India Investment Case

2021

India Working Group

IPPF International Planned Parenthood Federation
South Asia Region

NCPI+

Global Coalition of TB Activists

Table of Contents

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Abbreviations

API	Annual Parasitic Incidence
ART	Antiretroviral Therapy
CAG	Comptroller and Auditor General of India
C19RM	COVID-19 Response Mechanism
CBO	Community Based Organizations
CHE	Catastrophic Health Expenditure
CSO	Civil SocietyOrganization
CSS	Community System Strengthening
DOT	Directly Observed Therapy
GDP	Gross Domestic Product
GFAN	Global Fund Advocates Network
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HBHI	High Burden to High Impact
IIC	India Investment Case
IWG	India Working Group for Health Advocacy
MDR	Multi-Drug resistant
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NTEP	National Tuberculosis Elimination Programme
NVBDCP	National Vector Borne Disease Control Programme
OI	Opportunistic infections
OOP	Out-of-pocket
PLHIV	People Living with HIV
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPE	Personal Protective Equipment
RNTCP	Revised National Tuberculosis Control Programme
RR	Rifampicin Resistant
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable Development Goal
TB	Tuberculosis
UHC	Universal Health Coverage

Executive Summary

The complex relationship between gender and health equity across the domains of social determinants, health behaviours, and health-system responses are important for progress on the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC). Since 2017, India made slow progress on SDGs with some improvements in fulfilling its commitments to health and gender equality. Low public spending on health and high private out-of-pocket (OOP) spending continue to be a cause of concern for India in its journey towards UHC. External funding and contributions of multi-national health financing facilities such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) for sustainable development are therefore essential in the Indian context.

One of the largest investors globally in health, the Global Fund has disbursed more than US$44.9 billion as of April 2020 in the fight against HIV, TB, and malaria and to strengthen the health systems since its inception in 2002. The Global Fund raises funds in multi-year cycles known as Replenishments, and the Investment Case for the Sixth Replenishment of the Global Fund for the allocation cycle 2020 – 2022 called for a minimum of US$14 billion in stepping up the fight against the three diseases. India remains one of the largest implementers of Global Fund grants and demonstrates a shared commitment towards the fight against HIV, TB, and malaria. For the Sixth Replenishment of the Global Fund, India pledged US$22 million and has contributed a total of US$ 60.5 million since 2006. Given eligibility requirements, economic growth, and reduction of disease burden, there have been discussions on the possibility of Global Fund transitioning from India, despite the acute need for external funding as well as technical support especially in light of the COVID-19 pandemic.

Therefore, this document, developed by the India Working Group for Health Advocacy (IWG), provides context-specific, strategic, and financial needs necessary to respond to uncertainties emerging from the COVID-19 pandemic to strengthen health and community systems (particularly placing communities at the centre) to deal with the burden of the three diseases through increased and sustainable domestic investments in health and better-nuanced funding for and from the Global Fund.

Recognized as the worst public health and economic crisis in a century, the COVID-19 pandemic has disrupted the SDGs and UHC trajectory globally and nationally. It reemphasized inter-connectedness of responses through partnerships of international agencies, domestic governments, communities, and civil society. In the Indian response to COVID-19, the importance of community support systems, and strengthening of the health system was highlighted. India's response to the pandemic reiterated a serious threat to the fragile and struggling health system of India with a low level of health expenditure. Active and enhanced community leadership and involvement of the Global Fund is critical to combat COVID-19 and defeat interconnected epidemics of HIV, TB, and Malaria, and for a resilient and sustainable system for health (RSSH). Sustained domestic investment and support from the Global Fund must continue as India requires exceptional support amidst the unprecedented crisis of multiple reinforcing epidemics.

In July 2019, the IWG developed the India Investment Case[1] which called for the collective action needed to end AIDS, TB, and Malaria as epidemics in achieving the SDGs and UHC. This Investment Case thus reflects on the health and development landscape given the impacts of the COVID-19 pandemic for a strengthened case and calling for stronger and increased commitments made by India in achieving UHC and ending the three diseases as epidemics.

Accordingly, the IWG after a series of community consultations, desk review of key literature, and analyses of domestic and external health investments, advocates Indian parliamentarians and bureaucrats, and the Global Fund and its donors for:

a) Increased focus on disease prevention of the four interconnected diseases;
b) Investment in enhanced community leadership and ownership through community system strengthening;
c) Doubling of domestic investment in health from 1.2% of GDP to 2.5%;
d) Increased investment in the Global Fund; and
e) Continued investment of the Global Fund in India beyond 2025.

1. India Investment Case, July 2019.

1. Sustainable Development Goals

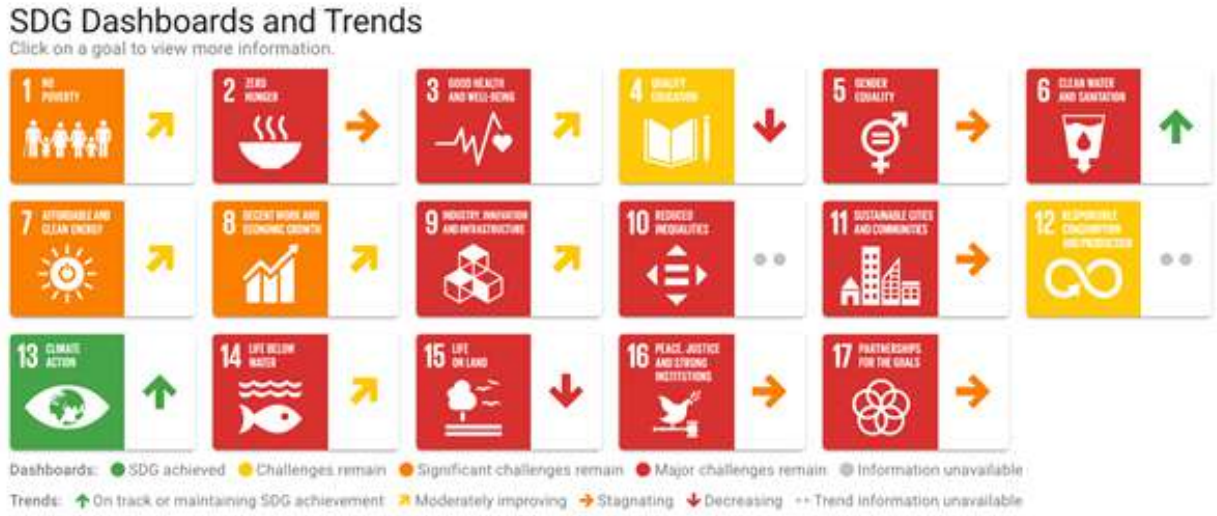
The 2030 Agenda for Sustainable Development – a shared blueprint for peace and prosperity for people and the planet was adopted by all United Nations Member States in 2015 - offered a call for action by all countries for 17 Sustainable Development Goals (SDGs) to be fulfilled through a global partnership. The goals recognized the importance of ending poverty and other deprivations along with strategies for a) progress in the areas of health and education, b) reduction in inequality, c) increase in economic growth, d) tackling climate change, and e) preserving our oceans and forests.

Of the 17 goals, the third goal (SDG3) calls for healthy lives and promotes well-being for all ages. Among the 13 indicators of SDG 3, indicator 3.3 refers to 'ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030. Additionally, among others, SDG 5 which is to achieve gender equality and empower all women and girls and SDG 10 which is to reduce inequality within and among countries are also important goals as given interlinkages with SDG 3.

It is important to unpack, globally as well as nationally, the complex relationship between gender and health equity across the domains of social determinants, health behaviours, and health-system responses for progress across all SDGs, and not just SDG 3, 5, and 10.

1. 1. SDG in India

India recognized the 2030 Agenda for Sustainable Development in 2015 and reiterated its commitment through its regular mandated and voluntary reviews to monitor and guide the progress. It has not only converged the national development agenda with that of the SDGs but has also involved different levels of governments and non-government players, like civil society, key and vulnerable communities, and the private sector in the adoption of goals and objectives, implementation of activities towards meeting them and evaluation thereof.



With an overall SDG index score of 60.1 India slipped three places in the SDG rankings of the United Nations from 117 in 2020 to 120 in 2021[2]. Major challenges remain across the majority of the SDGs, including SDG 3, SDG 5, and SDG 10 despite moderate improvements only in SDG 3 where India has shown some improvements in fulfilling its commitments to health with under-five mortality rate declining from 125 per 1,000 live births in 1990-91 to 34 in 2019 (against a target of 25 by 2030), and its maternal mortality rate declining from 212 per 100,000 live births in 2007-09 to 113 in 2016-18 (against a target of 70 by 2030). Specific indicators on HIV and TB also showed that incidence for TB was stagnating and that no trend information was available for new HIV infections and Universal Health Coverage (UHC) index of service coverage was only moderately improving.

In addition, with one-third stunted children and more than half of its women anaemic, India is severely lagging in the connected goals around hunger (Goal No. 2). Similarly, India also fares poorly in the area of gender equality (Goal No. 5) with one in three women experiencing violence in their lifetime.

2. The UHC Agenda and Domestic Health Financing in India

Established in 2016, the International Health Partnership for Universal Health Coverage 2030 (UHC2030) monitors and guides partner countries in their journey towards UHC. After multi-stakeholder consultations in 2019, the UHC2030 developed core requests for governments and political leaders to act on UHC. These are known as "Key Asks from the UHC movement". Out of the seven asks, an important key ask is for increased and better investments in health. Acknowledging the need for improving efficiency and equity in the use of existing resources and for reducing reliance on impoverishing out-of-pocket (OOP) payments, the movement calls upon all national governments to adopt ambitious investment goals for UHC by 2023 and make progress in mobilizing domestic pooled funding and reduce catastrophic OOP health expenditure. This is important given that despite being one of the economic powerhouses of the world, India has one of the highest proportions of OOP health expenses leading to Catastrophic Health Expenditure (CHE).

While India's total per capita income nearly quadrupled in two decades between 2000-2018, per capita health expenditure in India only tripled over the same duration. While India's Gross Domestic Product (GDP) increased, its overall public spending has not changed much and remained close to one-fourth. Similarly, the total health expenditure as a proportion of GDP declined from approximately 4% to 3.5%, with a continued low share of public spending. According to the national health profile 2019, India spends only 1.28% of its GDP (2017-18 BE) as public expenditure on health – a marginal improvement over 1.12% in 2009-10.

Responding to the situation, the National Health Policy 2017 provided three health financing-related goals viz. a) Increase health expenditure by Government as a percentage of GDP from the existing 1.15% to 2.5 % by 2025, b) Increase state sector health spending to more than 8% of their budget by 2020, and c) Decrease in the proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025[3].

2. Source: https://dashboards.sdgindex.org/rankings. Accessed 6th September 2021.
3. National health Profile 2019

Health coverage in India remains low, given its chronically low level of public health spending. The revised budget estimates of 2020-21 were Rs 829,280 million[4] indicating that India's public health expenditure stayed at 1.1% of GDP in 2020-21. The latest budget of the Ministry of Health and Family Welfare, presented in the backdrop of the COVID-19 pandemic, has an allocation of Rs 739,320 million for 2021-22 period[5 6]. This is a meagre 7% increase over actual expenditure made in 2019-20. These additional resources are presumably allocated and/or diverted to the COVID-19 response and not towards strengthening the overall health system and the three diseases.

A significant challenge in attaining UHC in India lies with the financial burden of healthcare on the majority of Indians relying on OOP expenditure. Despite having a nationwide health insurance scheme – Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) which was approved in 2018 and was hailed as a historic step towards achieving UHC, India yet faces overwhelming challenges because of COVID-19.

In 2020 alone, the economic recession caused by the COVID-19 pandemic pushed 75 million more people in India into poverty and accounted for nearly 60% of the global increase in poverty in 2020 who live on US$2 or less daily[7]. The Economic Survey 2020-21 observed that the overall OOP expenses in India on healthcare is 60% of the total expenditure on public health. Looking at the current level of health expenditure, the health financing goals envisaged in the National Health Policy 2017 seem very ambitious, unless strong financial commitment is ensured, domestically and from external donors.

3. The Global Fund to Fight AIDS, Tuberculosis and Malaria in India

One of the largest investors globally in health, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) was created in 2002 as a global partnership. Since then, the Global Fund has disbursed more than US$44.9 billion in the fight against HIV, Tuberculosis (TB), and malaria and to strengthen resilient and sustainable systems for health across more than 155 countries[8]. Since 2006-07, the Global Fund raises funds in multi-year cycles known as Replenishments. Various replenishment cycles enable more stable and predictable financing for countries and the Global Fund Secretariat[9]. From the second cycle onwards, the replenishment moved on to a funding period of three years.

4. This included Rs 142 billion for COVID-19 emergency response and health system preparedness package, and COVID-19 vaccination for healthcare and frontline workers

5. Source: https://prsindia.org/budgets/parliament/demand-for-grants-2021-22-analysis-health-and-family-welfare
Source: Demand Nos. 44 & 45, Ministry of Health and Family Welfare, Union Budget 2021-22, https://www.indiabudget.gov.in/doc/eb/allsbe.pdf

6. It is important to note here that Rs 350 billion has been allocated for the COVID-19 vaccine under the Ministry of Finance. This will cater to the need to vaccinate millions of Indian against COVID-19. It will not be used fo the screening and treatment of infection-related illness.

7. https://www.cnbc.com/2021/03/19/covid-pandemic-pushes-75-million-more-people-into-poverty-in-india-study. Acessed 4th October 2021.

8. https://www.theglobalfund.org/en/overview/

9. https://www.theglobalfund.org/en/archive/replenishment/

The Global Fund Investment Case for the Fifth Replenishment (2017-19) estimated that the fifth replenishment of around US$12 billion would yield broad economic gains of up to US$290 billion over time, and provide for an estimated return of around 17, 27, and 28-40 dollars for every dollar invested in HIV, TB, and Malaria, respectively [10]. The Investment Case summary for the Sixth Replenishment of the Global Fund called for a minimum of US$14 billion in stepping up the fight against the three diseases to save 16 million lives, cut the mortality rate from HIV, TB, and malaria in half, and build stronger health systems by 2023. Nearly three-quarters of the funds (74%) in 2018-20 were disbursed for interventions in the African region, followed by Asia and Pacific (16%) based on the Allocation Methodology[11] which determines the amount that each country receives based on quantitative and qualitative factors.

In addition, the Global Fund also encourages and stimulates domestic investments in health through co-financing requirements which require countries to show progressive government expenditure on health and progressive uptake of key programme costs, including those supported by the Global Fund[12]. The US$14 billion raised for the Sixth Replenishment seeks to spur domestic investment of around US$46 billion through co-financing requirements, and technical assistance on health financing. It is therefore important for countries to explore co-financing options in such a way to provide for full domestic funding of their systems for health, including their HIV, TB, and malaria programs to end the epidemics by 2030. In this context, a background on the contribution of India in the Global Fund and its investment in India is presented below.

3. 1. The Global Fund and India

India has been one of the largest recipients of Global Fund grants for HIV, TB, and malaria. Between 2003 and March 2021, the Global Fund has disbursed more than US$2.38 billion in grants to India for programs to fight the three diseases. While nearly half of the total disbursement has gone for the HIV response and to mainly support care and treatment efforts, TB received around one-third of total investments with a recent increase. These details can be seen below in Figures 2 and 3.

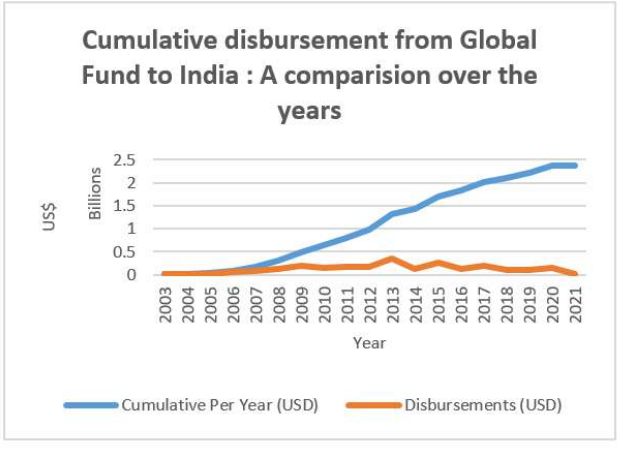


Figure 2: Cumulative disbursement from Global Fund to India

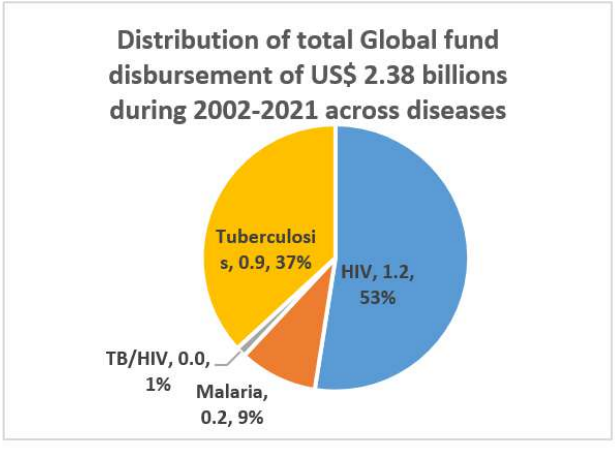


Figure 3: Distribution of Global Fund disbursement across diseases, 2002-2021

10. https://cerf.un.org/document/global-fund-investment-case-annex-3-draft-preliminary-report-global-best-practices-new
11. https://www.theglobalfund.org/en/funding-model/before-applying/allocation/. Accessed 4th October 2021.
12. https://www.theglobalfund.org/en/funding-model/throughout-the-cycle/co-financing/. Accessed 4th October 2021.

In addition, since joining the Global Fund as a donor in 2006, India has also contributed a total of US$53.5 million to date. The Government of India pledged US$22 million to the Global Fund's Sixth Replenishment for allocation cycle 2020-2022, demonstrating a shared commitment towards ending the epidemics of HIV, TB, and malaria. Its contribution to the Global Fund can be seen in Figure 1 given below.

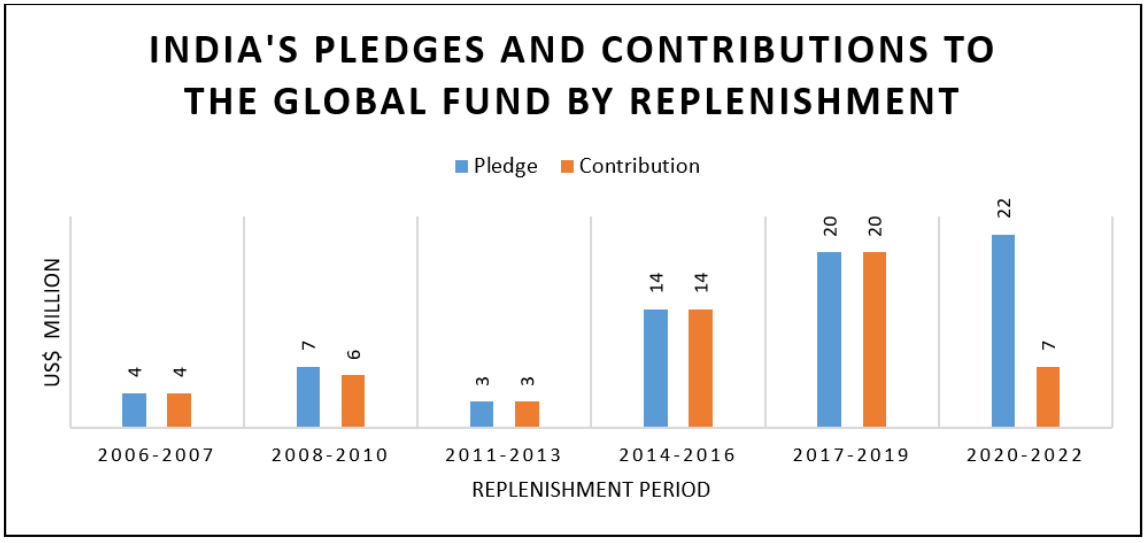


Figure 1: India's pledges and contributions to the Global Funds by Replenishment, 2001-2020

In addition, as will be explained later in detail, the Global Fund also initiated the COVID-19 Response Mechanism (C19RM) to provide support to the countries in their fight against Covid-19 and to sustain their continued fight against the three diseases. This includes fresh funding as well as reprogramming and flexibilities in the execution of existing grants.

To access Global Fund grants, recipients (both countries and regional initiatives) have to meet the eligibility criteria which is determined by its income classification and disease burden which determines that the investments from the Global Fund are in countries with the highest disease burden, the least economic capacity, and where the key and vulnerable populations are disproportionately affected by the diseases[13] . The funding allocated to countries is determined at the beginning of each funding period and is dependent on the funding raised during each three-year Replenishment cycle. Allocations to individual countries are based on a formula that is predominantly based on each country's disease burden and economic capacity and refined to account for important contextual factors through a transparent and accountable qualitative adjustment process[14] . Given the trajectory of declining disease burden and India's economic growth, there have been discussions on the Global Fund's transition from India.

However, given the impacts of COVID-19 and the dismal increase in annual health expenditure, the need for global involvement, especially in mainstreaming the response at the community level remains acute. Such need for external funding as well as technical support got highlighted more than ever in light of the COVID-19 pandemic. It is therefore important to advocate with the help of context-specific investment cases for more and better-nuanced funding for and from the Global Fund.

13. https://www.theglobalfund.org/en/funding-model/before-applying/eligibility/. Accessed 4th October 2021.
14. https://www.theglobalfund.org/en/funding-model/before-applying/allocation/. Accessed 4th October 2021.

4. India Investment case: An introduction

Civil society, advocacy partners, and the voices of champions and affected communities from Global Fund implementing and donor countries use the Global Fund's Replenishment Cycle as an entry point to push for higher domestic investments in health, especially for the three diseases.

Before every funding cycle, the Global Fund and technical partners of the three diseases develop the investment case for the period for which the resources are mobilized. This provides a target for donors to contribute towards the replenishment of the Global Fund and provides an overview of the "return on investments" with the target contribution to achieve the relevant SDGs and its targets. Each investment case is also based on the existing strategy of the Global Fund to achieve its mission and strategic objectives.

Similar efforts are carried out by community and civil society organisations leading up to the Sixth Global Fund Replenishment, including Get Back on Track report developed by the Global Fund Advocates Network, and the first India Investment Case (IIC) published in 2019 by the India Working Group for Health Advocacy (IWG) [15]. The IIC 2019 [16] called for continued domestic and international commitments for the Sixth Global Fund Replenishment to achieve the SDG goal of ending the three epidemics. It also called for greater involvement of the communities affected by these diseases as active partners in identifying priorities and shaping the programmes, as well as providing domestic resources necessary to complement and spur external funding for the three diseases.

While advocating for greater investment in health to achieve UHC in India, the IIC 2019 focused on three Key 'asks': a) India to increase its contribution to the Global fund to USD 40 million, b) India to double public domestic investment in health from 1.2% of GDP to 2.5%, focusing on higher funding to the three diseases, and c) the Global fund must continue to support India in its fight to end the three diseases beyond 2025.

The large-scale advocacy efforts of the IWG with the national government, the Global Fund, and High Commissions and Embassies of various donor countries associated with the Global Fund resulted in dual success. India increased its financial contribution to the Global fund by 20% and continued commitment and support to India from the Global Fund. In addition, (as explained later in the document), the advocacy efforts resulted in India slightly increasing its domestic investments in the three diseases.

4. 1. The rationale of India Investment Case 2021

In the light of the above discussion, the India Investment Case 2021 intends to provide a revised version of the India Investment Case to take contextual stock of the epidemiological situation of the three diseases and investment therein in the years to come given the unprecedented impacts of COVID-19. Along with the success of developing and using the previous case successfully, it is expected that the revised country case will highlight the emerging strategic and financial need for the strengthening of the Indian health system, including community systems necessary to deal with the burden of the three diseases as well as the uncertainties emerging out of the COVID-19 pandemic.

15. The India Working Group (IWG) is a collective of communities and civil society Health Advocacy, which was established in 2018 to mobilise efforts for increasing the pledge for the Fifth Replenishment of the Global Fund. The group influences the national health policy and budgetary processes to advocate for inclusive and sustainable health financing.
16. Source: https://gfanasiapacific.org/wp-content/uploads/2020/03/India-Investment-Case-report-by-India-Working-Group.pdf

5. COVID-19: A Global Health and Development Emergency that Disrupted the SDG and UHC Trajectory

The world is facing the worst public health and economic crisis in a century from the COVID-19 pandemic. As of November 5, 2021, 248 million Covid-19 cases and around 5 million deaths were reported from across the world[17]. The health crisis is affecting all countries. While the high-income countries in Europe and North America were hit hard in the early phase of the pandemic, emerging economies such as Argentina, Brazil, India, Indonesia, and Vietnam bore the brunt of a massive surge in infections in late 2020 and early 2021. The immediate impact of the pandemic has been severe on the health and livelihood of key, vulnerable, and marginalized communities.

Several international studies have shown that the overarching effects of COVID-19 could deepen inequalities between rich and poor nations, between urban and rural populations, and between communities of socioeconomic levels, age, gender, and colour[18] . Massive inequalities that existed and were faced by key, vulnerable, and marginalised communities were exacerbated by COVID-19.

The 2021 UNAIDS Global AIDS Update "Confronting Inequalities"[19] pointed out that HIV infections and AIDS-related deaths remain unacceptably high where 680,000 people were lost to AIDS-related illnesses in 2020 and 1.5 million people were newly infected with HIV, and 10 million people living with HIV (PLHIV) – including 800,000 children – are not accessing life-saving treatment that should be cheap and easily available. Overall, key populations and their sexual partners accounted for 65% of HIV infections worldwide in 2020 and 93% of infections outside of sub-Saharan Africa. The societal disruptions caused by COVID-19 have accelerated the adoption of HIV service delivery innovations, HIV testing and diagnoses, and treatment initiations. The Global Fund reported, according to data collected at 502 health facilities in 32 African and Asian countries that HIV testing declined by 41% and referrals for diagnosis and treatment declined by 37% during the first COVID-19 lockdowns in 2020, compared with the same period in 2019.

"A Deadly Divide: TB Commitments vs TB Realities"[20] published by the Stop TB Partnership in November 2020 pointed out that TB continues to be the world's biggest infectious killer with 10 million people falling sick with the disease, and an estimated 1.4 million die, including 230,000 children – more than 50% of whom are below the age of five. 95% of TB cases and deaths are also in developing countries with 87% of new TB cases occurring in the 30 high TB countries, and where eight account for two-thirds of new TB cases: India, Indonesia, China, Philippines, Pakistan, Nigeria, Bangladesh, and South Africa[21]. In addition, half of the global burden of Multidrug-resistant TB (MDR-TB) is in three countries – India, China, and the China Federation. In addition, new data from the Stop TB Partnership shows that UN TB Targets 2022 will not be met, citing COVID-19 as one of the drivers coupled with lack of funding, lack of access to the latest diagnostic tests, and slow roll-out of TB prevention.[22]

According to the WHO's latest World Malaria Report 2020[23], progress against malaria continues to plateau, particularly in high burden countries in Africa, and the COVID-19 pandemic is expected to set back the fight even further. And while India contributed to the largest absolute reductions in the WHO South-East Asia Region, from about 20 million cases in 2000 to about 5.6 million in 2019, India accounted for about 85% of all malaria deaths in the WHO South-East Asia Region. The report also states that despite considerable progress made since 2000, the Global Technical Strategy 2020 milestones for morbidity and mortality will not be achieved globally.

17. https://covid19.who.int/ Accessed on November 8, 2021
18. https://www.channelnewsasia.com/singapore/covid-19-inequality-virus-further-widened-rich-poor-gap-2127951. Accessed 4th October 2021.
19. https://www.unaids.org/sites/default/files/media_asset/2021-global-aids-update_en.pdf
20. http://www.stoptb.org/assets/documents/communities/The%20Deadly%20Divide_TB%20Commitments%20vs%20TB%20Realities%20FINAL%20HLM%20Report.pdf
21. https://www.who.int/news-room/fact-sheets/detail/tuberculosis
22. http://www.stoptb.org/news/stories/2021/ns21_035.html. Accessed 4th October 2021.
23. https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2020

In addition to human-rights violations increasingly experienced during COVID-19, massive gender inequalities in India were aggravated further by COVID-19. COVID-19 and its preventive measures like lockdowns have increased domestic violence, compromised access to sexual and reproductive health services, and affected livelihoods through a massive reduction in labour force participation and jobs for women[24]. Although the long-term consequences of the pandemic remain highly uncertain, it is certainly a major setback for the world's and India's ambition to achieve the SDGs, in particular, SDG 3, 5, and 10 (on health, gender equality, and reduced inequalities.[25]

Above all, the element of inter-connectedness of countries got emphasized, more than ever, in this pandemic – in the spread of the infection as well as in the need of solidarity and partnerships in responding to the worst ever health, economic, and humanitarian crisis that affects unequally. Such collective actions with international and domestic governments, communities, and civil society are particularly needed for poor and vulnerable population groups affected by HIV, TB, and Malaria. This is especially true for low and middle-income countries like India, as described below.

5. 1. COVID-19 in India

India, reeling under the severe second wave of infections with a rapid and exponential increase in infections and death, was the second-worst affected country during March-April 2021. India recorded a cumulative 34.3 million cases with 459,873 deaths as of 5th November 2021[26]. Experts believe this statistic is likely to be substantial underestimates[27]. In its second wave, India witnessed more than 400,000 new infections every day in most of the second half of April 2021, which also exposed the vulnerability of the already fragile health system in India as people faced an acute shortage of medical oxygen, hospital beds, medicines, and other medical necessities.

In light of the ravaging pandemic, the poor domestic investment in health not only affects India's response to the pandemic but also limits its focus on existing health issues like sexual and reproductive health, non-communicable diseases, and existing communicable diseases like HIV, TB, and Malaria. While high COVID-19 morbidity and mortality pose a serious threat to the already struggling health system, it also means that the attention and investment of the public sector to existing diseases like HIV – and the health of vulnerable and marginalized key populations - will remain insufficient.

As of 8th November 2021, a total of 1088 million vaccines have been administered[28] in a nation with an estimated 1.39 billion population[29], with only 32% of the population fully vaccinated against COVID-19 and additional 37% of the people partly vaccinated against COVID-19.

24. Source: https://www.nature.com/articles/d41586-020-02006-z; https://doi.org/10.1038/d41586-020-02006-z
25. Source: https://sdgindex.org/reports/sustainable-development-report-2020/ and https://s3.amazonaws.com/sustainabledevelopment.report/2020/2020_sustainable_development_report.pdf
26. https://covid19.who.int/region/searo/country/in. Accessed on 8th November 2021.
27. Source: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01052-7/fulltext
28. https://dashboard.cowin.gov.in/. Accessed 8th November 2021.
29. https://www.worldometers.info/world-population/india-population/. Accessed 4th October 2021.

Equitable access to COVID-19 vaccination across and within states remains a major challenge. In addition to a fragile and underfunded health system, global vaccine inequality has also hampered efforts to combat COVID-19. South Africa and India are among countries pushing for a temporary waiver of intellectual property rights to boost vaccine production in developing countries and address the vast inequity in access. In a country where 93% of rural women and 77% of urban women are in informal employment, there is a real threat to women being left behind in India's vaccination drive where misinformation and access issues combined with patriarchal social norms have fuelled disparity in the distribution of vaccines across most states[30]. Furthermore, data on transgender people, non-binary people, or people of other marginalised genders have not been accurately tracked, with all groups falling under a singular category of "other".

The media reported the unprecedented efforts of the communities and civil society in providing a range of medical and non-medical support to those who are affected as the public and private healthcare systems collapsed.

Similar stories of community members providing support to each other were also reported during the lockdown in March-May 2020 when the transportation, as well as public and private healthcare systems, came to a standstill affecting access to essential medicines for HIV and TB patients. The community members supported each other through the timely distribution of ART medicines, medicines for opportunistic infections (OI), TB medicines, counselling, and consultations. Such timely community actions, that helped in sailing through tough times, emphasized the importance of investing in the community support systems in addition to the health system.

30. https://www.theguardian.com/global-development/2021/jun/28/india-covid-gender-gap-women-left-behind-in-vaccination-drive. Accessed 4th October 2021.

"Last year due to COVID we took the responsibility that none of the PLHIV communities will be or left without essential services given by the network. During the epidemic we did not have funds, there was no support from SACS in delivering the ART medicines during the pandemic, it was only due to CSC that we collaborated with district-level networks and ensured the services were retained we distributed ARTs at every clients' home. If we don't continue to give the services, the systems of service delivery will collapse"

- A male PLHIV stressing the need for community support to PLHIV

Overall, the recent community support during the lockdown also highlights the importance of strengthening of community system in addition to ongoing efforts of health system strengthening. The ongoing pandemic calls for a major overhaul and greater investment in prevention programs and healthcare system preparedness to deal with treatment needs and resilience to pandemics in the longer run. Ultimately, for timely attainment of the UHC and SDG goals in India, a massive and consistent domestic and international investment in health is essential and Global Fund must continue to play an important role in advancing the global and national response.

5. 2. The Global Fund and COVID-19

In light of the pandemic, Global Fund initiated the COVID-19 Response Mechanism (C19RM) to a) reinforce national response to COVID-19, b) support countries to mitigate the impact of COVID-19 on programs to fight HIV, TB, and malaria, and c) make urgent improvements in health and community systems to help fight COVID-19, HIV, TB, and malaria. Through C19RM, the Global Fund has deployed nearly US$1 billion in more than 100 countries on tests, treatments (including medical oxygen), personal protective equipment (PPE), and health systems strengthening [31]. Against a target of US$10 billion for 2021, the Global Fund has raised US$3.7 billion by April 2021 from donors including Germany and the United States.

While there is a shortage of COVID-19 related healthcare, there is also a massive disruption in non-COVID health services especially in testing, diagnosis, and treatment of HIV, TB, and malaria. Active and enhanced involvement of the Global fund is critical at this juncture to not only combat COVID-19 but to defeat HIV, TB, and Malaria as they remain interconnected, and it is not possible to 'get back on track' on the three diseases for India as it struggles to stay afloat amidst COVID-19 crisis.

With this background, details of epidemiological and financial updates on the three diseases are presented below.

6. HIV, TB and Malaria in India: Epidemiological Progress

To contextualize the next level of needs across three diseases and advocacy efforts thereof, a detailed account of the epidemiological progress of the three diseases is provided below.

6. 1. HIV in India

With an estimated 2.35 million PLHIV and an adult HIV prevalence of 0.22% in 2019, India has seen significant progress in its response to HIV over 35 years of its fight since the first case was detected in 1986 [32]. Of these, more than three-fourth (76%) were aware of their HIV status, nearly two-thirds (63%) were on Antiretroviral Therapy (ART) and around half (53%) were virally suppressed. Although a significant achievement, it falls a little short of global performance as globally 81% of estimated PLHIV were aware of their HIV status, 67% were on ART and 59% showed viral suppression in 2019 [33], as well as its targets for the year 2020 (71% for PLHIVs on ART and 90% for PLHIVS who knew their HIV status).

There were 69.2 thousand [34] new HIV infections in 2019 with most states reporting a reduction in the annual rate of new infections. This reduction in new infections can be better understood in Figure 4 below. There were 58.9 thousand [35] AIDS-related deaths in 2019, and the annual AIDS-related deaths declined during the last decade in most Indian states. The reduction in AIDS-related deaths can be better understood in Figure 5 below.

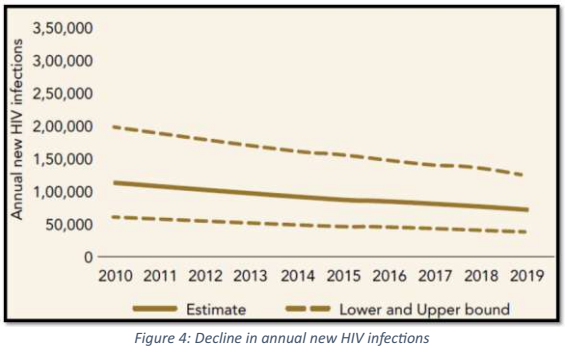


Figure 4: Decline in annual new HIV infections

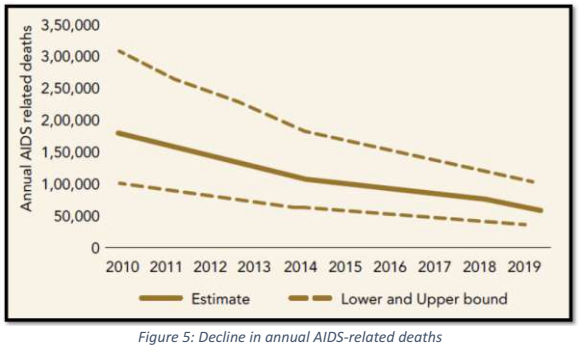


Figure 5: Decline in annual AIDS-related deaths

31. Source: https://www.theglobalfund.org/media/10800/covid19_2021-04-16-situation_report_en.pdf
32. Source: National AIDS Control Organization & ICMR-National Institute of Medical Statistics (2020). India HIV Estimates 2019: Report. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.
33. Source: National AIDS Control Organization (2020). Sankalak: Status of National AIDS Response (Second edition, 2020). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.
34. Source: http://naco.gov.in/hiv-facts-figures. National AIDS Control Organization & ICMR-National Institute of Medical Statistics (2020) India. HIV Estimates 2019: Report. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.
35. Source: http://naco.gov.in/hiv-facts-figures. National AIDS Control Organization & ICMR-National Institute of Medical Statistics (2020) India. HIV Estimates 2019: Report. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.

The two decades of interventions backed by improved evidence generation have led to a substantial reduction in new HIV infections. Continue to remain a concentrated epidemic, the HIV prevalence among Key Populations declined during the period 2010- 2017 from 7.1% to 6.2% among People who Inject Drugs, from 8.8% to 3.1% among Transgender people, from 4.4% to 2.6% among Men who have Sex with Men, and from 2.7% to 1.5% among Female Sex Workers[36]. The coverage of key populations also increased in recent times. An estimated 94% of Injecting Drug Users, 91% of Female Sex Workers, 80% of men who have sex with men, and 67% of Transgender people were covered through the national programme in 2019-20. The higher HIV prevalence and lower coverage of transgender people remain a cause of concern.

The active participation of civil society, representing people living with or affected by HIV including key populations, has contributed significantly to the progress of HIV response in India. The National Strategic Plan 2017-2022 reiterated the importance of dialogue and collaboration between government, communities, people living with and affected by HIV, civil society organizations (CSOs), academics and researchers, development partners, private sector, and parliamentarians in this fight. The active role of key population and community members remained important inputs to the national response.

> "... The communities have stood by each other especially in the times of COVID in the overall national program whether it is prevention whether it is treatment, or whether it is caring for each other or psychosocial support or local resource mobilization I think as united community members we have already contributed a lot in the national program." – A female PLHIV from Delhi, who leads state-level Global Fund-supported Care and Support Programme, emphasizing the importance of community support

As an intermediate goal of the seven-year plan, it was envisaged that by 2020, there will be a 75% reduction in new HIV infections, along with the achievement of the 90-90-90 i.e., 90% of those who are HIV positive in the country know their status, 90% of those who know their status are on treatment and 90% of those who are on treatment experience effective viral load suppression. The recent estimates indicate that while India reached close to achieving the goal of a 75% reduction in AIDS-related deaths by 2020, the goal of an 80% reduction in the new HIV infection by 2024 needs concerted action.

36. Source: National AIDS Control Organization (2020). Sankalak: Status of National AIDS Response (Second edition, 2020). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.

"There are some facilities like CD4 testing and viral load which at times are not available at district-level hospitals. In our state, while services have been expanded, the accessibility of the services is not smooth."

- A male PLHIV from an eastern state of India

"Capacity building of communities is a priority in our state.....if we can build the capacity of district-level networks then we can raise this to the state level too. The efforts at the project level are working as per need, but we need more involvement on community-level and at district-level."

- A female PLHIV from a north-eastern state of India

Lastly, like many other diseases, OOP expenditures remains a stark reality of PLHIVs and other key populations in India despite the free ART program owing to OI treatment and hospitalization. A majority of PLHIV, like many Indians, are in the informal sector and thus, lack social security and health insurance options available to formal sector employees, including government officials and workers. This includes PLHIV employed at the Non-Governmental Organizations (NGOs) through projects, who remain excluded from such coverage owing to the nature of their employment. While on one hand, the commercial and private health insurance sector continues to exclude HIV-related ailments, most PLHIVs are also excluded from the PMJAY as well. This lack of financial protection, especially in the time of COVID-19, poses a serious risk of catastrophic health expenditure for many.

"There is no provision of insurance if a person is living with HIV and infected with COVID... HIV itself does not have insurance so my out of pocket expenses are directly or indirectly increasing, if I am going to a private health care facility for OI management...so my risk is more in this situation." – A female PLHVI from western India explaining the burden of high OOP among PLHIV in absence of health insurance.

"... Government should think of health insurance for us. The staff from the government sector will get all the benefits if they are hospitalized. But what about NGO workers like us?! For the future, we need to plan as the situation is going to be worse. We should be prepared for the same."

- A male PLHIV from Delhi, underscoring the need for insurance for people working for PLHIV

6. 2. TB in India

With 26% of the global TB burden and being the country with the highest number of cases, India has set a target during the 2018 Delhi End TB Summit for the elimination of Tuberculosis by 2025, five years ahead of SDG goals for 2030. To gear up for the ambitious goal, India in 2020 revamped its existing interventions of erstwhile Revised National Tuberculosis Control Programme (RNTCP) under the rechristened program known as the National Tuberculosis Elimination Programme (NTEP).

With an estimated incidence of 2.7 million cases in 2019 and the highest-ever notification of 2.4 million cases in 2019-20[37], India recorded the biggest contribution to the global increase in TB[38]. India's case notification has been consistently improving since 2017-18. Although the 12% annual increase over the last three years since 2016-17 is a very encouraging sign, India is 50% short of achieving the National Strategic Plan (NSP) for TB target of 3.6 million new notifications by 2020. Similarly, the incident notification rate of 1590 cases per million against the estimated incidence rate of 1990 cases per million population indicated that there were estimated 54 million missing cases across India.

Late diagnosis, non-adherence to treatment, lack of social support, co-morbidities like HIV, drug-resistant TB continue to be challenges for the national program. While according to the World TB report 2020, India continues to lead globally with around 50% of total Multi-Drug resistant (MDR) and Rifampicin Resistant (RR) TB cases, there is slow progress in the management of drug-resistant TB. Around 66,255 MDR/ RR TB cases were diagnosed in India in 2019 against the target of 92000 in 2020. According to the India TB report 2020, the National TB Elimination Programme misses 10% of estimated DS-TB and 50% of estimated DR-TB cases. The stigma of TB continues to affect screening and treatment. Particularly if the person with TB is a woman the stigma and related discrimination increases many folds. Therefore, often the culture of silence in TB also kills many women infected by TB.

"In my case also I wasn't mentally stable when I got my TB positive report (in the last half of 2014) thankfully I had a supporting family. Even today my in-laws subtly discriminate against me, they don't socialize with me as before. They feel if they eat food prepared by me they will contract TB. …. There is a change now (since I was diagnosed five years ago when I faced a lot of trouble regarding documentation, transport, and access to medicine) as for the people with co-infection, medicines of TB are also given from ART centres. I started my medicines in 2015, the TB centre staff was very rude in their behaviour. Even if I touched their dispensing window by mistake they have behaved badly with me shouting at me not to touch the window. Stigma is still there when I go to the DOT centres. (The) clients are made to sit at a distance (from service providers), (therefore) if they need to ask something they can't explain themselves properly. The doctors get irritated if more questions are asked on medicine regimes. They have started disbursing medicines but only a little has changed in terms of their behaviour. They just leave the patients with the medicines. They don't have feelings for their patients."

– A female TB-HIV survivor working with a community organization in northern India

37. Source: India TB report 2020, accessed at https://tbcindia.gov.in/showfile.php?lid=3538
38. Source: World TB Report 2020, accessed at https://apps.who.int/iris/bitstream/handle/10665/336069/9789240013131-eng.pdf

The role of communities and their support to TB patients is vital in the absence of adequate psycho-social support from the health care system. Along the lines of the peer-led support system in the ART programme of HIV, the TB program should also have a peer-led component wherein the survivor tells about his /her story for stronger impact among the patients. The importance of counselling and peer support through NGOs, Community Based Organizations (CBOs), and formal networks of TB patients are, therefore, an important strategy not only for improved treatment outcomes but also for mitigation of socio-economic impact from TB and HIV-TB co-infection.

"...when I was passing through the same phase, Mr. X - a person living with HIV-TB coinfection - had come to (my city). He heard my story and then counselled me properly. He advised me of treatment. Later when my condition was serious and my health had worsened and I was hospitalized, he used to visit me daily and stood by me very strongly. He used to give me confidence (in the progress of my treatment). It was only due to that I had a ray of hope for myself and did recover fast."
– A male TB-HIV coinfection survivor from eastern India

"... in North East (India), we have been successful to create a TB survivors' network. We are reaching out to the remotest parts. I can see the change happening especially at the government officers' level. Earlier their behaviour was full of indifference and now they are responsive. The attitudes have changed. They want to work with us. There is a positive change in the government sector, to work with the TB communities, is visible. But lower levels lack sensitization... the challenges are the attitudes and change in mind-set we have to work with people on this. I am confident that by 2027 we will have a TB-free India."
– A representative from Touched by TB, National Coalition of TB survivors

Many patients with HIV-TB coinfection and TB re-infection face a large pill burden due to strict adherence to ART and Directly Observed Therapy (DOT) TB treatment guideline. While the absence of counselling makes it difficult for patients to follow up proactively on the treatment, the situation worsens if one has extra-pulmonary TB affecting the mobility of the patients. Ultimately, many such patients either discontinue their treatment or turn to the private sector, which remains flexible in providing tailor-made regimes at an OOP payment. The lack of counselling remains an issue even in the private sector.

"... I had TB infection once and my husband was infected with TB twice. There was no one to guide us when we used to go to take medicines. There was no response from anyone even if we used to ask. Finally, I had to take medicines from a private hospital and there was no counselling and follow-up during those times. In my husband's case, he took medicines for one month there was no counselling in that. Due to the follow-up gap, my husband got TB the second time. So, counselling for treatment and follow-up on medicine consumption is a must. If this would have been a community-led program, there would have been a follow-up process."

–A female TB-HIV coinfection survivor from eastern India

"... I have been infected with TB twice. My last TB was extra-pulmonary and my spine was infected by it, due to spine TB I had issues with my mobility but still, I had to go for my DOTS treatment due to TB infection. It was only after a lot of requests that the health care provider gave me medicines for a week. Since I am co-infected with HIV & TB, my medicine intake was very heavy... as the pill burden was a big issue for me, finally I had to discontinue my government treatment of TB and started my treatment in a private hospital. Due to this, my pill burden came drastically down my treatment went on for one and a half years, and now I am completely fine."

–A male TB-HIV coinfection survivor from eastern India

The Joint Monitoring Mission of RNTCP in November 2019[39] indicated that OOP expenditures remains high for private TB patients, which comprises a large share of total patients. It indicated the scope of improvement in managing drug-resistant TB patients. It also admitted to delays in fund transfers from the centre to states affecting the expenditure. Overall, this calls for a) strengthening of the health system efforts with sustained and additional funding to reduce the financial burden of treatment on the patients, and b) increased focus on counselling at all levers to reduce stigma at the facility, household, and community level.

Lastly, the COVID-19 pandemic affected the ongoing efforts of TB control in India. According to the World TB report 2020, there were large drops in the reported number of people diagnosed with TB between January and June 2020 in the public and private sectors. The Indian government's TB notification system, "Nikshay," reported a 70% drop between the 10th and 15th weeks of 2020[40]. This could have a similar effect on morbidity, access to treatment, and tuberculosis-related mortality. It is also plausible that TB could worsen the treatment outcome in people with COVID-19 as evidence shows that people infected with both TB and COVID-19 have three times higher mortality than people infected with TB alone[41]. The situation has slowly improved after the pandemic induced-lockdown, but there is a major setback to the consistent progress of many years.

6. 3. Malaria in India

With about 20 million cases in 2000 to about 5.6 million in 2019, India has made considerable progress in reducing its malaria burden, especially in recent years. During this period, Malaria case incidence reduced by 78% from about 18 to 4 persons at risk of Malaria per 1000 population. Similarly, Malaria deaths reduced by 74%, from about 35,000 in 2000 to 9,000 in 2019[42]. India is the only high endemic country that has reported a decline of 17.6% in 2019 as compared to 2018. The Annual Parasitic Incidence (API) reduced by 27.6% in 2018 compared to 2017 and by 18.4% in 2019 as compared to 2018. India has sustained API less than one since the year 2012. India achieved Goal 6 of the Millennium Development Goals (50-75% decrease in case incidence between 2000 and 2019) through a reduction of 83% in malaria morbidity and 92% in malaria mortality between the year 2000 (20, 31,790 cases, 932 deaths) and 2019 (3, 38,494 cases, 77 deaths)[43]. While in terms of the global burden, India contributes around 2% of Malaria cases and death by Malaria, it is one of the highest in the South Asian region.

Within India, Malaria seems to be concentrated in few states only. Apart from the most populous state of Uttar Pradesh which has more than one-fourth of the total 338 thousand cases (27%), an additional 40% of India's Malaria cases (160 thousand cases) were reported from Chhattisgarh, Odisha, and Jharkhand. With 120 thousand cases out of a total of 156 thousand cases, these four states also contributed around three-fourth of falciparum Malaria cases (76%) in 2019. More than half of the total Malaria death (40 out of 77) were reported from Chhattisgarh (31) and Odisha (9)[44]. With a stronger response, rapid decline in the Malaria cases are reported in the high endemic states of Odisha (40%), Meghalaya (59%), Jharkhand (35%), Madhya Pradesh (37%), and Chhattisgarh (23%) in the year 2019, as compared to 2018. While Malaria continues to remain concentrated in tribal regions of central, eastern, and north-eastern India, the increase in Uttar Pradesh could be a result of improved programme implementation.

The shrinking of Malaria – in terms of API - over the last five years can be seen in the maps below (Figure 6). India started the implementation of the "High Burden to High Impact (HBHI)" initiative in four states i.e., West Bengal and Jharkhand, Chhattisgarh, and Madhya Pradesh in July 2019.

39. The report of Joint Monitoring Mission of the revised national tuberculosis programme 2019. Available at: https://tbcindia.gov.in/showfile.php?lid=3536
40. Source: http://www.stoptb.org/news/stories/2021/ns21_011.html
41. Source: http://www.stoptb.org/news/stories/2021/ns21_011.html
42. World Malaria Report 2020. Accessed at: https://apps.who.int/iris/rest/bitstreams/1321872/retrieve
43. MOHFW Press release of December 2, 2020. Accessed at: https://pib.gov.in/PressReleasePage.aspx?PRID=1677601
44. Source: Malaria Situation India since 2016

Alongside the decline in Malaria prevalence, there is a looming threat of drug-resistant Malaria in India. Around 80 districts across 21 states and union territories in India have been recognized as chloroquine-resistant areas as they reported high failure to chloroquine (CQ) based therapies. Accordingly, since 2009, the ACT therapy (Artesunate + sulfadoxine-pyrimethamine) has been prescribed as first-line therapy in 50 high endemic districts in the endemic states of Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, and Orissa and 67 districts of the North-eastern States of India [45]. The therapeutic efficacy of the ACT therapy also showed a decline, and thus, it was replaced with Artemether-lumefantrine (AL) specific to north-eastern India in 2013 [46]. There is a possibility of artemisinin resistance in northeast India and therefore, it is important to intensify the efforts to prevent the spread of drug-resistant Malaria in other parts of India [47].

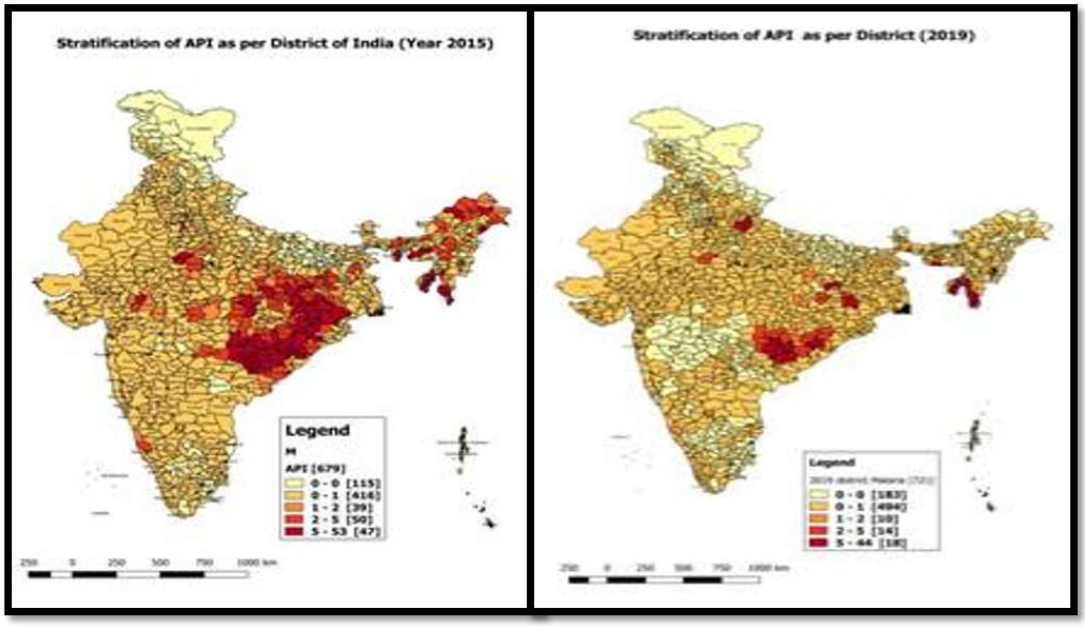


Figure 6: Stratification of API as per districts of India, 2015 and 2019

National Vector Borne Disease Control Programme (NVBDCP) spearheads the Indian response to Malaria along with other vector-borne diseases. To eliminate malaria by 2030, the NSP 2017-2022 and the National Framework for Malaria elimination in India 2016-2030 provide overall strategic directions to the district-level programmatic efforts, classified according to the severity of the illness. While the country has made progress towards the goal, the NSP acknowledged the importance of long-term political and financial support.

45. Source: https://nvbdcp.gov.in/WriteReadData/l892s/6663118952161415223 9.pdf
46. Source: Mishra, N., Kaitholia, K., Srivastava, B. et al. Declining efficacy of artesunate plus sulphadoxine-pyrimethamine in northeastern India. Malar J 13, 284 (2014). https://doi.org/10.1186/1475-2875-13-284
47. Source: https://blogs.biomedcentral.com/bugbitten/2019/10/01/the-relentless-march-of-falciparum-malaria-the-deadly-parasite-in-india/

7. HIV, TB, and Malaria in India: Financial updates

Investment in HIV: The total budget envelope to meet envisioned goals and targets under the seven years NSP for HIV/AIDS in India is estimated at Rs. 330,880 million. The year-wise distribution of the NSP budget along with an annual allocation of the domestic budget to the national AIDS and STD Control Programme is presented below in Table 1.

Around 59% of the NSP budget is for prevention activities including 14% for Targeted Interventions, 2% for Sexually Transmitted Infections, 24% for Basic Service Division, 8% for Blood Transfusion Services, 5% for Advocacy, Communication and Social Mobilisation and 6% for laboratories. In addition, about one-third of the budget (32%) is for care, support, and treatment, around 8% towards the management functions, and the remaining 2% of the total estimates is allocated for strategic information management.

The first five years of the plan saw a total investment of around Rs. 120 billion against the plan of Rs. 210 billion. This is a massive 42% shortfall amounting to Rs. 90.4 billion. The stagnation of domestic investment in the last two years – owing largely to the COVID-19 epidemic – has especially affected the domestic investment in HIV. This calls for a massive effort to ramp the investment towards fulfilling the commitment to control the AIDS epidemic in general, and in particular, to achieve the NSP targets. In absence of such financial and political commitments, India is most likely to miss the financial target, and therefore, physical targets of the national HIV response.

Year	HIV/AIDS NSP estimates (In Rs. Billion)	MoHFW allocation to National AIDS and STD Control Programme (In Rs. Billion)	Shortfall (In Rs. Billion)	Annual incidence of new HIV infection (in '000)	NSP targets for 2024
2017-18	31.82	20.00	11.82	87.6	1) 80% reduction in new HIV infections, 2) Ensuring that 95% of those who are HIV positive in the country know their status, 95% of those who know their status are on treatment, and 95% of those who are on treatment experience effective viral load suppression
2018-19	39.04	21.00	18.04		
2019-20	44.87	25.00	19.87	69.2	
2020-21	47.93	29.00	18.93		
2021-22	50.76	29.00	21.76		
2022-23	55.49				
2023-24	61.05				
Source: National Strategic Plan for HIV/AIDS and STI 2017 – 2024, various statement of budgetary expenditure documents (2017-18 to 2021-22) of MoHFW[48].					

Table 1: Allocation and Shortfall in allocation for AIDS as compared to NSP estimates

Investment in TB: While the Joint Monitoring Mission of RNTCP 2019 recommended an increase in the financial envelope for scaling TB control activities, the amount of budget requested for India's NTEP has seen a sharp decline during 2019-20[49]. Under NSP TB, an estimated budget of Rs. 240 billion will be required from 2021 to 2023-24. The year-wise estimation of the NSP budget along with an annual request for a domestic budget is presented below in Table 2.[50]

While India has seen some improvement in financial allocation to NTEP in recent years, there remains a shortfall in NSP estimates and actual budget allocation. With a real threat of more funding being diverted to COVID-19 responses, India needs to significantly increase its resources to meet the 2025 targets. With the effect of the pandemic on the health sector still looming large, adequate financial, administrative, and technical attention on the TB programme remain crucial during 2021-22.

48. This includes https://www.indiabudget.gov.in/budget2017-2018/ub2017-18/eb/sbe42.pdf
https://www.indiabudget.gov.in/budget2018-2019/ub2018-19/eb/sbe42.pdf
https://www.indiabudget.gov.in/budget2019-20/doc/eb/sbe42.pdf
https://www.indiabudget.gov.in/budget2020-21/doc/eb/sbe42.pdf,
https://www.indiabudget.gov.in/doc/eb/sbe44.pdf

49. Source: India TB report 2020, accessed at https://tbcindia.gov.in/showfile.php?lid=3538 and India Investment case 2108

50. NSP to end TB 2020-2025 Draft V7 Available at: https://tbcindia.gov.in/showfile.php?lid=3577

Years	Estimated budget of NSP (Rs. in Billion)	Budget requested (Rs. in Billion)	Shortfall (Rs. in Billion)	TB cases notified (in Million)	NSP Target for TB cases notified (in Million)	Other NSP Targets by 2025
2017-18	31.36	22.00	9.36	1.9	1.5	1. 80% reduction in TB incidence (217 0/million in 2015 to 43 0/ million) 2. 90% reduction in TB mortality (32 0/million in 2015 to 3 0/million) 3. 0% patient having catastrophic expenditure due to TB (35% in 2015 to 0%)
2018-19	41.16	31.40	9.76	2.12	2.4	
2019-20	50.76	35.25	15.51	2.4	2.6	
2020-21	31.30	30.34		1.5	2.5	
2021-22		63.48		2.4		
2022-23		71.05		2.6		
2023-24		76.05		2.5		

Table 2: Estimated budget by NSP, requested and shortfall in budget compared to notified TB cases (in million)

Additionally, stricter implementation of the recommendations of the NSP 2020-25, regarding a) obtaining robust estimates on TB expenditures, b) periodically measuring and monitoring the OOP Expenditure and CHE for TB and c) strengthening of the linkages with the National Health Authority for better coordination on financing from PMJAY for in-patient care and potentially Out Patient package, must be enforced.

Investment in Malaria: While the budgetary allocation to the NVBDCP has increased recently, there remains a shortfall when compared to the estimated need according to the NSP Malaria, whose total requirement for 2017-22 is Rs.106 billion. These financial details of current funding, future needs along the ground-level realities of morbidity and mortality are presented below in Table 3.

Year	Budget details		Malaroa Stitution[51]			NSP Goals For Elimination Malaria By 2030
	Requirement according to Nsp Malaria (Rs. Billion)	Actual Allocation to NVBDCP2[52] (Rs. Billion)	APL	Malaria Cases (In Million)	Malaria Death	
2015			0.92	1.17	384	1. Eliminate Malaria In category 1 districts(APL<1) by 2020 2. Eliminate Malaria in category 2 districts (APL,1-2) by 2022 3. Reduce Transmission in category 3 districts to stabilize API at< 1by 2022
2016		8.39	0.85	1.09	331	
2017	11.41	8.84	0.64	0.84	194	
2018	21.95	9.55	0.32	0.43	96	
2019	21.02	12.02	0.25	0.34	77	
2020(P)	23.27		0.11	0.15	55	
2021	28.89					

Table 3: Budget details for Malaria, with Malaria mortality and morbidity related data, 2015-2021

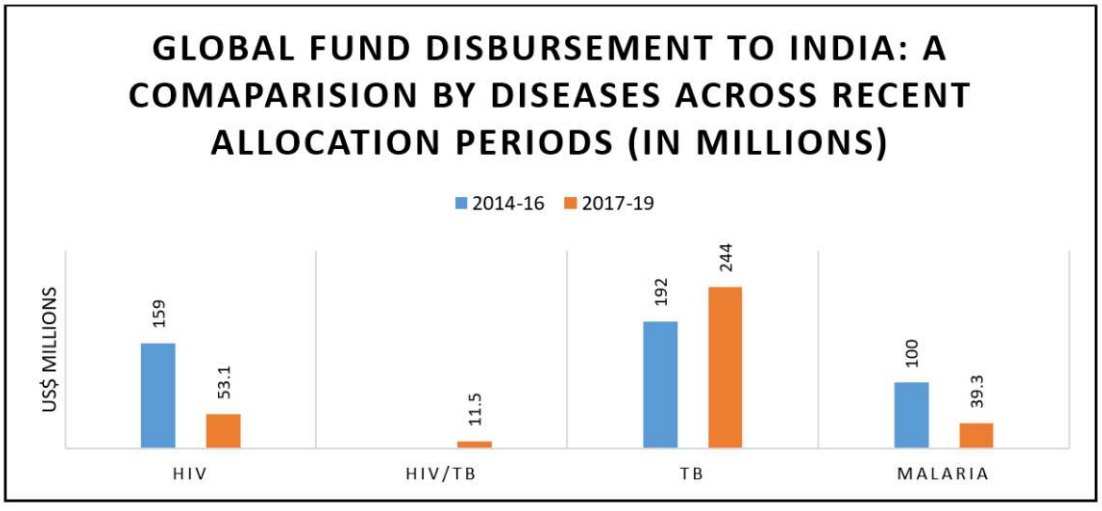
51. Source: https://nvbdcp.gov.in/index4.php?lang=1&level=0&linkid=420&lid=3699

52. Sources: 2016-17 - https://nvbdcp.gov.in/WriteReadData/l892s/92061985541536735353.pdf, 2017-18 - https://nvbdcp.gov.in/WriteReadData/l892s/30296766441536735384.pdf, 2018-19 - https://www.who.int/malaria/mpac/mpac-april2019-session2-hbhi-presentation.pdf , 2019-20 - https://nvbdcp.gov.in/WriteReadData/l892s/45936453061583133318.pdf

Additionally, while increased funding remains a strategic goal for Malaria elimination, the additional funding must be utilized optimally. The Comptroller and Auditor General of India (CAG) report 2018-19 [53] indicated that Rs. 11.8 billion from the flexible pool for communicable diseases under the National Health Mission was surrendered due to non-procurement of drugs and supplies under NVBDCP and RNTCP. The report recommended that the government examine the adverse impact caused by such non-procurement of drugs for critical illnesses and non-payment of bills for supplies made and medical services rendered.

8. The Global Fund in India in recent years

While due to the civil society advocacy there was an increase in domestic investment in HIV, TB, and Malaria; India received relatively decreased funding from Global fund during 2017-19 as compared to 2014-16. The Global Fund has planned to transition out from India in a nine-year plan from 2016 since India is now rated as a Lower Middle-Income country. The disbursement of the Global Fund to India over the two rounds is presented in Figure 7 below. While the Global Fund investment in HIV and Malaria declined in this period, TB received more funding.



During 2015 -17, the Global fund allocations catered to 52% need of Tuberculosis NSP, 45% NSP needs of HIV, and 22% of that of Malaria in India. For 2018-20, it was expected that the Global Fund will cover 28% of the total planned/budgeted investment of US$ 1.03 billion in Tuberculosis intervention, 21% of 287 million in Malaria interventions, and around 9% of 1.46 billion in HIV interventions in India. Continuing its support to India's goals to end HIV, TB, and malaria as epidemics, the Global Fund allocated US$500 million each for 2017-19 and 2020-22 to the fight against the three diseases, as can be seen in Table 4 below.

Global Fund allocation to In dia over three time periods (in US$ Million)			
	2014-16	2017-19	2020-22
HIV	562	155	155
Malaria	55	65	65
Tuberculosis	233	280	280
Total	850	500	500

Table 4: Global Fund allocation to India, 2014-22 (in US$ Million)

53. SOURCE : https://cag.gov.in/webroot/uploads/download_audit_report/2020/Report%20No.%204%20of%202020_Eng-05f808ecd3a8165.55898472.pdf.

In addition, to support the Indian response to the COVI-19 pandemic, the Global fund funded an additional US$36.8 million through its C19RM during 2020 for the said three objectives of enhancing response to COVID-19 and its impact on HIV, TB, and Malaria. As India was reeling under a severe second wave of COVID-19, the Global Fund also approved an additional US$75 million in fast-track funding to support India in purchasing oxygen concentrators and Pressure Swing Adsorption oxygen plants to help meet the medium-term needs for medical oxygen [54].

This success story of advocacy efforts in increasing domestic investment and ensuring sustained support from the Global Fund needs to be acknowledged and capitalized upon in the years to come as the country needs exceptional support as it struggles with an unprecedented crisis of multiple reinforcing epidemics.

9. Key Asks 2020 and recommendations for Post-2022 scenario

Based on the analyses and community consultations and their experiences from the ground, IWG would like to put forth the following five 'key asks' to parliamentarians, bureaucrats, the Global Fund, and the donor countries of the Global Fund. Of these four are directed at Indian policymakers and one is targeted towards the Global Fund.

1. Invest in Community System Strengthening (CSS) to enhance community leadership and ownership: All the programmes and projects that are aimed at CSS must be designed, lead, and managed by the community (key population including PLHIV) organizations. While the government needs to ensure the implementation, such endeavours need to be supported by technical agencies like UNAIDS.

54. Source: https://www.theglobalfund.org/en/news/2021-05-06-global-fund-approves-usd75-million-for-india-covid-19-response/

As discussed earlier, the success of the HIV programme in India is mainly due to the active engagement of the community in policy as well as programme development and implementation. It is also as per the focus of the new strategy of the Global Fund – to keep communities in the centre of all work relating to community, rights and gender interventions. The COVID-19 pandemic showed how the community helped in providing HIV, TB, and Malaria services and information at a time when the private sector, civil society, and even government struggled to do the same. Despite the challenges, the community leaders and members facilitated access to screening and treatment for HIV, TB, and Malaria through successful negotiations with the government. This showcased the importance of the significant role that communities could play through CSS. It is therefore important to support community systems for improved access to treatment and social protection. Technical agencies like UNAIDS could support such efforts.

2. **India urgently needs to increase domestic financing for health from 1.2% of GDP to 2.5% as promised by the government.**

In addition to exposing the weakened health system, the COVID-19 pandemic also exposed poor financial protection of the poor and vulnerable Indians. While policy changes, programmatic efforts, and financial resources are focused on COVID-19, it is important to ensure that this must not be at the cost of other health conditions. In absence of increased allocation, there remains a real threat of an increased financial burden on the patient for the treatment of these conditions apart from treatment of COVID-19 related illnesses. The pandemic is a wake-up call for and an opportunity to address the issue of low and stagnant public investment in health so that the investments in HIV, TB, and malaria remain on track, and expanded investment reduces the OOPE.

3. **Sustain and increase focus on prevention of HIV, TB, and Malaria, and COVID-19.**

The recent success in the control of HIV and TB in India needs a renewed focus on prevention efforts. The efforts for expanded treatment must be met with refined and sustained prevention efforts, especially among difficult-to-reach geographical areas and hard-to-reach sub-population groups, for overall disease control. In India, district-specific and youth-centric approaches to reach these segments are essential to reduce the overall disease burden. The COVID-19 reiterated the need for concerted public health efforts for the prevention and control of infectious diseases. If India does not achieve its target of control of HIV and TB, the world targets will remain unachieved due to sheer numbers in the country. Therefore, India must live up to its promise and commitments of controlling HIV, TB, and malaria.

4. India to increase investment in the Global Fund and demonstrate the effectiveness of the partnership.

India has been a pioneer in some of the most important global issues such as Patent Laws and Decriminalisation. Historically, India is known as the 'pharmacy of the world' due to its vital role in delivering cost-effective and high-quality generic drugs globally. In continuing with the critical role that it plays in the response to SDG and UHC, we urge India to increase its contribution to the Global Fund. By setting such an example of continued support for a global cause, India will continue to influence other countries in ensuring that no one is left behind.

5. Global Fund to continue to invest in India beyond 2025.

The Global Fund continues to remain an important external funder and a catalyst for domestic investment in the fight against COVID-19 as well as HIV, TB, and Malaria in India. Not only such support is required for its fight against COVID-19, India expects strain on existing health investment and fiscal mobilization in the post-Covid era as well. Therefore, India needs to continue to have such international collaborative support to improve upon the current levels of prevention and control efforts, and to move toward UHC.

10. Conclusion

India has made good progress in the prevention and control of HIV, TB, and Malaria in recent years. By setting ambitious targets for the elimination of the diseases, India has upped its response further. This is supported well by political will and financial allocations to a certain extent. This initial success must be supported with more nuanced responses that need additional funding from domestic and international sources. The ongoing COVID-19 pandemic exposed the limitations of the health system and can potentially widen the existing financing gap. Higher, better, and sustained financial investment is therefore essential. This requires an increase in domestic investment and continued support from international sources like the Global Fund. The additional resources must result in better investment in marginalized areas and among the disadvantaged communities in the form of community-based approaches and gender-sensitive strategies are needed for equitable distribution of outcomes. In addition, it is also essential to study the socio-economic and financial impacts of COVID-19 on programmes and households. The impact mitigation efforts must be identified and incorporated into ongoing programme efforts to minimize the long-term effects thereof. This must be done in a multi-sectoral approach by involving government, donors, non-governmental partners, and the community affected by the diseases.