of malaria deaths in the WHO South-East Asia region in 2019. At the same time India contributed to the largest drop in cases region-wide – from approximately 20 million to about 6 million.[4]

[1] https://www.statista.com/statistics/1247848/india-government-healthcare-expenditure-as-a-share-of-gdp/.
[2] https://www.indiabudget.gov.in/economicsurvey/.
[3] India TB report 2020, accessed at https://tbcindia.gov.in/showfile.php?lid=3538.
[4] World Malaria Report 2020, WHO.

INDIA COUNTRY SNAPSHOT

PROGRESS AND STRENGTHS	• India has seen major improvements across the three diseases, particularly in averting malaria incidence. • The 2018 Delhi End TB Summit for the Elimination of Tuberculosis by 2025 indicated the Government of India's commitment to ending TB. • India's USD 22 million pledge to the Global Fund Sixth Replenishment in 2019 demonstrated India's commitment to global health and solidarity. • India's strong community and civil society systems proved their effectiveness during the COVID-19 response, providing lifesaving medicine, testing, prevention tools, care and support were to those who affected by and vulnerable to the three diseases.
CHALLENGES	• Health coverage in India remains low, as a result of its chronically low level of public health spending. • Continued high (60%) out-of-pocket expenses means that UHC remains a distant reality. • Major financial gaps for the three diseases will prevent India from achieving 2025 and 2030 goals. • Human rights violations increased during COVID-19, including the aggravation of existing gender inequalities.
RECOMMENDATIONS	1. The Government of India should invest in **community system strengthening (CSS)** to enhance community leadership and ownership. Health programmes and projects must be designed, led, and managed by community-based organisations, and include key populations, such as PLHIV, with UNAIDS support. 2. The Government of India should **increase domestic financing** for health from 1.2% of GDP to 2.5%, as promised. 3. The Government of India should sustain and increase its **focus on prevention** of HIV, TB, and malaria, and COVID-19. 4. The Government of India should demonstrate the effectiveness of the Global Fund partnership through an increased and early pledge to its **Seventh Replenishment**. 5. The **Global Fund** should to continue to invest in India beyond 2025, despite the transition requirements.

INDONESIA COUNTRY SNAPSHOT

POPULATION	**2020:** 273.5 million
PER CAPITA INCOME	**2019:** USD 4,125 (World Bank) **2020:** USD 3,869 (World Bank)
GDP INVESTMENT IN HEALTH	**2017:** 2.87% of GDP **2018:** 2.87% of GDP **2019:** 3.0% of GDP[1]
OUT-OF-POCKET COSTS	34.8% of health expenditure in 2018[2]
SDG INDEX SCORE	**2019:** 64.2 **2020:** 65.30 **2021:** 66.34
SDG PROGRESS	
RESOURCE GAPS FOR NATIONAL HIV, TB AND MALARIA RESPONSES	• The estimated HIV funding shortfall is USD 55.2 million for 2022–2023, and USD 58.4 million in 2024. Around 72% of the 2022-2023 gap includes outreach to marginalised communities, addressing human-rights barriers to HIV services; and community system strengthening (CSS), including community-based and -led monitoring. The resource gap for CRG and CSS alone is USD 23.7 million, or 43% of the funding gap. • The estimated funding gap for community participation in TB is USD 123.7 million for 2022–2023. Total community resource needs for 2024 are estimated at USD 58.4 million. The TB request to the Global Fund for 2022–2023 includes minimal support for CRG and CSS interventions: 2.7% for 2022, and 1.8% in 2023. • The largest funding gap for community and civil society engagement is within the malaria programme, with an estimated gap of USD 87.6 million for 2021–2023, including USD 37.1 million for 2023 alone. The 2021–2023 malaria request to the Global Fund did not include any funding for CRG interventions. Estimated funding needed for malaria programmes for 2024 amounts to USD 41.5 million.
HIV	In 2020, 540 000 people were living with HIV in Indonesia, of whom 66% were aware of their HIV status and 26% on ART. No data is available on viral suppression.
TB	In 2020, Indonesia recorded a TB incidence of 824,000. Only 47% were receiving treatment, 38% faced catastrophic total costs for TB treatment. There were 282,951 missing people with TB in 2020, of whom 71,908 were children. An estimated 24,000 people have developed Drug Resistant TB (DR-TB).
MALARIA	Indonesia has the second highest number of malaria cases in Asia (after India) according to the World Malaria Report 2020. Despite a declining number of malaria cases between 2010-2014, cases stagnated between 2014-2019. About 86% of malaria cases occurred in Papua Province 2019. Around 58% of the population now live in elimination areas, and 78% live in malaria-free areas.

[1] https://www.statista.com/statistics/780514/health-expenditure-share-of-gdp-indonesia/.
[2] *ibid*.

INDONESIA COUNTRY SNAPSHOT

PROGRESS AND STRENGTHS	• Civil society and United Nations outreach activities contributed to more key affected populations being tested for HIV. CSO-led initiatives for PLHIV in 147 districts in 27 provinces showed impressive results in terms of successfully identifying PLHIV (76%), HIV testing (62%), and finding cases (29%). • Domestic financing constitutes 69% of HIV programme spending currently. • Programmes to reduce human rights-related barriers to HIV services and CSS will be prioritised in 100 districts under the new Global Fund proposal, including expanding interventions in 77 districts with at an additional budget of USD 29 million for 2022–2023. • Communities and civil society engagement in malaria and TB responses have contributed significantly to the progress in both diseases.
CHALLENGES	• Despite high HIV prevalence among key populations in Indonesia, testing rates are low, and the positivity yield from outreach activities remains stagnant. • Cost allocations for programmes to reduce human rights-related barriers to HIV services and CSS for the 2022–2023 period decreased from 16% in 2019 to 9% for year 2022. • The human rights conditions of key and vulnerable populations to the three diseases in Indonesia, including women and girls, men who have sex with men (MSM), sex workers, transgenders (TG), and people who use drugs (PWUD) remains dire. The Global Fund baseline assessment in 2018 concluded that female sex workers, MSM, TG individuals, PLHIV, people affected by TB, PWUD, prisoners, and women and children were most affected by human rights-related barriers to HIV and TB services. • There is a funding gap for community participation in the TB response amounting to an estimated USD 203.4 million for 2021–2023. Estimated resource needs for 2024 are US$77.6 million.
RECOMMENDATIONS	1. **Increase financing:** The GoI should gradually increase its GDP allocation for health from 3% (in 2019) to at least 5% by 2030, ensuring that this includes sufficient funding HIV, TB and malaria responses, including for community and civil society engagement. In the context of the Global Fund Seventh Replenishment in 2022 and the GoI 2025–2029 strategic planning cycle, communities affected by or vulnerable to HIV, TB and malaria should advocate for increased domestic and international financing for more CSS and CRG in the three disease responses. 2. **Manage COVID-19 impact:** Future strategies addressing HIV, TB and malaria in Indonesia need to address the impacts of COVID-19 on existing interventions, and community and health systems. Sustainable and predictable domestic financing is needed to protect gains achieved so far, and to ensure that national HIV, TB and malaria targets are met. 3. **Community engagement:** The MoH, Country Coordinating Mechanism (CCM) and its working groups, Ministry of Finance, and Global Fund Country Team, should reprogramme existing and future Global Fund grants to facilitate community engagement in HIV, TB and malaria programmes, and in country-level UHC mechanisms, including community-based and -led monitoring. 4. **Address CRG issues:** National strategic plans for HIV, TB and malaria should prioritise addressing CRG and legal barriers in order to achieve national HIV, TB and malaria targets and international commitments, including the 2030 Agenda and SDGs. 5. **Enabling environment:** Partnerships, collaboration and coordination should be strengthened among the ministries of Health, Finance, Development Planning, Women's Empowerment, Law and Human Rights, and Home Affairs in order to ensure a multi-faceted socio-economic approach that creates an enabling environment for key and vulnerable populations to end the three diseases in Indonesia. 6. **Fund civil society:** The government must channel more funds to CSOs. A pilot initiative in 23 districts had been included in the 2022–2023 Global Fund HIV Funding Request, which must be supported by all as an opportunity to gather evidence and “get the ball rolling”. 7. **Mobilise the C20:** Civil society representing communities affected by and vulnerable to the three diseases in Indonesia and other G20 countries should work through the Civil 20 (C20) to advocate for the reprioritisation of HIV, TB and malaria in the G20 health agenda, particularly given that Indonesia will host the G20 presidency in 2022. 8. **Strengthen the investment case:** Use continually emerging data to develop a stronger case and more accurate estimates on returns on investments to calculate the resources needed to support a medium- and long-term strategy for predictable, sustainable, and meaningful involvement of communities and civil society in the health response of Indonesia.

SRI LANKA COUNTRY SNAPSHOT

POPULATION	**2020:** 21.92 million
PER CAPITA INCOME	**2019:** USD 3,852 (World Bank) **2020:** USD 3,682 (World Bank)
GDP INVESTMENT IN HEALTH	**2016:** 1.6% of GDP **2017:** 1.6% of GDP **2018:** 1.5% of GDP[1]
OUT-OF-POCKET COSTS	50.6% of health expenditure in 2018[2]
SDG INDEX SCORE	**2019:** 65.80 **2020:** 66.88 **2021:** 68.10
SDG PROGRESS	
HIV	Sri Lanka has a low HIV prevalence at 0.02 HIV positive people per 100,000 population (0.01 per 100,000 blood donors and 0.003 among pregnant women). The HIV epidemic is currently concentrated among KP groups with an overall positivity rate of 0.5%. The positivity rate of MSMs is 1.3%, and 0.4% for transgender women (TGW). HIV prevalence among female sex workers (FSWs) is 0.1 per 100 000 population. As of the end of 2020, there were 3,994 people reported as living with HIV, and 566 AIDS related deaths. The male to female ratio of HIV cases reported in 2020 is 4.4:1.[3]
RESOURCE GAPS FOR NATIONAL HIV RESPONSE	• Expanding HIV prevention services targeting key populations requires approximately an additional LKR 20 to 30 million (USD 100,000 to USD 150,000) per year until 2030. • To support the CRG interventions required to achieve 2030 targets, an additional allocation of approximately LKR 35-37.5 million (USD 174,000 to USD186,000) annually for eight years, in addition to a one-off LKR 280,000,000 to 300,000,000 (USD 1.4 – 1.5 million) investment to support communications addressing community, rights and gender issues for key populations. • To ensure that key population communities have access to services, are knowledgeable and informed of HIV risks, and regularly check their HIV status, the country will need to additionally invest approximately LKR 279,197,000 (USD 1,395,985) – LKR 313,602,600 (USD 1,568,013) each year for at least another eight years, plus a one-time investment of LKR 300,000,000 (USD 1.5 million) to ensure that Target 1 (90-95% know their HIV status) is achieved – a total investment of LKR 2,533,576,000 (USD 12,667,880) – LKR 2,808,820,800 (USD 14,044,104). • To reach the 90%/95% of the target on percentage of PLHIV on treatment, investment needs to increase by LKR 118,242,694 (USD 591,213) – LKR 140,566,402 (USD 702,832) respectively over the next eight years. • To ensure that 90%/95% of the people living with HIV on treatment are virally suppressed, additional allocations of LKR 3,312,000 (USD 16,560) to LKR 5,449,500 (USD 27,248) are required. • To ensure adequate community systems to reach 2030 targets, an additional LKR 704,118,502 (USD 3,520,593) is required per year for a period of eight years.

[1] https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=LK.

[2] *ibid*.

[3] HIV/AIDS Surveillance Report for end of Quarter 4, 2020 from NSACP website, https://www.aidscontrol.gov.lk/images/pdfs/hiv_data/quarter_report/HIV-4th-Q2020new.pdf.

SRI LANKA COUNTRY SNAPSHOT

PROGRESS AND STRENGTHS	• In 2020, only 70% of people living with HIV in the country knew their status and of those, 83% were on antiretroviral treatment. Among that group, 91% were virally suppressed, being the only one of the three 90% targets reached. • No new cases of mother to child transmission were reported after 2017 due to the introduction of the elimination of the mother to child transmission programme (EMTCT) in 2016. More than 90% of all pregnant women are screened for HIV at an early stage, and 100% of PLHIV mothers benefit from treatment. • Approximately 60% of the annual HIV budget is financed by the Government of Sri Lanka. Since 2006, antiretroviral drugs are purchased solely by the Ministry of Health showcasing the commitment of the government to finance the country's response.
CHALLENGES	• Sri Lanka's government health spending as a share of GDP is relatively low by regional standards and is currently constrained by low government revenue. Out-of-pocket spending accounts for about 40% of total health expenditures. • Major gaps remain in terms of additional resources required to achieve 90.90.90 and 95.95.95 targets. With Global Fund potentially transitioning out of Sri Lanka from 2025, there is a risk the national HIV response will be underfunded and key and vulnerable communities will be left behind. • The legal and policy environment, including the human rights situation for key populations in the country, is not conducive to an effective HIV response. Criminalising laws and policies still continue to drive away key and vulnerable populations from accessing sexual health services. • As revealed by the Transition Readiness Assessment 2020 of Sri Lanka, stigma and discrimination by health care workers and other service providers, and legal and human rights related barriers prevent many key population members from reaching out to HIV prevention and care services provided by STD centres and those provided via key population intervention groups. • Community Systems Strengthening (CSS) remains significantly challenged within the HIV response in the country. The NSP of the NSACP does not specify any strategic intervention to build community systems or to strengthen them. A major challenge is channelling public funds for CSS to CSOs in the context of Global Fund transition.

VIETNAM COUNTRY SNAPSHOT

POPULATION	97.34 million
PER CAPITA INCOME	**2018:** USD 2,566.4 (World Bank) **2019:** USD 2,715.2 (World Bank) **2020:** USD 2,785.7 (World Bank)
GDP INVESTMENT IN HEALTH	**2016:** 2.6% of GDP **2017:** 2.7% of GDP **2018:** 2.6% of GDP[1]
OUT-OF-POCKET COSTS	44.9% of health expenditure in 2018[2]
SDG INDEX SCORE	**2019:** 71.10 **2020:** 73.80 **2021:** 72.85
SDG PROGRESS	
RESOURCE GAPS FOR NATIONAL HIV, TB AND MALARIA RESPONSES	The Global Fund remains a major contributor to the three disease responses, contributing USD 574.35 million since 2003 (mostly for HIV: USD 241 million, followed by TB: USD 162 million, then malaria: USD 63 million). USD 62 million has been invested in resilient and sustainable systems for health. Out-of-pocket expenditure currently accounts for almost half of total healthcare expenditure. Domestic resources for HIV are set to increase, however, from 74.6% in 2021 to 97.2% in 2030, although targets for TB and malaria are not as ambitious (and these targets have not been revised since prior to the COVID-19 pandemic). COVID-19 resulted in temporary reductions in budget expenditure due to restrictions limiting activity implementation. The economic impact of COVID-19 also affected some people's ability to pay their social health insurance (SHI) premiums, reducing domestic financing available for health care. In some cases, civil society organisations stepped into cover some bills for vulnerable populations.
HIV	By June 2020, it was estimated that 250,000 people are living with HIV in Vietnam with an estimated 10,000 new cases detected each year. Vietnam has reduced the transmission rate by 50% since 2010, and the HIV epidemic is concentrated among key populations, including people who inject drugs (PWID), female sex worker (FSW), and men who have sex with men (MSM), with prevalence rates of 12.7% (2019), 3.1% (2020) and 13.25% (2020), respectively. The rate of HIV transmission from mother-to-child remains at 6%.
TB	Although TB-related mortality declined remarkably in recent years, Vietnam is still ranked eleventh among 30 high TB burden countries, and multi-drug resistant TB (MDR-TB) burden countries globally. In 2019, it was estimated that 9,400 deaths occurred due to TB, with an incident rate of 176 per 100,000 population. The estimated prevalence of bacteriologically confirmed adult pulmonary TB was 322 (95% CI: 260–399) per 100,000, compared to equivalent 307 prevalent cases per 100,000 population in 2006-2007 survey.

[1] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=VN.
[2] *ibid*.

VIETNAM COUNTRY SNAPSHOT

MALARIA	Vietnam reported no malaria-related deaths in 2019, and the total number of malaria cases dropped from 19,252 cases (0.21 cases per 1,000 population) in 2015 to 5,887 cases in 2019 (0.06 per 1,000). Despite this success, malaria epidemiology remains complex, varying by location and population group. Intense malaria transmission is largely restricted to hilly, forested areas in southern and central provinces where malaria transmission tends to be perennial with a season peak in December through February.
PROGRESS AND STRENGTHS	• The Government of Vietnam has invested substantially in hospitals, health centres, and human resources in recent years. In 2019, 87.2% of people enjoyed UHC in Vietnam via its SHI scheme, which subsidises vulnerable groups such as the poor, ethnic minorities, children under six, and the elderly (above 80 years of age). • HIV-related deaths in Vietnam decreased by 21.8% between 2007 and 2017. HIV prevalence among key populations, except for MSM, has decreased steadily since 2005. For 73% of patients on ART who received a viral load test in the last 12 months, viral load suppression is 92%. • Although Vietnam's TB burden remains high, TB-related mortality has decreased annually by an average of 4.6%, prevalence by 4.4% and incidence by 2.6% since 1990. An estimated 81% of people living with TB have been diagnosed and enrolled on treatment, and the treatment success rate among this group is 91%. • Vietnam is entering the pre-elimination phase for malaria. Between 2013 and 2017, confirmed malaria cases decreased from 17,128 to 4,548.
CHALLENGES	• Vietnam's state budget is relatively low due to poor income tax compliance, weak property tax levies, and high international debts with government debt to GDP at 46.7% in 2020, up from 43.5% in 2019. • Although catastrophic health expenditure (defined by health spending exceeding 40% of non-subsistence household spending) has fallen, out-of-pocket payments for health remains high at 41% of total expenditure. • The reduction in the AIDS epidemic is considered insufficient and unsustainable as the number of newly diagnosed cases continues to rise in some regions, particularly in mountainous and hard-to-reach areas. High mortality and morbidity levels continue due to high costs as a result of limited and delayed access to Antiretroviral Therapy (ART), and limited treatment for patients with co-morbidities (such as TB and Hepatitis C). • Despite recent success in reducing TB mortality, Vietnam was still classified as a high-burden country for TB and MDR-TB by the WHO in 2016–2020. The increasing number of cases MDR-TB poses a significant challenge to achieving the SDGs for TB control. • While malaria decreased from 280 cases per 100,000 persons in 1991 to 30 cases in 2014, the prevention and control programme continued to be challenges by increasingly drug-resistant parasites and chemical resistant mosquitoes.
RECOMMENDATIONS	1. **Financing:** National and local authorities need to maintain, if not increase funding for HIV, TB and malaria programming, particularly to ensure that (a) key populations receive subsidies through national insurance, and (b) civil society is supported to reach and support vulnerable and marginalised populations, including flexible cash transfers to contribute food security and livelihood support. 2. **Human resources:** Ensure that HIV, TB and malaria health staff remain available during the COVID-19 pandemic by re-arranging regular staffing arrangements, and engaging civil society and community-based health-care workers to ensure service continuity. 3. **Infrastructure and supply:** Provide key populations with critical supplies including nutrition products, food, personal protective equipment, and sanitisers to contribute to maintaining health, and support civil society to facilitate communication and supplies. 4. **Information and knowledge:** Work with civil society to effectively use social media to better inform the public – particularly vulnerable communities – on key health messages, particularly during the COVID-19 pandemic, regarding prevention, appropriate treatment seeking behaviour, and any changes related to service provision. 5. **Governance:** Ensure that Vietnam's decentralised governance does not result in delays in information or service provision, and that provincial funding commitments are appropriate to local needs. Decisions should be made in partnership with civil society at each level. 6. **Service delivery:** Scale-up innovative service delivery models, including telehealth and virtual-based service delivery, which is providing to be effective in HIV in Vietnam, including by civil society service providers, and boosting peer-based service delivery to reach marginalised populations.

ENDNOTES

1 United Nations General Assembly, 2019, "Political Declaration of the High-level Meeting on Universal Health Coverage "Universal health coverage: moving together to build a healthier world", 74th Session of the United Nations General Assembly: New York, September. https://digitallibrary.un.org/record/3833350.

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