The Global Fund in the MENA Region: An Aidspan Regional Report 2015

Authors and Acknowledgements

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Photos on cover courtesy of: Robert Bourgoing, UNHCR, IRIN

Preface

Aidspan (www.aidspan.org) is an international NGO based in Nairobi, Kenya, whose mission is to reinforce the effectiveness of the Global Fund. Aidspan performs its mission by serving as an independent watchdog of the Fund, and by providing services that can benefit all countries wishing to obtain and make effective use of Global Fund financing.

This is the first regional report published by Aidspan. These regional reports seek to provide a snapshot to country partners, advocates and other stakeholders of comparative information, to make it easier for them to assess their countries' progress and performance and understand the regional picture of Global Fund programmes.

Other reports and analyses, and guides to different aspects of the Global Fund ecology are available at www.aidspan.org/page/research and www.aidspan.org/page/guides-global-fund.

Aidspan publishes news, analysis and commentary about the Global Fund in its twice-monthly Global Fund Observer newsletter, available by free subscription through the Aidspan website.

Aidspan finances its work primarily through grants from governments and foundations. Aidspan does not accept funding of any kind from the Global Fund.

Abbreviations:

ALCS	Association for the Fight Against AIDS (Morocco)
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
CCM	Country coordinating cechanism
GDP	Gross domestic product
GNI	Gross national income
IDP	Internally displaced ersons
IDU	Injecting drug users
LLIN	Long-lasting insecticidal nets
MDGs	Millennium Development Goals
MDR-TB	Multi-drug-resistant tuberculosis
MENA	Middle East/North Africa
MENAHRA	Middle East and North Africa Harm Reduction Association
MSM	Men who have sex with men
NFM	New funding model
OST	Opioid substitution therapy
PMTCT	Prevention of mother-to-child transmission
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV and AIDS
UN-OCHA	United Nations - Office for the Coordination of Humanitarian Affairs
WHO	World Health Organization

INTRODUCTION

The Global Fund has designated 15 countries as Middle East/North Africa (MENA region) using its own classification system, each with its own burden of disease and ability to pay for prevention, care and treatment. While each country has a unique profile based on the demographics, cultural and religious traditions and the political and socio-economic status of its population, there is an interconnectedness and some degree of similarity in the way each country responds to the challenges of providing a comprehensive public health response to AIDS, TB and malaria. In most of these countries, HIV epidemics are relatively concentrated among a small subset of the population; also in most of them, there is limited human resource capacity to respond to the particular needs of those vulnerable groups.

Photo Courtesy of Georgina Cranston/IRIN

Some of these states – South Sudan, Somalia and Syria – are in heightened states of conflict, or post conflict, which limits the access to services and care for the majority of the populations or communities most affected. Others, including Yemen, Mauritania and the Gaza Strip/West Bank, suffer perpetual unease with flashes of violence, or are rebuilding, like Iraq, after more than a decade of conflict that has eviscerated the health system.

There are countries like Jordan and Morocco whose health systems made it through a sweep of reform and uprising known as the Arab Spring relatively unscathed and unchanged; then there is Egypt, which continues to grapple with the lasting legacy and implications for health infrastructure of the overthrow of decades of an autocratic leadership that, despite its political implications, maintained some degree of service provision for most.

Included in the region, too, are Djibouti –about which little is known beyond its strategic importance and influx of military assistance and attendant support for public services – and Eritrea, a nation with severe restrictions on both civil society and the media, but an enthusiasm for infectious disease control and prevention and a somewhat surprisingly rigorous reporting system.

And finally, MENA includes Algeria, which had graduated from direct Global Fund assistance in 2008 only to become eligible again under the new funding model (NFM) due to concerns about its concentrated HIV epidemic.

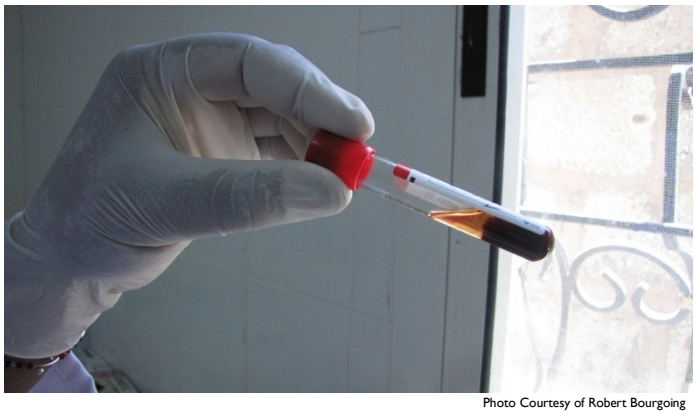

Photo Courtesy of Robert Bourgoing

All these countries are also included in a regional initiative known as MENAHRA – the Middle East and North Africa Harm Reduction Association, which works to change behaviors among injected drug users to prevent HIV transmission.

Of the $28 billion disbursed by the Global Fund since 2002, MENA countries have received just 7%. Under the country allocations announced in March 2014 as part of the roll-out of the NFM, that percentage held steady, reflecting new eligibility classifications based on burden of disease and ability to pay. Countries that would typically be included in the MENA region, such as Sudan, have been reclassified by the Global Fund as High Impact, and therefore do not figure in this calculation.

Some countries have found their envelopes to be smaller than before, due to their economic classification; others are phasing-out of eligibility entirely, with countries such as Iraq receiving relatively small amounts of funding for transition only.

Irrespective of the size of the allocation, all of the countries are being asked to develop robust, comprehensive concept notes that will help them achieve the goals established in their National Strategic Plans. Getting to 'yes' will require concerted efforts to respond to the particular needs of key populations, as well as to the human rights challenges that affect both the health system and the wider socio-cultural environment.

Gender inequality, institutionalized discrimination against members of vulnerable groups and a punishing legal environment for behavior seen as beyond the norm in conservative societies are among the major human rights considerations confronting health activities supported by the Global Fund. At both a regional and country level, these human rights concerns can limit the effectiveness of health programming, and will be a

decisive indicator for effectiveness and impact of Global Fund-supported work in prevention and mitigation of disease, as well as treatment and care. Institutionalized discrimination and widespread social stigmas mean that women are unwilling to present themselves to be tested for HIV or treated for TB, and HIV positive children often don't go to school. It means that men who have sex with men are failing to protect themselves in casual sexual encounters, widening the web of those at risk of HIV infection. And it means that people who inject drugs are sharing needles, failing to report overdoses among their friends for fear of arrest, and generally consigning themselves to lives lived underground. We found little information on transsexuals in MENA.

How to integrate health system strengthening in a post-conflict environment, and what emphasis to place on ensuring access to care and treatment for large migrant populations are also conundrums facing MENA countries. Low-income states in the region have severe deficiencies in infrastructure and human resources for health, and correspondingly low investments by governments in overcoming those gaps. Promising advances have been made in countries with more

Photo Courtesy of Robert Bourgoing

robust economies, but mostly in their sprawling urban environments rather than in the remote, rural areas where disease often goes undetected. Urban areas are increasingly crowded with refugees, either those fleeing conflict or dire economic circumstance. In cash-strapped health systems there is very little room to respond to the needs of these migrants and the attendant threat to public health looms large.

Responding to these challenges requires a robust, evidence-based approach, relying on valid, credible data. Here, too, are bright signs of improvement in some countries, though often more a function of collaboration with international technical partners than a national commitment to improving data management systems. Electronic record-keeping systems are slowly being introduced, and national-level population surveys for key indicators are being carried out more regularly. But the need for bio-behavioral studies in order to effectively target interventions remains acute.

This report provides a snapshot at this particular point in time of each country's history with the Global Fund and the ways in which it is approaching its burdens of disease for AIDS, TB and malaria. Data referred to in the report were gathered from highly credible sources including UNAIDS, the WHO and the Global Fund itself. Wherever possible, citations are annotated. We have also tried to put a human face on the challenges faced in each of the 10 countries, with anecdotal portraits of health care providers, and beneficiaries, in each of the unique national contexts. We have also included graphs measuring a country's individual performance, by disease component, against regional performance for that disease component. This is based on the Global Fund's own performance assessment data, with performance being defined as how a country does in spending its disbursments against targeted grant-supported activities.

May this provide a window into not only the obstacles the MENA countries must overcome but the innovative tools each state is using to tackle these treatable, and preventable, diseases.

Photo Courtesy of Georgina Goodawin /Vestergaard Frandsen

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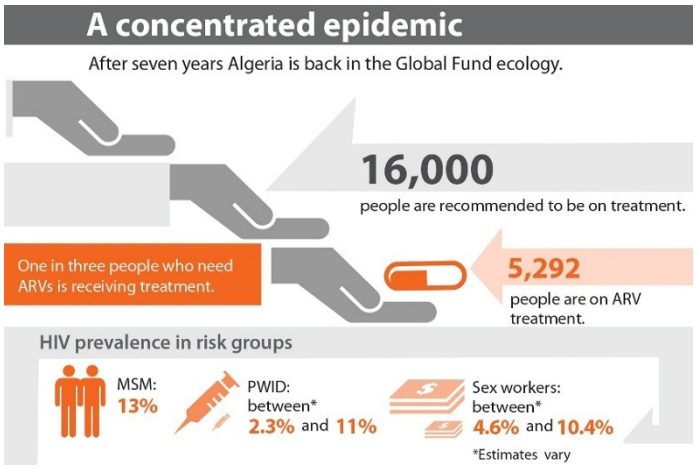
ALGERIA



As an upper middle-income country with a low generalized HIV prevalence rate, Algeria was deemed ineligible for Global Fund support with the end of its Round 3 multisectoral grant in 2008. The recent identification, however, of a worrying concentration of the epidemic among key populations including sex workers, economic migrants and long-distance truck drivers has reopened the North African country to Global Fund resources for HIV -- to be administered through the network of civil society groups waging a targeted fight against the disease.

Limitations identified in Algeria include a difficulty in maintaining disease records: an opacity that is not unexpected from a country considered among the most closed states in the world. Falling oil prices have hit this resource-dependent economy, which is slashing public spending as a response to declining revenues from its sales of oil and gas. How this will affect the health sector -- in terms of recruitment, retention and continuing education of health care workers -- remains to be seen.

One bright note could be the decision to rehabilitate the country's 14 teaching hospitals, announced in January 2015. If these facilities are renovated to international standards, as ordained by the government, they could include resources to respond to the diagnostic and counseling needs for HIV.

HIV

UNAIDS estimates in 2013 put the number of confirmed cases of HIV at 25,000: a prevalence rate of roughly 0.1% in the general population. Fifty-four percent of those infected are women. The number of new cases confirmed annually is less than 1,000. Among key populations, infection rates are at 10.4% for sex workers and 12.5% for men who have sex with men.

The country's national strategic plan (2013-2015) aimed to enable Algeriato move closer to the Millennium Development Goal #6: halting the spread of the disease and increasing the number of people on treatment. Currently, the number of people on ARV treatment is 5,292: a third of those who need them.

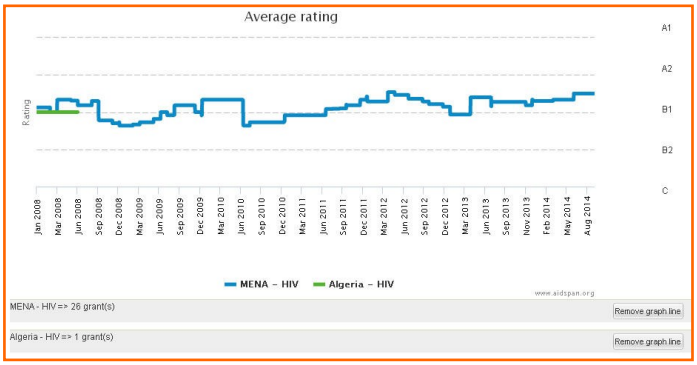


Photo Courtesy of UNAIDS

The Global Fund

With the end of Global Fund support to Algeria in 2008 came a dismantling of all structures to support grant implementation. Talks have opened between the Fund and the country's national program as well as non-governmental stakeholders to reconstitute a CCM, including members representing key populations and people living with the disease. Under the NFM, the country was allocated $6.5 million.

Algeria and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	1	($28,208)	$0	$6,533,577	$6,533,577

Algeria General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	31 million	39 million
GNI (per capita) PPP current international $	$7060 (98)	$13070
Under 5 mortality / 1000 live birth	41/1000	25/1000
Life Expectancy	69 years	71 years
Human Development Index (medium HDI - country)	.634 (2000) Rank	.717 Rank 93

* or nearest year.

Civil society as the strongest link in the HIV response in Algeria

Photo Courtesy of UNAIDS

In Oran, on the Mediterranean coast of Algeria, one of the main goals of the Association for Protection Against AIDS is to promote greater solidarity among groups vulnerable to infection. Since 1998, this NGO has been engaged in the fight to end stigma and discrimination against people living with HIV.

Among their activities, explains Abdelaziz Tadjeddine, is the creation of peer support groups who help individuals improve their self-esteem, fight feelings of guilt and, increasingly, work with religious leaders and imams to promote messages of respect and tolerance.

Groups like this illustrate the critical role civil society is playing in the national response to HIV. General HIV prevalence is a miniscule 0.1% of the population, thereby concentrating the epidemic into a few key populations, including sex workers (10.4%) and men who self-identify as engaging in sexual relations with other men (12.5%) according to a 2014 UNAIDS report.

To reach these key populations, NGOs work discreetly but determinedly at the community level in order to cultivate relationships built on confidence and mutual respect and that overcome entrenched taboos. According to Adel Zeddama, the country director for UNAIDS in Algeria, it is anticipated that new funds -- a total of some $6.5 million for 2014-2017 -- being allocated to the country by the Global Fund will be directed towards these groups, to bolster civil society.

Algeria is only just returning to the ranks of countries eligible for Global Fund support. Since 2011, improved data collection and analysis -- again courtesy of civil society -- revealed an upswing in infections among key populations. That the epidemic was clearly concentrated among certain populations allowed for Algeria to ask and be approved for external assistance.

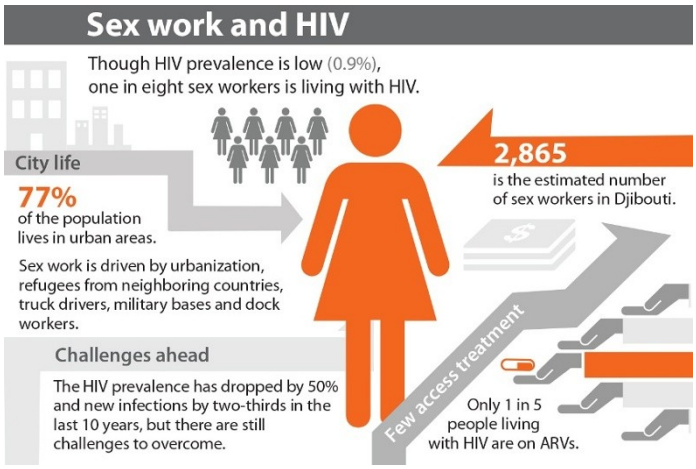
Going forward, more community-level and program-level data will help to enhance the national database, which draws information from screening centers, case notifications from the national reference lab and treatment centers.

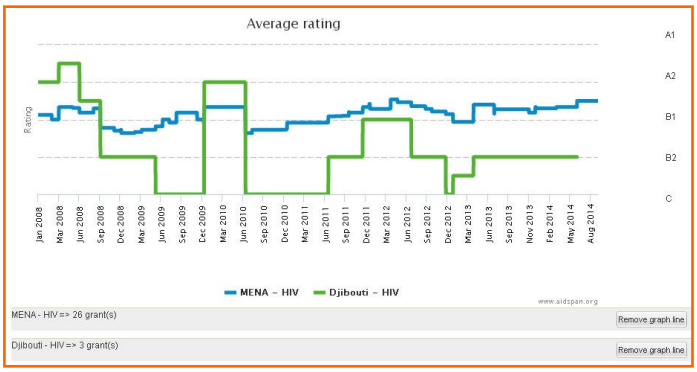
"More must be done to improve the knowledge of the epidemic to better target key populations, and reduce new infections among those groups," says Zeddama.

Targeting key populations was one of the main topics of discussions in November 2013 on the margins of a UNAIDS meeting in Algiers between the Global Fund, civil society and the health ministry, which will likely continue into 2015. Plans are under way to relaunch the process to install a country coordination mechanism that is inclusive and robust enough to oversee the implementation of the new grant.

Due to the nature of the epidemic in Algeria and where grant monies are likely to be directed, it is anticipated that key populations, civil society and people living with HIV will fill prominent roles in the CCM.

DJIBOUTI





Djibouti is a lower middle-income country at the tip of the Horn of Africa, known as a strategic military and security anchor for international foreign deployments to monitor instability in the region.

The large military presence as well as the massive Djiboutian port has resulted in considerable migration through Djibouti. Large numbers of economic and political migrants live around the port, and there is a sizable community of mobile populations: all of whom, by dint of poverty, mobility and low awareness about risky behavior, are some of the main drivers of the country's disease burden.

Djibouti is considered a high-priority country for co-morbidity of HIV and TB, is largely malaria endemic and has a concentrated HIV epidemic -- primarily among mobile populations and sex workers.

HIV

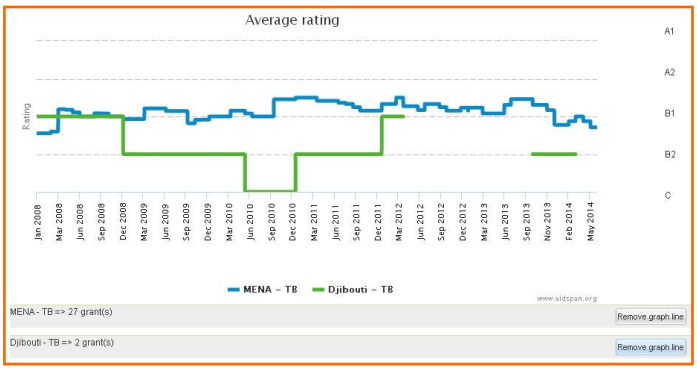
The HIV prevalence rate among the general population is 1.2%, representing some 7,261 confirmed infections, according to national reporting to UNAIDS. Sex workers and their partners are responsible for an estimated 22% of all new cases of HIV. Prevention efforts are primarily focused on youth and on sex workers and their partners -- including long-distance truck drivers who ply the East African and Red Sea corridors.

Djibouti's national HIV response relies heavily on international partners and is expanding to include a more holistic approach to engaging with civil society, especially groups that are working with targeted populations engaging in risky behavior.

Funding challenges have meant that the number of women who have tested positive for HIV and were put on ARVs, as well as whose newborns are under ARV treatment, is very low.

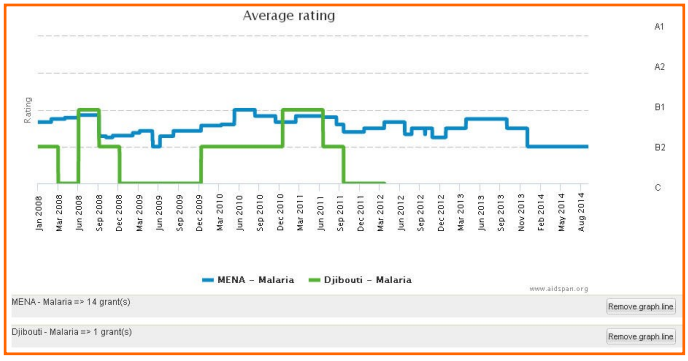
TB

Djibouti had an estimated Tb prevalence rate of 890 per 100,000 in 2012, and reported nearly 3,500 new and relapsed cases, but it is not a priority country for MDR-TB. Patterns of migration, especially due to the transport corridor linking the country with Ethiopia, has complicated the provision of TB services.



Malaria

Djibouti faces an unstable cyclical malaria situation, with malaria epidemics resurfacing in 2013 and 2014 after several years of drought. The country is at the malaria control stage, according to WHO, with 872,000 at risk of contracting the disease, according to 2013 figures.



The Global Fund

Djibouti has experienced bottlenecks in disbursement of grants from the Global Fund, which has limited the consistent provision of interventions. The country was allocated $6.0 million for HIV, $6.4 million for TB and $7.8 million for malaria under the NFM.

Djibouti and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	2	$7,461,584.92	$1,843,129.26	$4,110,723.27	$5,953,852.53
Tuberculosis	1	$1,698,267.68	$6,401,665.86	$0	$6,401,665.86
Malaria	1	$304,142.00	$7,794,954.48	$0	$7,794,954.48

Djibouti General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	.7 million	.9 million
GNI (per capita) PPP current international $	$1630	$ _
Under 5 mortality / 1000 live birth	105/1000	70 (2012)
Life Expectancy	57 years	62 years
Human Development Index (medium HDI - country)	_ Rank	.467 Rank 170

* or nearest year.

In Djibouti, 'makalifs' are the most exposed to HIV

Zamzam Abdillah, a technical advisor to the Djibouti national HIV program, recounts the story of a young 'makalif', or sex worker, that continues to drive her work. It's a story she heard while helping in 2014 to carry out a nationwide bio behavioral study of sex workers and long-distance truck drivers: two of the groups most vulnerable to HIV infection.

Photo Courtesy of Didier Ruef

"So the young woman got divorced, at age 23. When they divorced, the ex-husband chased her away from the house, with nothing but her month-old baby," she says. "She had no choice but to resort to prostitution. She had no idea about safer sex or how to protect herself and within a month she was HIV positive."

This anecdote corroborates the data collected by the IBBS and underscores Djibouti's need for focused HIV prevention programming that targets sex workers; while the generalized HIV prevalence rate is 0.9%, among sex workers it is an estimated 13%, according to a 2013 UNAIDS report.

Divorce, unplanned pregnancy, rape, difficult situations at home that they need to escape: all of these drive Djiboutian women to transactional sex as a desperate means of survival. A 2011 UNAIDS report found that these women, known as makalifs, are preyed upon and abused because of just how vulnerable they are. Ironically for many, in trying to leave behind a terrible situation and turning to prostitution as a means for survival, they are even more exposed to violence and discrimination and their survival is under threat.

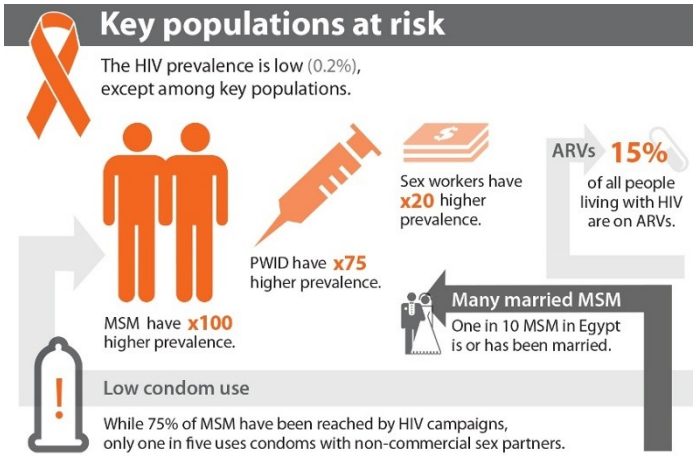
While prostitution is, officially, illegal in Djibouti, it is tolerated. There are about 82 hotspots for the scores of women who ply their trade in the capital, most of them focused on the clients of the popular bars and nightclubs in the city center. Others make their living in the rougher, poorer parts of town. Rates for the top-level escorts can go as high as $30 for a date, while bar girls can earn around $16 per client and women who work clandestinely in the community can earn around $8 for each encounter.

Migrant and refugee women, most of whom hail from Ethiopia or Somalia, are among the most difficult to reach with prevention and safer sex messaging due to their uncomfortable status in the country. They are also the most likely to be abused or exploited in their transactional relationships because of how vulnerable they are in their everyday life. And the more vulnerable they are, the less likely they are to insist that clients use condoms.

UNAIDS recommended in a 2011 report that more resources be devoted to improving Djibouti's condom distribution network and according to Zamzam Abdillah, this will be an integral component of the activities being proposed to the Global Fund in the concept note under development.

A holistic approach to the particular needs and challenges in reaching sex workers is also foreseen under the concept note, she adds.
"The priority is to improve the distribution network of condoms and to improve the prevention through peer educators who are specifically trained in this field," she says.

EGYPT



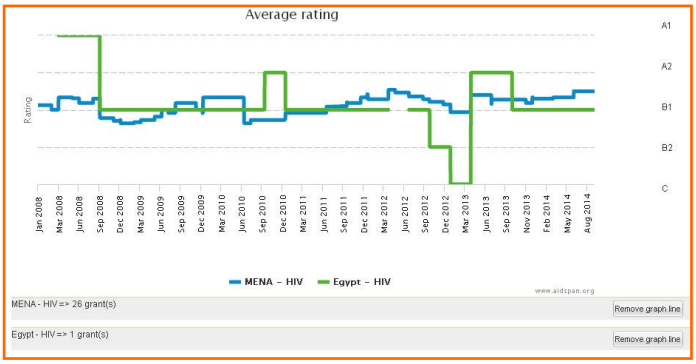
Egypt is a complex and sprawling country in transition, with a health care system to match. The network of public facilities is staffed with trained professionals, and operated by ministries, the military and police as well as by faith-based and community-based organizations.
Regional inequalities, however, are pronounced, with Upper Egypt significantly less developed and with greater poverty than Lower Egypt. The country is highly urbanized, leading to overcrowding that can be ideal contexts for disease, particularly TB.

Despite the political challenges of recent years, the country is moving along the path towards universal coverage, a scheme led by the Ministry of Health and Population that draws on the sturdy primary health care infrastructure already in place. A strong workforce of trained professionals is the envy of Egypt's neighbors, but like the rest of North Africa the country faces challenges of unequal access and planning, as well as a lack of harmonization of the national agenda and the priorities of Egypt's many international donors.

Photo Courtesy of UNAIDS

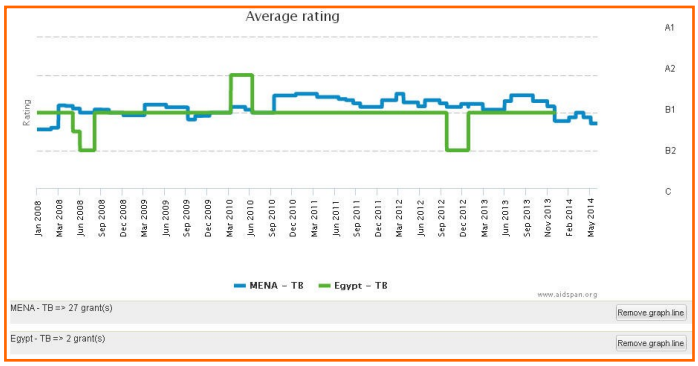
HIV

HIV prevalence in the general population is estimated to be below 0.1% but there are few estimates of the size of, and HIV prevalence within, the most at-risk populations in the country. The rapid shifts in the socio-political context that accompanied Egypt's Arab Spring are likely to bring risk-seeking behavior out of the shadows, which could be accompanied by an increase in the HIV burden. More resources are being devoted to conducting representative studies among vulnerable groups -- women, youth, uniformed services, prisoners and refugees -- as well as among the at-risk populations in order to better target prevention messaging.



TB

A total 8,183 cases of TB were recorded in 2013. Egypt has also been working to bring its cost per notified case for treatment down from a high of $1,200 in 2008. This effort is primarily because of the demographics of TB patients in Egypt, most of whom are poor and vulnerable, residing in the rural areas or in the teeming urban slums. Training of health workers and laboratory technicians in TB case management and detection are at the core of Egypt's national strategic plan for TB.



Global Fund

Egypt was allocated $11.1 million for TB and $7.0 million for HIV under the NFM.

Egypt and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	1	$4,018,130.62	$3,047,862.51	$3,992,606.18	$7,040,468.69
Tuberculosis	2	$3,694,590.65	$5,993,557.20	$5,061,132	$11,054,689.00

Egypt General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	64.1 million	82.1 million
GNI (per capita) PPP current international $	$5590	$ 10790
Under 5 mortality / 1000 live birth	52/1000	22/1000
Life Expectancy	68 years	71 years
Human Development Index (medium HDI - country)	.621 (2000) Rank	.682 Rank 110

* or nearest year.

Repression of homosexuality a major obstacle preventing the success of HIV prevention programs in Egypt

Photo Courtesy of UNDP

In early December 2014, a spectacular raid by police of a bathhouse in Cairo was televised and then splashed across the front pages of Egyptian media. More than 30 clients were beaten, stripped and bundled into police cars; of the 26 arrested on charges of debauchery, 21 have submitted to medical exams to determine whether they have had anal sex.

The journalist who filmed the raid as it happened denounced the individuals, declaring that the raid was "a moral victory against sexual deviance" and called for further, similar action to reveal other festering nests of AIDS.

While same-sex relationships are not expressly banned in Egypt, they are taboo -- and subject to intensive harassment both by media and security forces. Which means that those who would wish to help men who have sex with men engage in safer sex face major obstacles in providing education, awareness and support for prevention efforts.

This has served to concentrate the HIV epidemic, at a miniscule 0.02% prevalence among the general population, within the gay community. Estimates from a 2010 IBBS survey -- the most recent data available due to the political instability that has engulfed the country since the 2011 revolution -- set the prevalence rate at 5.7% in Cairo and 5.9% in Alexandria among self-identified men who have sex with men.

"The main challenges facing outreach currently include the current crackdown on MSM by the police," says Ahmed Khamis, country manager for UNAIDS in Egypt. "This hinders significantly the efforts of outreach programs and drives the population further underground, making it difficult to convey information and services to a population very much at need."

Anecdotal evidence about the stigmatization, harassment and outright persecution of the gay community has earned new credibility. In a study entitled *Stigma experienced by people living with HIV in Egypt*, (ESPSRH, november 2013), authors from the Egyptian Society for Population Studies and Reproductive Health reported that 40% of survey respondents failed to disclose their HIV status when seeking health treatment. For those who do, more than half reported a reluctance or outright refusal by health workers to treat them.

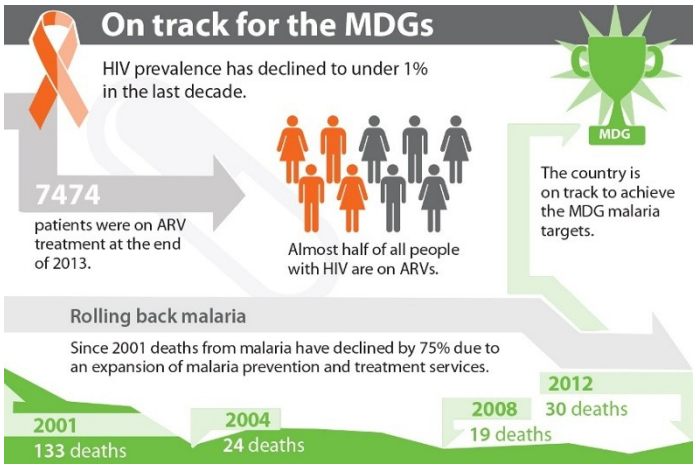
Feelings of guilt and shame are amplified by such discrimination, and then compounded by the police aggression -- leading to a dwindling number of people actually accessing the services they need.

So in response, the outreach programs developed a legal service to provide legal counselling and defense as needed to beneficiaries. UNAIDS is also supporting an outreach model that deviates from the typical programming for MSM.

Implemented since 2009, with Global Fund financial support, outreach work uses a network model of private service providers who provide stigma-free monitored services backed by street outreach carried out by professional teams. Each beneficiary is entered into the system using a coded system, guaranteeing confidentiality. Rather than using the traditional drop-in center, which some consider to be too high-profile in environments where homosexuality is highly taboo, the network model also allows for patients to integrate into the wider health care system as they choose.

Global Fund support has been vital to Egypt's HIV fight, which was why the suspension in July 2013 of a grant due to challenges in implementation has been so damaging. Since then, only life-saving commodities have been purchased, using the Global Fund's pooled procurement mechanism. Ahmed Khamis said the priority now is to reform the country coordination mechanism to become more robust and efficient, and in line with the requirements laid out by the Fund. Data to support the development of a new national strategic plan is being collected and analyzed, which will also be used as the foundation of Egypt's concept note to access the $7 million it was allocated under the new funding model (NFM).

ERITREA



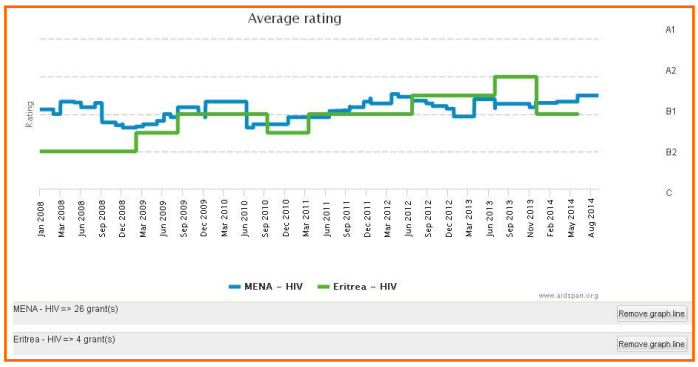
Having opted to forego the wealth of international support that its Horn of Africa neighbors can count on, beyond grants from the World Bank and a small handful of other partners, Eritrea has nevertheless made significant progress in controlling the spread of the three diseases and approaching the targets set under the health MDGs.

HIV prevalence is showing a year-on-year decline, and Eritrea is moving towards 100% ARV coverage of those cases that have been confirmed. It is also moving toward pre-elimination of malaria, with a combination of net campaigns and mass spraying as its primary prevention activities.

Strengthening the health information system and investing in human resources for health remain top priorities for the Eritrean government. Its few international partners and many of its observers continue to be concerned about human rights, with respect to care for at-risk populations as well as those already diagnosed with HIV.

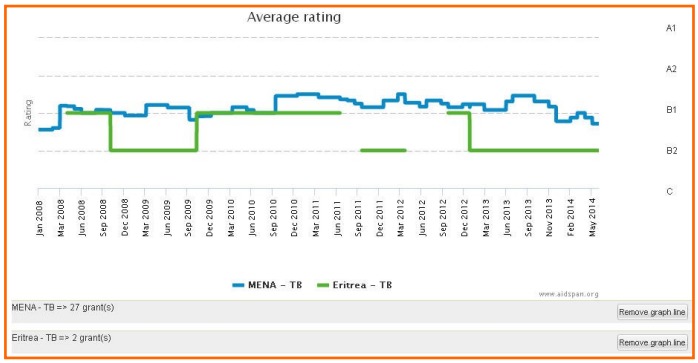
HIV

General prevalence of HIV is 0.6%, for an estimated 18,000 cases. ARV adherence is high due to intensive monitoring done through the public health system at the community level. Annual deaths attributable to AIDS have also declined. The country still grapples with pockets of concentrated epidemic, primarily among sex workers and their clients, and truck drivers. Of the new infections recorded annually, one in five is a truck driver.



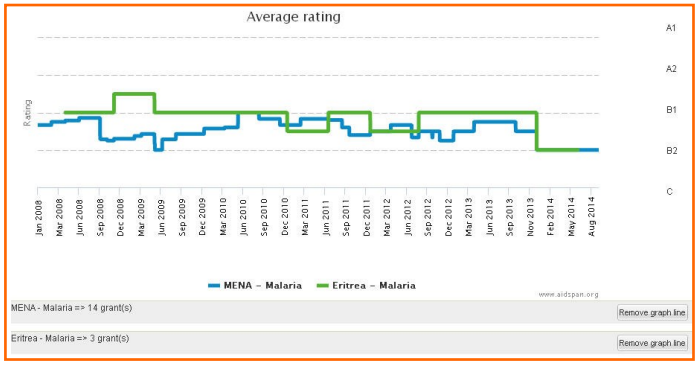
TB

Eritrea recorded nearly 3,000 cases of TB in 2013. The MDR-TB burden in the country is around 1%. Co-morbidity with HIV is around 35%. The national TB program is 99% funded by the Global Fund, for a value of approximately $4.6 million in 2013. Nationwide, DOTS coverage is 100% and treatment success hovers around 85%. Case detection remains below the global target of 70%, a function of the poor health information system management in the country.



Malaria

Eritrea is moving into pre-elimination of malaria, bringing its case burden down substantially over the last two decades. During the El nino driven epidemic of 1998, disease rates reached 110 cases per 1,000 population. By 2012, those rates had fallen to 11.9 cases per 1,000 population. The country is stratified into low and moderate-risk areas, rather than facing endemicity comparable to its neighbors. This is partially due to investment in prevention; one of every two dollars spent on malaria management in Eritrea is spent on bed net campaigns. Diagnosis and treatment have also improved; in 2012, 92.8% of malaria cases were treated according to the national guidelines.



Global Fund

Eritrea was allocated $39.2 million for HIV, and $9.5 million for TB under the NFM. The TB allocation will represent around 99% of the national investment in TB in the country. The malaria response was allocated $36.1 million.

Eritrea and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	4	$52,221,771.08	$34,870,998.00	$4,295,330.31	$39,166,328.31
Tuberculosis	2	$9,830,114.00	$9,524,784.00	$0	$9,524,784.00
Malaria	3	$48,979,533.09	$9,265,592.00	$26,877,123	$36,142,715.11

Eritrea General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	3.7 million	6.3 million
GNI (per capita) PPP current international $	$1230	$ 1180
Under 5 mortality / 1000 live birth	99/1000	50/1000
Life Expectancy	55 years	63 years
Human Development Index (medium HDI - country)	_ Rank	.381 Rank 182

* or nearest year.

In expanding antiretroviral coverage, Eritrea giving its population new opportunities

Photo Courtesy of Gabriela Escudero

In 1993, three-year-old Adhanet fell ill. Fever, diarrhea and an abrupt weight loss sent her and her mother straight to hospital, where HIV infection was detected. Fifteen years later, she began taking antiretroviral drugs. Now, in 2015, she is married and the mother of two healthy, thriving children who, despite being born to two HIV-positive parents, show no signs of infection.

There are many stories like Adhanet's in Eritrea, a country that has succeeded in bringing the HIV prevalence rate in the general population down to under 1% in 2011. While some high-risk populations continue to register higher HIV prevalence -- including sex workers, at 7.9% of the self-identified population -- efforts since 2005 to expand ARV coverage alongside targeted prevention messaging appear to be working.

Five hospitals began in 2005 to dispense ARVs; since then the number of facilities able to respond to patients' needs has expanded to 21. By the end of 2013, 7,474 patients were on ARV treatment and another 417 began their own treatment regimens in early 2014. This commitment to universal coverage puts isolated Eritrea in an unfamiliar position: as a role model and exemplar to other nations.

In a 2014 UNAIDS report, Eritrea's success in approaching universal coverage was attributed to strict adherence monitoring and innovations including nutrition programs implemented by the national association of people living with HIV: a group that works very closely with government.

"To start ART, all clients need to be counseled on adherence at least three times," explains Araia Berchane, director of the infectious diseases program at the Ministry of Health. "If the client is not motivated to start ART, treatment is not initiated and more adherence counseling is given. ART is only initiated when the client understands the benefits including side effects and that it has to be given lifelong. Then, if a client misses an appointment for four days, a partner or family member is called and asked why the client did not come."

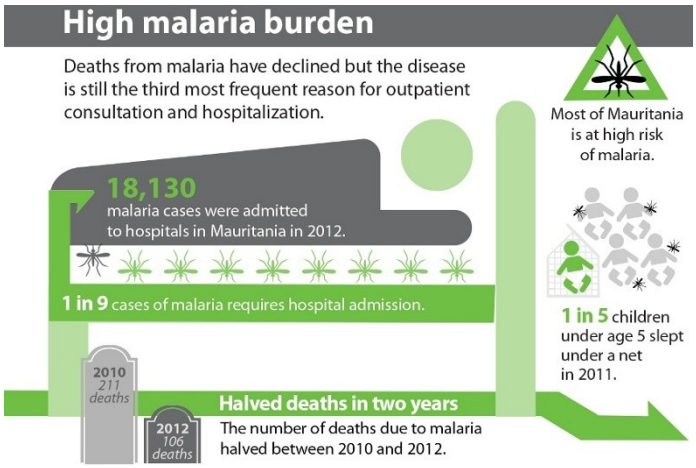
Despite the official push for universal coverage, however, stigma remains one of the largest barriers to access particularly in rural areas. The result? Some 60% of all patients enrolled in ART therapy travel monthly to the capital, Asmara, to receive their medicine.

Other challenges flagged by UNAIDS include a lack of space for counselling and testing at health facilities and incomplete or delayed reporting of HIV-related activities.

Araia Bechrane acknowledges that the evaluation system that also includes patient monitoring is tough to manage, particularly since it is a paper-based, rather than electronic, platform. Transforming the system into an effective one will require extensive training of health workers -- many of whom are not equipped for the rigors of caring for HIV patients to say nothing of a more sophisticated record-keeping system.

But if Eritrea is still lagging behind the global standard of 23 health professionals per 10,000 population, there have been enormous gains made over the past 20 years in terms of health system strengthening. Some 10,000 health workers have been trained since 1991 to achieve the figure of 10.5 health workers per 10,000 population. By the end of 2013, there were 5,502 health professionals deployed across Eritrea's six zobas, or regions -- an increase from 3,368 ten years earlier.

MAURITANIA



Sitting on Africa's Atlantic coast as a waypoint between North Africa and the Sahel, Mauritania is a complex country with considerable natural resources and with an equally high risk of natural disasters. Political instability and porous borders send thousands of people moving across the shifting sands of the Sahara desert and into the country every year, adding to the levels of poverty.

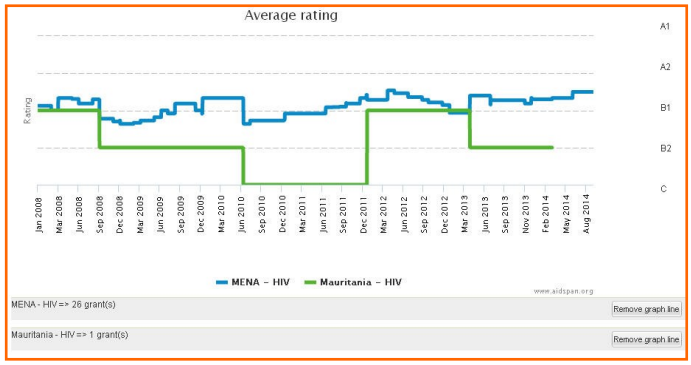
It is currently hosting a sizeable population of refugees from eastern neighbor Mali, which has stretched limited health infrastructure to capacity and driven the national disease burden up.

Performance of the health system is limited by a lack of trained personnel, particularly in rural areas. Human resources development is a key component of the national health plan, alongside efforts to integrate disease programming into a revitalized, primary health care system.

Photo Courtesy of Robert Bourgoing

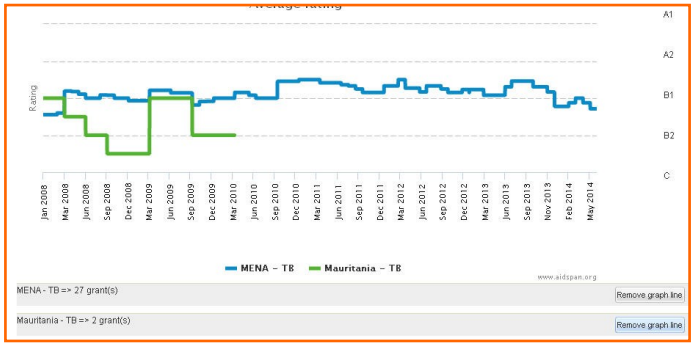
HIV

General prevalence of HIV is 0.6%, for an estimated 18,000 cases. ARV adherence is high due to intensive monitoring done through the public health system at the community level. Annual deaths attributable to AIDS have also declined. The country still grapples with pockets of concentrated epidemic, primarily among sex workers and their clients, and truck drivers. Of the new infections recorded annually, one in five is a truck driver.



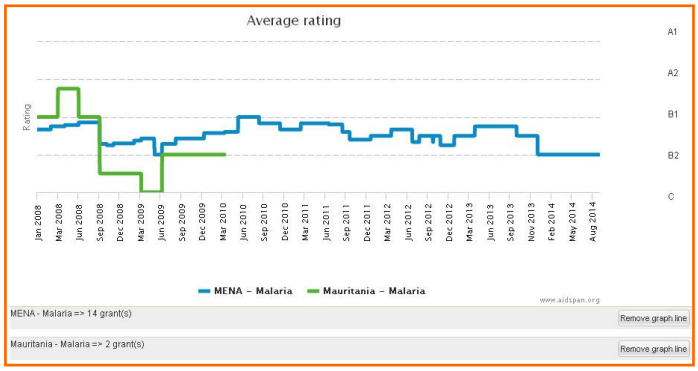
TB

There were 2,223 new cases of TB notified in Mauritania in 2013, representing a prevalence rate of 203 per 100,000 population. The country's case detection rate hovers around 50%. Mauritania is not considered a high-burden country for TB, although the influx of refugees from elsewhere could drive the burden higher, crammed as many are into informal settlements. The country's TB burden has declined over the past two decades, although the systems of reporting of data are weak and could be contributing to the decline.



Malaria

Some 3.9 million people were at risk of contracting malaria in Mauritania in 2013. Most of the southern half of the country, on the border with Senegal, is malaria endemic. This puts Mauritania below the MENA regional average in terms of reported cases but with a disease burden that is around five times greater than the global average.



Global Fund

After several years of suspension due to financial management challenges, Mauritania has carried out an overhaul of its Fund-related policies and systems to see a resumption of its relationship with the organization. Under the NFM, Mauritania was allocated $11.5 million for HIV, $4.8 million for TB and $15.6 million for malaria.

Mauritania and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	1	$697,429	$3,882,296	$7,632,506	$11,514,802
Tuberculosis	2	$44,371	$0	$4,839,053	$4,839,053
Malaria	2	($34,377)	$0	$15,645,145	$15,645,145

Mauritania General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	2.6 million	3.9 million
GNI (per capita) PPP current international $	$1860	$ 2850
Under 5 mortality / 1000 live birth	113/1000	90/1000
Life Expectancy	59 years	62 years
Human Development Index (medium HDI - country)	.433 (2000) Rank	.487 Rank 161

* or nearest year.

Community meals and nutritional kits on the menu for Mauritania's fight against HIV

Photo Courtesy of Robert Bourgoing

Three times a week, groups of around 20 to 25 people sit down and share a meal together at the outpatient clinic administered by the French Red Cross in the Mauritanian capital, Nouakchott.

The initiative seeks to encourage people living with HIV to share their experiences and counter some of the isolation born from the stigma and uncertainty still surrounding the disease. It's also a great opportunity to remain in contact with the clinic to make sure their treatment is going well and to be reminded about the importance of good nutrition as a weapon in their personal fight against their disease.

In a country where nearly half of the population lives below global poverty levels, "we are drawing them in through their stomachs; it's a great lure," smiles Dr Mohamed Idoumou Ould Mohammed Vall, head of the planning department of the national AIDS commission.

Before the meal, under the watchful eyes of a doctor, a social worker and outreach counselors, the patients receive nutritional counselling: how to prepare a balanced meal using local products and on a tight budget. The participants are encouraged to ask questions and share tips -- another way to counter the stigmatization that is also self-perpetuated.

As part of a pilot project financed by the Global Fund, the clinic also distributes food items including rice, sugar and oil to 400 individuals and 800 families every month. These people have been identified as either gravely malnourished by the clinic personnel, or as temporarily incapable of feeding their families.

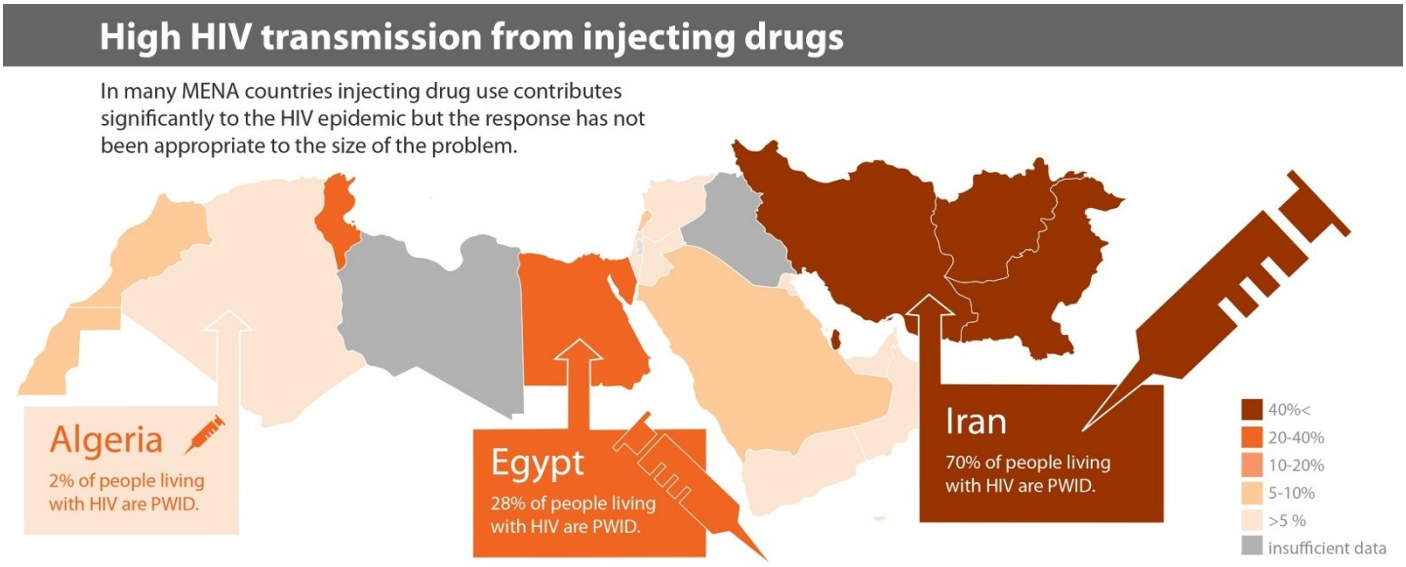
"In principle, the Global Fund doesn't pay to buy food, but they were convinced of the need to do so," explains Dr Barikalla Ould Sid Ahmed Ould Ely Litim, the chief resident of the clinic. "Our clients are generally very poor and very malnourished. In the beginning it was mostly to help very weak patients gain some weight, and to help people through a difficult period. But we have observed that it attracts people and helps with our outreach and, ultimately, contributes to their adherence to their treatment regimens."

Better nutrition and adherence to treatment can at times produce spectacular results. "One woman came in and she barely weighed 30 kg," recalls Dr Barikalla. "By the end of the year she weighed 130 kg and is now working as a trader between Mauritania and Senegal."

Since the outpatient clinic was inaugurated in 2004, the Red Cross has taken a holistic approach to the HIV response, providing everything from anti-retroviral drugs and treatment for opportunistic infections to counseling, nutrition support and -- most importantly -- a safe environment free of judgment and stigma to people living with HIV. The nutrition program is being maintained under a continuity of services agreement put in place by the Global Fund with the national AIDS commission that has endured despite the suspension of the Global Fund grant in 2009 due to corruption. The initiative not only enhances the credibility of the clinic but also helps people living with HIV to overcome self-stigma.

"There has been a major evolution in the acceptance of the disease," says Dr Barikalla. "Before, people used to hide their faces when they came in. Now they come in with their faces bare, their eyes wide open."

MENAHRA



The Middle East and North Africa Harm Reduction Association (MENAHRA) has since 2007 received international support for its efforts to promote harm reduction as a cost-effective way to respond to twin crises in public health: a growing HIV epidemic and rising incidence of injected drug use.

The HIV epidemic in MENA has been mirrored by a parallel epidemic of injecting drug use. The region's states lie along major opiate trafficking routes carrying product from the poppy fields in Afghanistan to market in Europe and North America.

This trafficking has resulted in spill-over into the community, which has led to an increase in injected drug use to a total in the region estimated at over one million people. Injected drug use is a major mode of HIV transmission in a range of countries in the Middle East and North Africa, including Afghanistan, Iran, Pakistan, and Libya with considerable values of HIV transmissions attributed to IDU in Oman and Bahrain.

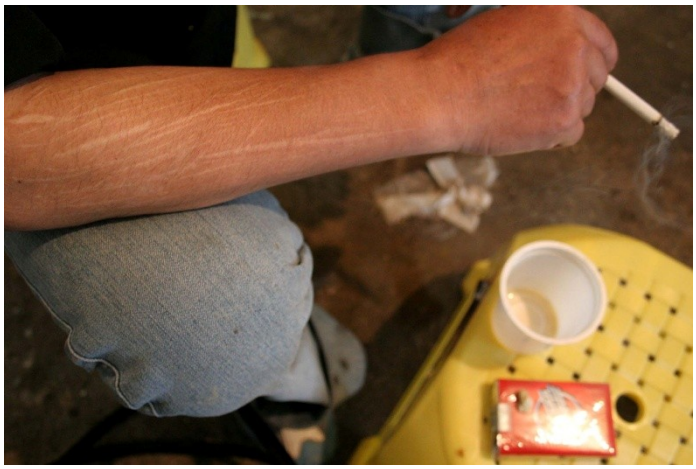
Shared cultural norms and religious values around the region have formed the backbone of rules and laws. Equally, they present an opportunity for collaboration and shared policy response, through various regional groupings and fora, and provide a way for peer influence rather than external. It is through this shared experience that MENAHRA bases its advocacy and efforts to strengthen civil society.

MENAHRA's work joins regional advocacy with country -level support for policy change, developing an evidence base to demonstrate that money spent on harm reduction will be money saved on treatment and care. It also helps to fill the yawning gap in epidemic surveillance systems in the countries around the region.

MENAHRA's ultimate goal is for people who use drugs, people living with HIV and their support networks and communities to participate more fully in the development and execution of policies contributing to the national HIV response in their countries.
Among MENAHRA's achievements include:

- Training more than 700 civil society practitioners from 19 countries in harm reduction and advocacy
- Grants to civil society organization projects, including needle and syringe exchanges, voluntary HIV counselling and testing, and opioid substitution therapy
- Developing and distributing educational and advocacy materials, including posters, brochures and television commercials
- Organizing a regional conference in 2009 and hosting an international conference in 2011 that generated high-profile conversations.

Working closely with policymakers, civil society and technical partners, MENAHRA has begun to see some results from its advocacy and empirical research. The Jordanian Ministry of Health has begun developing guidelines for opoiod substitution therapy (methadone) and other programs. Pilot programs for OST in Oman are being launched in 2015. OST pilots have also been launched in prisons in Lebanon as part of a package of therapies being provided to inmates.



A number of regional conferences, drawing representatives from ministries of health -- including Iran, Pakistan and Afghanistan: three very challenging operating environments -- have helped to dispel some of the myths around harm reduction and create strong regional advocacy.

Afghanistan has also asked MENAHRA to train healthcare providers in OST, a program that could be replicated in Iran, which has one of the highest concentrations of HIV among injected drug users in the world.

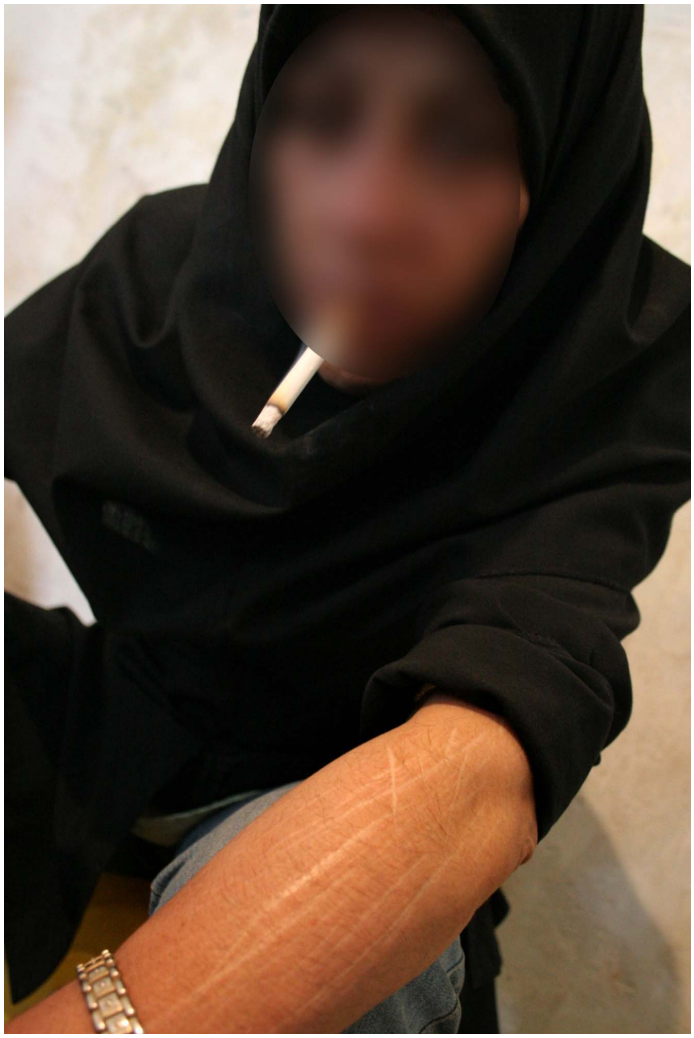
However, the political situation in the region has also thrown up its own obstacles. Egypt's evolving political situation has meant that any changes that happened under past governments were thrown out with the installation of new leadership.

Egypt's situation typifies some of the misconceptions and hurdles MENAHRA's advocacy has had to overcome; by casting harm reduction and prevention advocacy as a human right, it opens an entirely new avenue for political discussion. For many countries in the region, human rights have been synonymous with revolution -- a situation that all governments, even those who rose to power in their own revolutions -- have been keen to avoid.

Human rights for health, and public health rights, however, are less scary to governments, observes Elie Aaraj, the executive director of MENAHRA, and are easier to discuss more openly -- to the point that governments, and even the League of Arab States, are discussing human rights for health within the context of the HIV response.

The expanding role of civil society in delivering harm reduction services is also an area where MENAHRA is doing innovative work in the region. As with bringing discussions of human rights into the public sphere, so too have there been obstacles in assigning greater responsibility for service delivery to civil society groups. In many countries the potential within civil society has been sorely underdeveloped, which has necessitated a networked approach for MENAHRA.

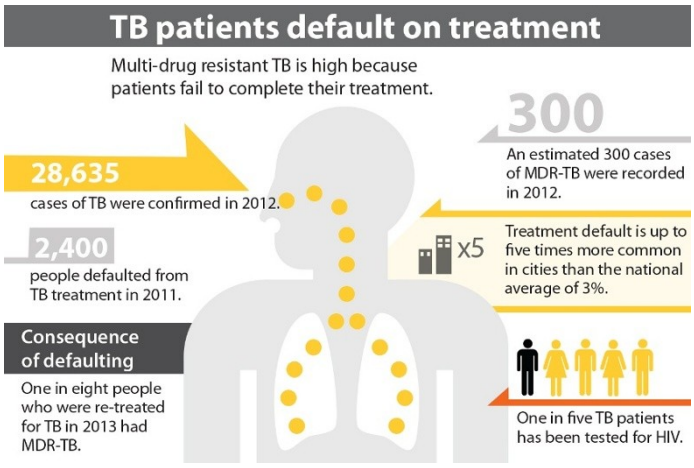
Under the framework developed by the association, collaboration across and within national borders is encouraged, underpinned by the firm belief that a wide and diverse chorus of voices is what is needed to strengthen advocacy with policy makers in order to reduce the stigma and reluctance to implement harm reduction activities. It is through the MENAHRA network of civil society actors that the most cost-effective, and enduring, harm reduction programs have been successful as part of a comprehensive HIV prevention strategy.



MENAHRA and the Global Fund

MENAHRA was able to win a five-year grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria from January 2012. It was the first grant in the Global Fund's history dedicated to a regional project in harm reduction that specifically targeted the strengthening of civil society organization capacity. The network secretariat is managing the grant as principal recipient. Of the $6.8 million in committed funds, some $3.6 million has been disbursed. Countries covered under the grant are Afghanistan, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Gaza and the West Bank and Syria.

MOROCCO



Like many of its North African neighbors, Morocco was recently reclassified as a middle-income country by the World Bank, with a GNI of $3030. This places it in the Global Fund's Band 4.

Conservative without being fundamentalist, Morocco is a mostly Muslim nation trying to improve its record on human rights. Stigma and discrimination against homosexuality, drug use and prostitution, however, still prevent many from accessing health services.

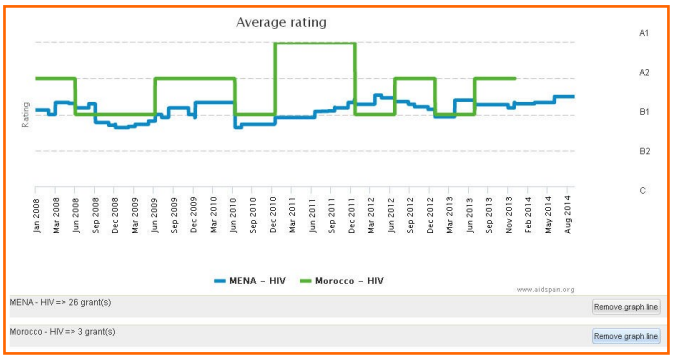
The country is committed to expanding its diagnostic services as part of its holistic HIV response. An investment in data collection and analysis is also helping to develop an evidence base to improve public and private-sector engagement with vulnerable groups including sex workers, migrants, truck drivers, drug users and the gay community.

Photo Courtesy of Robert Bourgoing

HIV

Morocco is a low-prevalence country for HIV (prevalence = .14%), with 3,400 new cases reported in 2013. The epidemic is concentrated among high-risk groups such as sex workers (2%), MSM (4.5%) and drug users (14%). Infection rates are higher in some cities than others, recent studies using respondent-driven sampling methods show. In Agadir, near the Atlas mountains, 5% of MSM are HIV-positive. In the coastal town of Nador, almost 25% of injected drug users are infected.

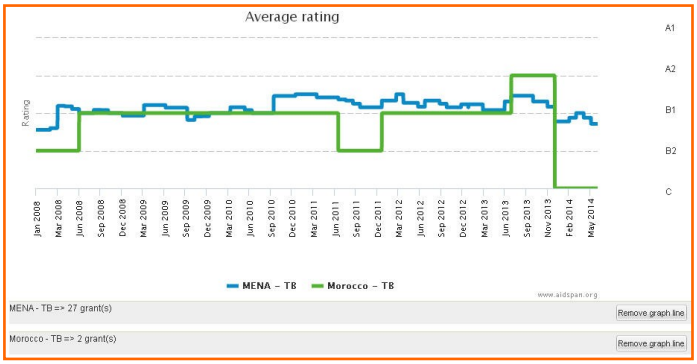
Morocco is emphasizing testing and counseling in its national strategic plan and is working to reach more vulnerable populations with targeted programming. A signature element of the strategy is a drive to eliminate mother-to-child transmission through comprehensive testing of pregnant women.



TB

Tuberculosis remains a challenge in Morocco, driven in part by economic migrants from across Africa. Morocco's TB burden has held steady at around 28,000 new cases annually since 2010, with MDR-TB on the rise. The treatment default rate was recorded in 2014 at around 3% nationwide, but up to 15% in urban areas -- where the highest numbers of cases are recorded.

There is considerable stigma associated with TB, despite a relatively high awareness among the general population about the treatability of the disease. Few in the country are aware that diagnosis and treatment are offered for free by the public health system, demonstrating an acute need for better communication about the disease.



Global Fund

Morocco's disbursments between 2010-2013 were $27.8 million for HIV and TB. Morocco was allocated $37.4 million under the NFM, which included $29 million in existing commitments and $8.4 million in new money. Most of this increase is for TB. It is anticipated that Morocco will submit its concept notes for TB and HIV in 2016. The CCM in Morocco is considered one of the most dynamic and organized in the MENA region.

Morocco and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	3	$22,576,422	$24,605,906	$0	$24,605,906
Tuberculosis	2	$5,251,708	$4,791,860	$8,029,632	$12,821,492

Morocco General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	27.6 million	33 million
GNI (per capita) PPP current international $	$3310	$7000
Under 5 mortality / 1000 live birth	56/1000	30/1000
Life Expectancy	68 years	71 years
Human Development Index (medium HDI - country)	.526 (2000) Rank	.617 Rank 129

* or nearest year.

In Morocco, an out-in-the-open plan to diagnose a hidden disease

In Morocco, the HIV epidemic remains concentrated among a few vulnerable groups: sex workers, men who have sex with men and people who inject drugs. But even among these groups three in four are unaware that they may be infected with the virus -- representing an estimated 22,000 people who unconsciously could be vectors for a widening epidemic in this country of 33 million people.

Since 1992, most diagnostic testing in Morocco has been carried out by ALCS: a nationwide non-governmental organization. But administering millions of tests is beyond the capacity of the organization and despite huge awareness campaigns -- some of which were partially funded by the Global Fund -- there remains a yawning gap between the testing that has been done and the testing that is needed. Just 30% of men who have sex with men and 25% of sex workers have been tested as of December 2014: significantly fewer than the 80% objective set by the Ministry of Health. To reach its goals, therefore, the ministry has amassed an arsenal of tactics.

Since 2013, ALCS and other Fund sub-recipients have pivoted their attention to focus almost entirely on key affected populations, cultivating relationships to build confidence and encourage behavior change that begins with knowing their status. In Agadir, teams of female educators ply the hotspots favored by sex workers so that, day or night, there is someone around to provide advice, support and encouragement for safer sex and self-protection. ALCS works closely with long distance truck drivers to mentor and encourage condom use, especially during transactional sexual encounters.

Photo Courtesy of Robert Bourgoing

Many of these groups have developed innovative but discreet ways of reaching into Morocco's mostly underground gay community. ALCS has a profile on PlanetRomeo, one of the most popular chat sites favored by gay men; there are 13,000 subscribers from Morocco alone.

"Pretty much every self-identified gay man in Morocco who can read and write has a profile on PlanetRomeo," says Abdullah Tif. He has created his own profile to interact with other users, to promote testing and encourage them to visit the ALCS offices.

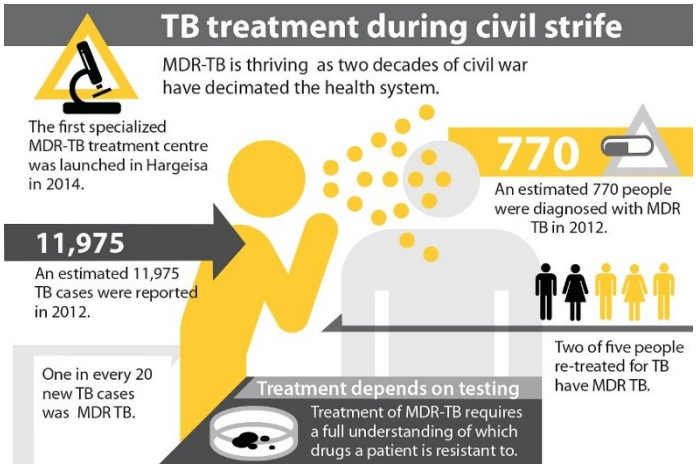
Despite notable progress in the fight against HIV-related stigma, improving testing within key groups remains complicated, according to Mouna Balil, who directs the Marrakesh office for ALCS. "We are having a hard time recruiting doctors. Some have even told us they are happy to help -- as long as the patient isn't gay."

It's a Catch-22 for the testing platform: on the one hand, few doctors will consent to work with gay men even anonymously through NGOs. On the other, few gay men are comfortable with presenting themselves at public clinics where they have to provide identification and face the scrutiny or opprobrium of health workers.

That's why ALCS is shifting its resources into community-based testing, a project that seeks to replace doctors with trained community members. These volunteers are well-known in their communities, are available and also acutely aware of the composition and character of their communities. Since the test is quick and easy, it doesn't require medical training -- all it takes is a drop of blood from a finger stick.

Another element of the strategy involves heavy promotion of knowing one's status, using social media and other popular channels. On television and on Facebook, the Health Ministry is advertising its annual testing campaigns -- and the results are impressive. In just three years, the number of HIV tests administered has jumped from 70,000 to 500,000. So, too, have the number of new confirmed HIV infections: 300 in 2011; 1,100 in 2012; and 1,200 in 2013.

SOMALIA



Considered one of the world's failed states, Somalia has been beset by crisis for over a generation. Mass population displacement and an economy in tatters have all-but destroyed the national health system, leaving it in the hands of only a skeleton staff of trained health professionals able to respond to both communicable disease and the raft of illnesses and injuries associated with conflict.

The massive influx of international humanitarian assistance appears to be tapering as the country sets itself slowly on course for reconstruction and rehabilitation: an immense development task that requires investment considerably larger than what has been forthcoming.

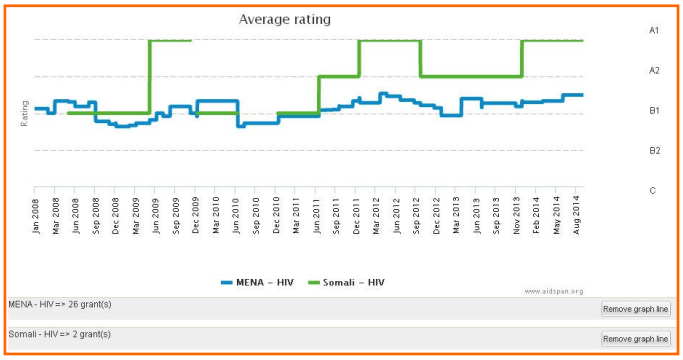
Another challenge confronting Somalia is the absence of a federal structure uniting the three regions: Somaliland, Puntland and south-central Somalia. This has led to gaps in programmatic coverage that have been exacerbated by instability.

The Global Fund underwrites almost the entirety of the country's response to AIDS, TB and malaria, but innovations in cost-saving and integration of these vertical programs into the primary health system could help Somalia in a new approach to case management.

HIV

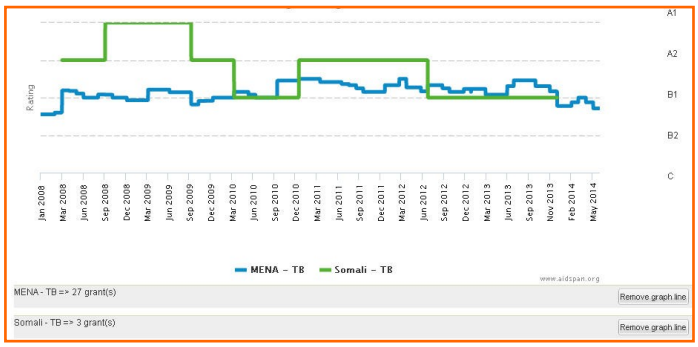
Estimates generated by UNAIDS put the number of people living with HIV in Somalia at 31,000 in 2012. This does not, however, account for the large number of Somalis packed into long-term refugee settlements in neighboring countries, Kenya in particular. This represents a 0.5% generalized prevalence rate, a figure almost equally split between men and women. Prevention of mother-to-child transmission rates are abysmally low, with just 3% of pregnant women taking ARVs prior to giving birth.

Data collection in Somalia has been a challenge particularly with respect to key populations. Rapid assessments have failed to produce any reliable figures of HIV prevalence among men who have sex with men or drug users, while a study to identify sex workers was halted for security reasons.



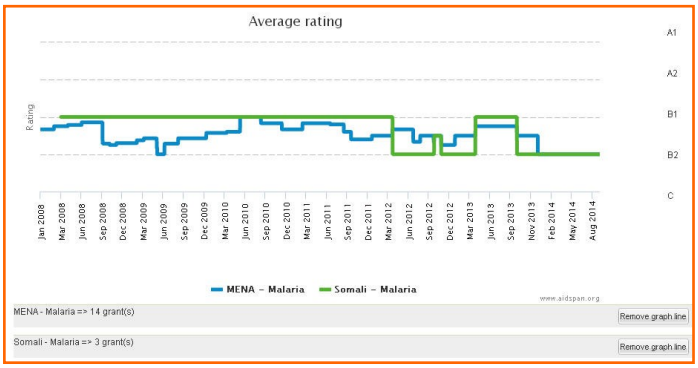
TB

TB is endemic in Somalia and still a leading cause of death. The most current estimate of prevalence is 290 per 100,000 population; with the incidence of sputum smear positive cases reported at 160 per 100,000 in 2013. TB epidemiology has been drastically affected by the enduring crisis and acute emergencies driven by natural disaster, making Somalia one of the countries worst afflicted by MDR-TB.



Malaria

Malaria is endemic in south-central Somalia but community-based interventions including indoor household spraying and bednet distributions have helped to reduce the disease burden. WHO estimates the number of reported cases at 24,553 in 2010: a marked decrease from the 49,000 reported cases in 2006.



Global Fund

Somalia's NFM allocation included $28.8 million for HIV, $33.5 million for TB and $49.9 million for malaria. The HIV concept note was submitted on 15 August, and was approved in December 2014. A revised Phase 2 proposal for malaria was resubmitted in November 2014 following the correction of limitations identified by the TRP, and was approved in December. Finalization of the TB national strategic plan is underway, ahead of a projected submission of a TB concept note in mid-2015.

Somalia and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	2	$38,986,270	$6,467,211	$22,301,328	$28,768,539
Tuberculosis	3	$30,899,256	$33,455,386	$0	$33,455,386
Malaria	3	$32,144,267	$49,874,124	$0	$49,874,124

Somalia General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	6.9 million	10.5 million
GNI (per capita) PPP current international $	$_	$_
Under 5 mortality / 1000 live birth	174/1000	146/1000
Life Expectancy	50 years	55 years
Human Development Index (medium HDI - country)	_ Rank _	_ Rank _

* or nearest year.

In Somalia, two-thirds of MDR-TB cases go undetected

It's not a list that is written down, or shared with anyone else. But in Dr Abukar Ali Hilowle's head is an accounting of every single family he has encountered that has suffered the loss of a loved one due to multi-drug resistant TB.

"Five members of the same family contracted the disease. Only one survived because the family delayed seeking health service and early diagnosis and their treatment in private clinics was not adequate. There is also the case of this four-year-old kid who was diagnosed after his father was not treated properly. Both are ill and now treated in Nairobi. The mother didn't make it. " Dr Abukar directs the Somali Health Ministry's TB program from the conflict-torn country's capital Mogadishu. After 30 years of working in the field, he has a singular passion: "to serve my suffering people as I feel that TB is killing more than what the civil war and all other disease added together has killed so far."

There has been no small amount of progress made in the Horn of Africa state's fight against TB, beginning with the incremental but steady expansion of training health workers in how to detect and treat the disease. The purchase in October 2013 by the Global Fund of two GeneXpert automated diagnostic testing machines has also meant a considerable improvement in how Somalia responds to MDR-TB. There are currently 7 machines in Somalia and 3 in Mogadishu.

Huge challenges, however, remain. "Hargeysa (the capital of Somaliland) takes three cases per week," he says. "The rest of the patients are without treatment and probably will not survive and continue to transmit the disease."

This, despite the opening of a specialized health center with a state-of-the-art laboratory in Hargeysa in September 2013. At the end of 2014 some 95 people were undergoing treatment at the facility: the culmination of a partnership with the Somaliland government, the World Health Organization and World Vision, itself a principal recipient of the Global Fund.

Making the journey is, for some, an impossibility for reasons financial, security, personal or otherwise. The cost for many is insurmountable, although the charges for treatment itself are free, when attendant costs for housing, transport and food are added.

Somalia currently has a disease burden of 280 confirmed cases of MDR-TB -- which Dr Abukar estimates represents about 40% of the total burden, meaning there are many more people out there who are unsuspecting carriers of the highly contagious disease thereby putting others at risk of infection.

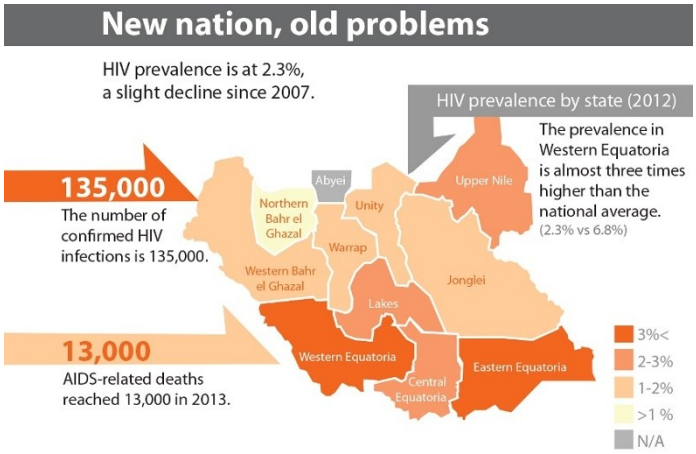
Years of civil war have contributed to the wholesale decline of the health system including any regulatory framework for the sale or distribution of medicines, which has flooded the market with low-quality or counterfeit drugs.

The absence of a specialized facility in the south and center of the country has forced many to find treatment across Somalia's borders, which has only increased the risk of contagion. In Kenya's Dadaab refugee complex, home to some 400,000 Somalis, there are 150 confirmed cases of MDR-TB, half of which are not yet under treatment, says Dr Abukar.

An upswing in anti-Somali aggression on the part of Kenyan police since April 2014, as well as a rising reluctance by the Kenyan health authorities to treat Somalis out of its own national drug stocks has sent many in pursuit of treatment elsewhere. The fortunate few have found the means to travel to Uganda or South Africa.

"Those who cannot travel will die, and the ones who survive will continue to spread the disease among the community," notes Dr Abukar, who says that a treatment facility for Mogadishu was in the planning stages, but not before 2015.

SOUTH SUDAN



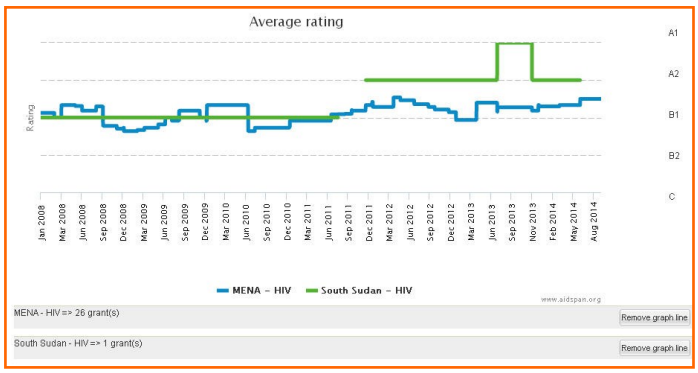
The world's newest nation has suffered many growing pains as part of its transition to independence. Despite billions of dollars of international aid, its infrastructure remains shaky and it faces a chronic shortage of human resources, lacking a generation of trained health workers to respond to the needs of a population in which communicable diseases constitute a major public health problem. Much of the country is difficult to reach even during the dry seasons and is rendered impassible during the five months of rains that lash the countryside.

Conflict, too, has played an outsized role in preventing development in South Sudan. Those provinces that are the most remote are also the ones most prone to instability, presenting major barriers to access to services for the population.

A massive effort to collect and analyze national-level data is underway with support from international partners. These data will help to more effectively target the populations in greatest need, and will drive the Health Sector Development Plan's identification of key areas in the health system that require more investment.

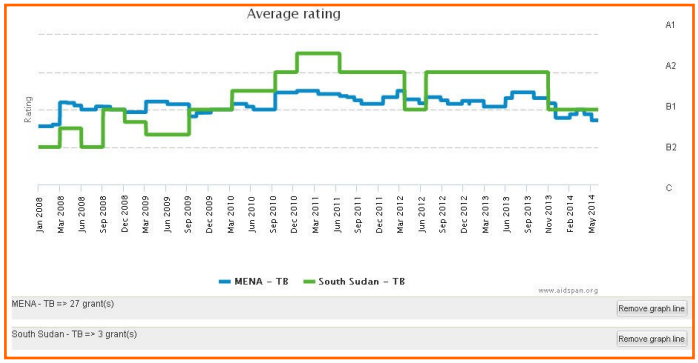
HIV

HIV prevalence is estimated at 3% and classified as a generalized epidemic in South Sudan. This means that targeted prevention activities for high-risk populations are virtually non-existent: all of the resources have been concentrated into responding to the wider population. There are just 75 facilities in the country with integrated PMTCT services. This is likely to mean that the burden of HIV among South Sudanese children -- estimated at 2,600 in 2013 -- will rise without a concurrent rise in the numbers of children on treatment, currently estimated at 2%.



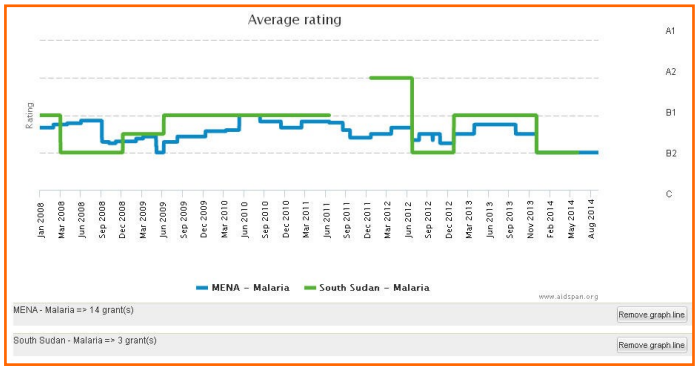
TB

TB prevalence is recorded at 140 cases per 100,000 of the population, which translates into an annual reporting of some 22,000 new cases. Poor access to screening and referral for diagnosis and treatment at community level leads to a low case detection rate. The national TB program faces a funding crisis, relying almost 100% on international partners.



Malaria

Malaria accounts for 30% of outpatient diagnosis in South Sudan, with children and pregnant women particularly vulnerable in this malaria-endemic country. More than 1.1 million cases were reported in 2013. Mass distribution campaigns for long-lasting insecticide treated nets represent the major weapon in the national prevention strategy.



Global Fund

Health systems strengthening support has been folded into each of the three disease components under South Sudan's NFM allocation. The country will receive $47 million for HIV, $15.6 million for TB and $73.2 million for malaria over the period 2014-2017.

South Sudan and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	1	$17,704,340	$9,545,969	$36,596,279	$46,142,248
Tuberculosis	3	$20,815,140	$7,815,526	$7,061,540	$14,877,066
Malaria	3	$65,317,501	$58,913,609	$8,797,025	$67,710,635

South Sudan General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	6.1 million	11.3 million
GNI (per capita) PPP current international $	$_	$1860
Under 5 mortality / 1000 live birth	200/1000	99/1000
Life Expectancy	48 years	55 years
Human Development Index (medium HDI - country)	_ Rank _	_ Rank _

* or nearest year.

In South Sudan, bad roads and insecurity are daily obstacles in the fight against malaria

If anything can illustrate the public health challenges wrought by the civil war in South Sudan, begun in December 2013 and showing little sign of interruption, it's the massive effort undertaken to distribute bed nets in the malaria-endemic country.

Photo Courtesy of RFI/Stéphanie Braquehais

In order to transport a shipment of nets to an opposition-held county in April 2014, IMA World Health had to "obtain flight security clearances from the government and opposition forces and monitor weather and airstrip conditions for three destinations -- all with cell phone service cut off and only intermittent satellite phone and internet," recalls Rebecca Waugh, the deputy country director for the organization, a sub-recipient of Global Fund support.

"Flights were planned and cargo was staged five times before all conditions were met for safe transport and nets were successfully delivered for distribution."

Ensuring that the nets got to the right beneficiaries was also a challenge, in light of the massive population displacement that has sent more than two million people fleeing their homes, according to UN-OCHA.

Conflict makes everything harder when working with difficult to reach populations; the three states most affected by the current civil war -- Upper Nile, Unity and Jonglei -- were already remote and underserved, and the war has only compounded the challenges facing South Sudan in its efforts to mitigate malaria. Even the smallest intervention can get held up by the smallest of details, with little hope of achieving scale.

Harriet Pasquale, who directs the malaria program for the Ministry of Health, says that a distribution of 348,000 nets to highly endemic Unity state was postponed due to insecurity. Instead, it was decided to focus on the most vulnerable populations: camps holding internally displaced people, with an emphasis on pregnant women and children under five.

"The vulnerability of the IDP is increased by the active fighting," she notes. "Aid workers have been killed and harassed, which has limited the number of skilled health personnel able to provide health services and limited local health workers in some locations given the risk that they will be targeted. There are many malaria offices that are deserted."

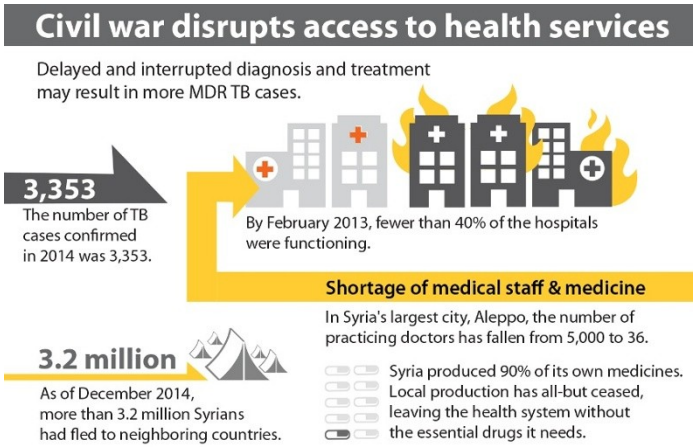
In early November 2014, Médècins Sans Frontières sounded the alarm about a worrisome lack of available medicine in many remote health centers that forced gravely ill people to make the long and difficult journey to more central locations to seek treatment.

The stockouts are due in large part to the decrepit road network -- difficult to navigate even during peaceful times due to the heavy rains that make most roads impassible for months. Strict regulations imposed by donors on procurement also has an impact, Pasquale says.

"Reporting requirements for commodity consumption are often a challenge for the majority of the health workers, who have minimal or no formal training." She says. "Their inability to complete required documents means that these facilities cannot receive basic commodities, limiting access to care."

Still, South Sudan is doing its best to fight the good fight against malaria, training nearly 700 health workers and laboratory technicians in better diagnosis and malaria case management. As of September 2014, millions of doses of drugs and rapid diagnostic test kits were delivered nation wide, a large percentage of which were paid for by the Global Fund.

SYRIA



Syria's humanitarian crisis has had a devastating effect on the civilian population, sending a once-prosperous nation spiraling into mayhem and disease. Over 60% of its population have been internally displaced, while a reported 1.5 million more have fled across the country's borders.

The lack of imminent political resolution to the three-year-old conflict means that investments in the health system have been stalled, making it even harder for people to access even basic services. Nearly two-thirds of the public facilities have been damaged or are out of service, and staff losses are pronounced. This is also having an impact on the production of medicines in a country that, prior to the outbreak of conflict, was making 90% of its medicines locally. Drug shortages are acute in both the public and private sector -- including life-saving medicines for TB and HIV.

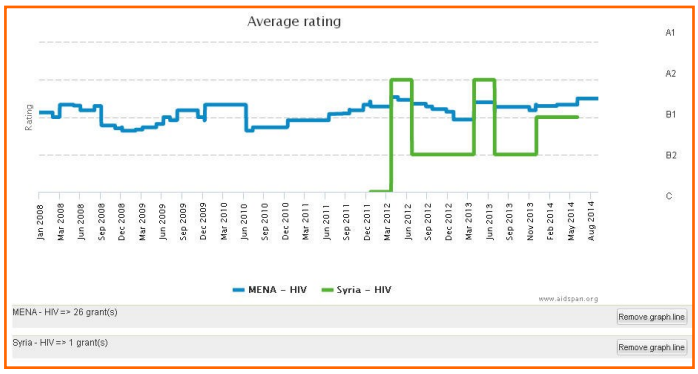
The lack of medical personnel also means that monitoring of patient care has deteriorated: a catastrophic challenge for people requiring long-term treatment and basic monitoring for HIV and TB. The lack of monitoring also extends to data collection and analysis.

HIV

The development of a national strategic plan in 2010 was already delayed before the conflict erupted in February 2011, which has stalled data collection to develop an accurate estimate of the HIV burden in Syria.

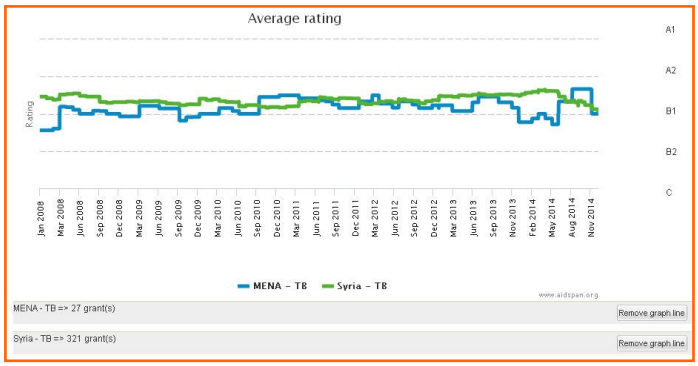
Prior to that, targeted prevention activities focused exclusively on young people and women; there were no activities specifically responding to the needs of other at-risk populations including drug users, sex workers and their clients, and men who have sex with men. Sex work, drug use and 'homosexual behavior' are all illegal in Syria.

A 15% increase in the number of people on ARVs was arbitrarily approved by the government in 2007, but this was not based on any epidemiological evidence. The general prevalence rate estimated in 2002 was 0.1%.



TB

Syria's TB burden prior to the unrest in 2011 was estimated at 23 per 100,000 population. Now, however, those figures have ramped higher -- particularly among the populations displaced by the conflict. Among the Syrian refugees in Lebanon, TB incidence was measured at 25 per 100,000 population, among the 1.5 million refugees crowded into the country. For the more than 600,000 refugees who have landed in Jordan, the TB incidence is 48 for every 100,000 cases.



Global Fund

Syrian refugees in Lebanon and Jordan will receive some Global Fund support to help fund prevention, diagnosis and treatment for TB, courtesy of the Emergency Fund: a special initiative designed to boost resources available in emergency situations. Provision of essential services for TB and HIV for those Syrians still in the country is also being supported by the Global Fund; the country was allocated $5.5 million for HIV and $7.2 million for TB under the NFM.

Syria and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	1	$754,773	$2,261,793	$3,271,785	$5,533,577
Tuberculosis	1	$3,954,591	$2,102,352	$5,145,008	$7,247,360

Syria General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	15.6 million	22.8 million
GNI (per capita) PPP current international $	$_	$_
Under 5 mortality / 1000 live birth	26/1000	15/1000
Life Expectancy	73 years	75 years
Human Development Index (medium HDI - country)	.605 (2000) Rank _	.658 Rank 118

* or nearest year.

Syria's neighbors concerned about TB spike accompanying refugee flight

Photo Courtesy of UNHCR

Four years ago, Syria boasted what was among the region's best resourced health systems. In just two decades the country had brought TB prevalence down from 85 cases per 100,000 in 1990 to 23 per 100,00 in 2011.

Then the war came and brought with it the wholesale destruction of most of the public health infrastructure. Equipment was damaged beyond repair or looted; even if facilities could keep the lights on, the massive exodus of Syria's trained personnel meant there was no one there to provide treatment.

Treatment and diagnosis of TB has declined significantly -- so much so that prevalence rates for both TB and MDR-TB are on the rise. But no one knows just how high, as most capacity for monitoring and evaluation has been wiped out.

"The number of TB cases notified currently stands at 3,353 against 973 in 2013," explains Fabien Lefrançois, a policy specialist with the UN Development Program. "Identification of new MDR patients continues to be a problem due to the difficulty in transferring samples for the culture. Also, limited information is available on TB patients who have left the country, and on their TB status."

A two-year MDR-TB treatment regimen is very expensive, and requires assiduous monitoring by health personnel as well as discipline from the patient to ensure adherence: conditions that are extremely difficult to maintain in a conflict environment.

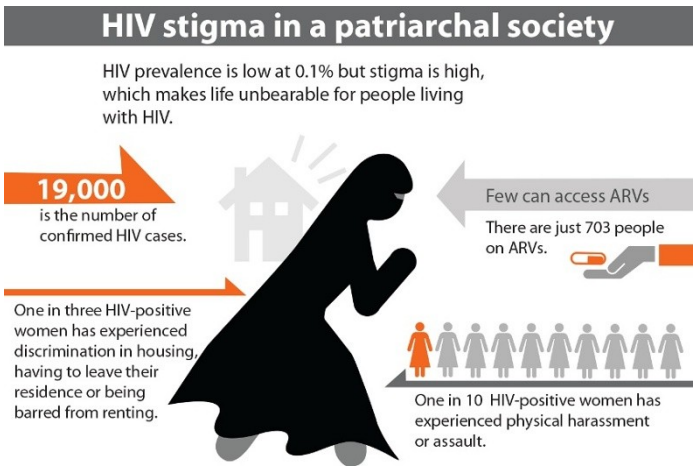
In Jordan, for example, which is currently home to some 600,000 Syrian refugees, the monthly cost for MDR-TB drugs is some $2,820 dollars -- more than ten times the cost of first-line drugs for a simple TB case.

Those 600,000 Syrians in Jordan are part of a larger refugee community of some 3.2 million people spread out across the region, most of whom have little to no access to treatment for the highly contagious and highly infectious TB, to say nothing of its more stubborn drug-resistant counterpart.

In an effort to take some of the pressure off the already stretched health systems in these refugee-receiving countries, the Global Fund in mid-December 2014 approved emergency assistance worth some $3.3 million to help Lebanon and Jordan respond to the increased TB burden among Syrian refugees.

Among the 1.3 million refugees already in Lebanon in formal and informal settlements, already 61 TB cases have been recorded -- an estimated 17% of all of the notified cases and reflective of estimates that 25 cases per 100,000 refugees will occur. In Jordan, it is estimated that TB incidence has reached 48 per 100,000 people.

YEMEN



Yemen's efforts to expand and improve its health system have been enterprising but limited, due in large part to a major resource shortfall. Just 50% of the low budget (about 4% of GDP) per capita expenditure on health falls short of the regional average, and the number of trained professionals remains decidedly low particularly in rural areas.

The country is beset by chronic crisis, which means that already isolated rural zones become more so when conflict erupts. Only 30% of rural areas are covered with health services, which adds logistics to the list of structural barriers to access. Human rights concerns play a major role in preventing access to services, as does the low level of literacy -- particularly among women -- within Yemeni society.

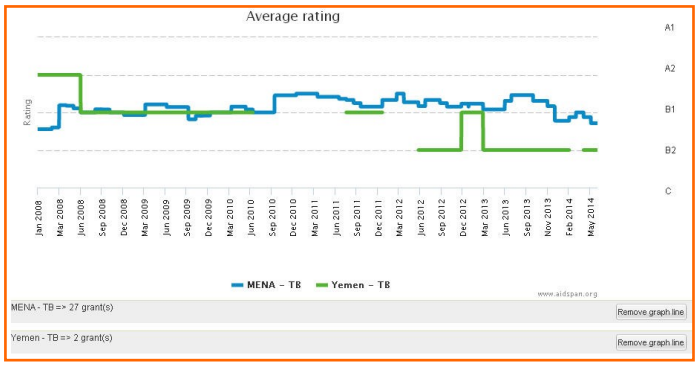
Photo Courtesy of Robert Bourgoing

HIV

The overall population's HIV prevalence is under 0.1% but there is growing unease about the paucity of data available for disease burden in marginalized or at-risk groups, including the internally displaced due to the continuing civil unrest in the country. Also of concern are the human rights violations systematically occurring as part of case management. Human Rights Watch reported in late 2014 that people with HIV were routinely being denied care -- with some of them even being discharged from hospital while seeking treatment for other illnesses.

TB

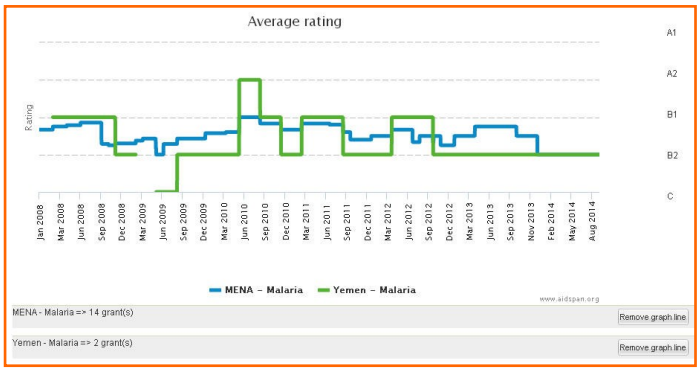
There were more than 10,000 cases of TB reported in 2013. MDR-TB has emerged as a public health challenge for the anemic health care system, due to the high cost of treatment and the shortage of trained professionals to detect and then care for MDR-TB patients. Yemen is a high-incidence country for TB, due in part to the high number of new cases in younger age groups: proof that the country may be in the early stages of an epidemic. Resources are being devoted to a community-based approach that includes home visits: an attempt to reach the 60% of children diagnosed with TB who either fail to begin or complete their treatment.



Malaria

Sixty percent of the Yemeni population is at risk of malaria. There were 891,000 suspected cases recorded in 2013, most of whom were among vulnerable populations including pregnant women, children under 5, health workers and internally displaced groups.

Mass distribution campaigns for LLIN constitute the bulk of malaria prevention activities in the country. Access to some of the communities in greatest need of nets, as well as the attendant diagnostic tests and treatment kits, has been limited by insecurity.



Global Fund

Yemen's NFM allocation included $11.5 million for HIV, $11.5 million for TB and $16.8 million for malaria. A significant portion from each disease component should support health system strengthening.

Yemen and the Global Fund ($)

Disease component	Number of Grants since 2010	Amount disbursed (2010 – 2013)	Amount available in existing grants	Amount Additional funding under NFM	Total Allocation available (2014 – 2017)
HIV	2	$5,371,974	$386,528	$11,145,685	$11,532,213
Tuberculosis	2	$6,546,873	$7,493,345	$4,038,868	$11,532,213
Malaria	2	$20,098,907	$5,971,216	$10,860,962	$16,832,178

Yemen General Statistics

General Statistics/ Year	1997/8*	2013*
Total population	16.6 million	24.4 million
GNI (per capita) PPP current international $	$ 2780	$ 3820
Under 5 mortality / 1000 live birth	104/1000	51/1000
Life Expectancy	60 years	63 years
Human Development Index (medium HDI - country)	.427 (2000) Rank _	.5 Rank 154

* or nearest year.

Photo Courtesy of Robert Bourgoing

Photo Courtesy of Robert Bourgoing

Against all odds, Yemen works to treat MDR-TB

One by one, the entire family was touched by tragedy, recounts Dr Najib Abdulaziz, director of the Ministry of Health's TB program. A 55-year-old farmer from Marib province contracted tuberculosis in 2004 but was never able to follow treatment through to the end. First to be infected was his 28-year-old daughter, who, like her father, never was able to continue her regimen. So she was sent to India for treatment of MDR-TB, but did not survive. Her sister, at age 23, suffered a similar fate despite seeking second-line treatment in Egypt. Then there were two more cases of MDR-TB in the family: the father and another sister. For now, 10 months since they began their second-line regimen, they are improving.

The tale is a sobering one and reflects the immense obstacles in Yemen that are fuelling the spread of MDR-TB. Prior to December 2013, there were no MDR-TB treatment facilities, forcing Yemenis to seek treatment elsewhere if they had means or suffer what fate wrought if not. Now there are four outpatient clinics, in Sanaa, Aden, Taiz and Hodaidah, and there are drug stocks to treat more than just the 50 people currently following a second-line regimen to conquer MDR-TB.

Now that four GeneXpert machines paid for by the Global Fund have been delivered the program will be equipped to challenge the threat of MDR-TB, says Dr Najib, which is steadily climbing at a rate of two to three new cases detected per month according to 2013 estimates. A resistance study released in 2011 indicated that MDR-TB prevalence among new cases of TB was 1.4% and 14.4% among recurrent infections.

Currently, diagnosis can take up to three months -- long enough that many patients expire before even beginning treatment, he adds.

For the program to work properly, Dr Najib emphasizes the need for a community-based support system that provides help not only to the patients themselves, but to their families carrying the burden of care.
"There is very limited participation in providing social support at the level of the community," he says. Training of community-level health workers about case management for MDR-TB is also imperative.

Yemen's continued insecurity has also stalled the expansion of the national TB program, most acutely preventing international medical teams from moving freely and monitoring performance and impact. The Health Ministry, however, has yet to draw any conclusions about the impact of insecurity on the incidence of MDR-TB.

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