Malawi:

Pioneering progress in HIV treatment threatened by uncertain funding situation

Malawi, one of the world's least developed countries, is among the top ten countries with the highest HIV prevalence worldwide. It is also the first country in Africa to implement the progressive prevention of mother-to-child transmission option PMTCT B+. But with donors retreating from HIV funding, the country is at high risk of reversing the progress made.

With an ambitious national programme, and thanks to the country's public health approach to the epidemic, which includes simplified treatment protocols and task-shifting amongst healthcare workers, significant progress has been made in the fight against HIV over recent years. As a result, people's access to treatment has increased substantially, and HIV prevalence appears to be decreasing.

Yet the country is almost entirely dependent on external funding for its HIV response. While Malawi supports at least five percent of its HIV programme through staffing, infrastructure and other expenses, 100 percent of its antiretroviral (ARV) drugs come from the Global Fund to Fight AIDS, Malaria and Tuberculosis (GF). This reliance on what is effectively a single donor makes Malawi extremely vulnerable to funding cuts or delays.

Malawi's existing GF grant, which pays for the majority of the country's HIV response including lifesaving ARVs, expires in early 2014. The resources will need to be raised for an estimated 450,000 to 500,000 people anticipated to be on treatment by then, as well as to ensure new initiations are not halted, with an estimated bill of US$500 million for five years for ARVs alone. Funding will also be needed to ensure the switch from the old regimen d4T (stavudine) to the better tolerated and more easily administered tenofovir (TDF) for all patients on d4T today.

Realistically, this almost exclusive dependence on a single donor is unlikely to change without some effort. Other major actors in the HIV response are hesitant to enter into ARV treatment provision. Even though involved in other areas in the HIV response, the US President's Emergency Fund for AIDS Relief (PEPFAR) in Malawi does not support regular ARV procurement, nor does the pooled Sector Wide Approach (SWAp) fund. Meanwhile, UNITAID/Clinton Health Access Initiative (CHAI) is planning to phase out its provision of paediatric ARVs by the end of 2012.

Facts and figures

- An estimated 960,000 people (or 10.6% of the adult population) are living with HIV.
- By the end of March 2012, 347,983 people were receiving ARV treatment.
- While Malawi offers ARVs to all children under the age of two, only 19 to 24% of eligible children are receiving them.
- The country suffers from major shortages of health staff, with vacancy rates of 65 percent, on average, amongst key cadres of healthcare workers.
- Retaining current healthcare workers in the public health sector will soon become a major challenge, as the GF grant that supported them with a 52 percent salary top-up allowance has run out, and the economic situation in the country is highly unstable. There is no clear plan, nor any commitment by the government or any donor, to support phasing in regular salary structures.

What is at stake?

- Malawi has adopted the latest WHO guidelines to provide early ARV treatment (CD4 count <350) and has adopted tenofovir (TDF), the first-line drug recommended by the WHO. However, due to funding shortfalls, Malawi has had to make difficult choices, and now only offers TDF to selected patient groups: pregnant women; TB/HIV co-infected patients; and patients with severe side effects.

- In order to protect infants and benefit maternal health, Malawi has adopted new national guidelines to include lifelong treatment for all HIV-positive expectant and lactating mothers (B+) – the first country to do so worldwide. Continued funding needs to be secured in order to ensure these plans are successful and can continue.

- Malawi has adopted viral load monitoring so as to be able to switch patients failing on treatment in a timely manner and avoid drug resistance; however, implementing and rolling this out is dependent on increased funding.

- Malawi failed to secure funding through GF Round 10, partly because its plans – which included full implementation of all WHO recommendations on HIV treatment, as well as prevention through male circumcision – were deemed too ambitious. Despite this, and despite the cancellation of Round 11, it has still managed to start implementing at least part of these plans through reprogramming existing money.

- With donors' money hard to find, governments like Malawi's are being pushed to increase resources to pay for their own HIV response. However, the burden is still too high for the country to be able to move quickly enough. For 2011, ARVs alone cost about US$60 million, compared to the country's total health budget of US$90 million. This cost cannot be absorbed in the short term. This was also confirmed in a study commissioned by UNAIDS that concluded that, even if all innovative financing mechanisms (airline levies, private sector mainstreaming, etc) were implemented in Malawi, the money raised would only cover 17% of the total estimated HIV financing gap expected by 2020/21. By then, even with all these alternative sources in place, the financing gap is expected to reach US$348 million. This translates to 4.5% of Malawi's GDP, or 16.4% of overall government annual expenditure (source: Sustainable Financing for HIV/AIDS in Malawi, Oxford Policy Management, March 2012).

> ***"We're committed to implementing programmes based on recent scientific progress. Yet just as success is within reach, we're up against a great financial squeeze. I truly believe that we can end AIDS. But we can't do it alone."***
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July 2012

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