Financial Gap Analysis Study

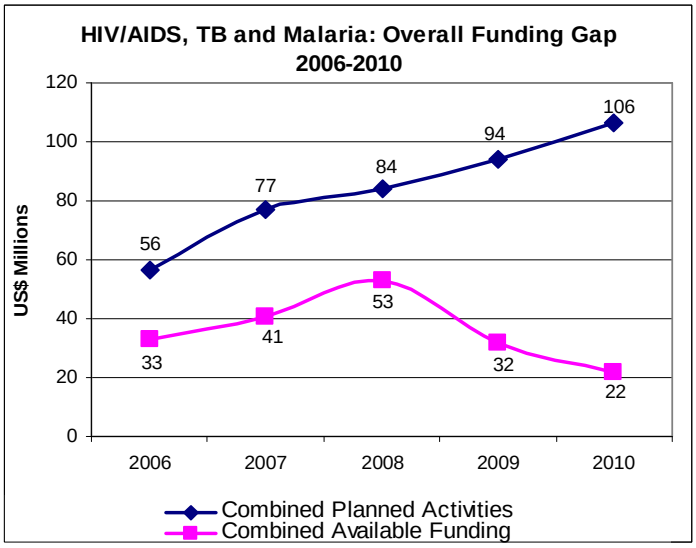
In order to establish the financial needs of the national programs for HIV, Tuberculosis and Malaria, to map the financial resources that are available to meet this need and to identify the financial gaps in coverage, the Three Diseases Fund (3DF) requested an international consultant to conduct a gap analysis study in April 2008. In addition to a desk review of relevant documents, a resource tracking survey was designed and data compiled from implementing partners and other relevant stakeholders.

The study concludes that investment in the national responses to HIV and AIDS, TB and Malaria in Burma/Myanmar continues to fall considerably short of what is required to implement the levels of service necessary to impact the spread of the epidemics as put forward in the National Operational Plans.

The table below summarises the actual funding gap for the three diseases for the period of the operational plans (2006–2009) and estimates of the funding gap up to 2010, based upon known commitments.

	2006	2007	2008	2009	2010	Cumulative Total
Operational Budget						
HIV and AIDS	30,346,972	43,470,970	51,983,506	62,581,609	74,644,928	**263,027,985**
Tuberculosis	13,467,871	18,809,749	18,477,025	18,477,025	18,477,025	**87,708,695**
Malaria	12,504,148	14,678,328	13,860,365	13,193,077	13,193,077	**67,428,995**
Total	**56,318,991**	**76,959,047**	**84,320,896**	**94,251,711**	**106,315,030**	**418,165,675**
Available Funding						
HIV and AIDS	26,979,076	30,860,121	38,280,146	23,755,598	15,661,263	**135,536,206**
Tuberculosis	3,599,811	4,882,590	8,163,328	3,327,675	1,646,510	**21,619,915**
Malaria	2,765,937	4,971,026	6,847,118	4,760,278	4,517,126	**23,861,485**
Total	**33,344,824**	**40,713,738**	**53,290,592**	**31,843,552**	**21,824,900**	**181,017,605**
Overall Funding Gap	**22,974,167**	**36,245,309**	**31,030,305**	**62,408,159**	**84,490,130**	**237,148,069**

The chart below maps the combined planned activities and investment in the national responses to HIV and AIDS, TB and Malaria in Burma/Myanmar. It indicates the considerable and widening gap in the amounts required to implement the levels of service necessary to impact the spread of the epidemics.



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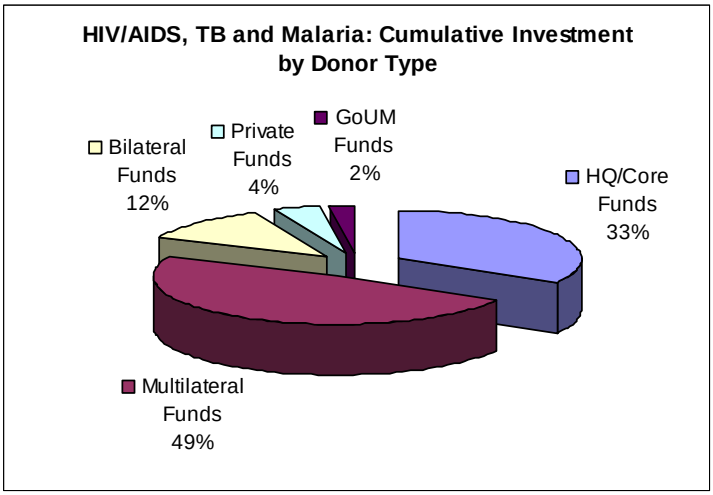
Resource availability has shown some increase, from 2006 to 2008, albeit at a slow pace and maintaining a consistent funding gap. Pledged funding falls sharply again for 2009 and 2010, widening an already substantial gap to US$84 million by 2010, which equates to 80per cent of total financial requirement. This corresponds with acute gaps in coverage for activities and service delivery for the population of Burma/Myanmar affected by the HIV and AIDS, TB and Malaria.

Cumulatively, for the period 2006–2010, multilateral funding accounts for almost half of all available resources, and core funding contributes one third of all available funding (of this, UN funding accounts for approximately half). Bilateral aid constitutes 12 per cent, private donations contribute 4 per cent and GoUM contributes 2 per cent of all investment.



User fees

The operation of user fees or private payments for services by the patient exists in the public health system in Burma/Myanmar through a cost recovery programme for some services and/or drug provision. This should be acknowledged as a resource, but the consultant was unable to access any detailed information of the operation of the programme or its usage.

Analysis of allocations and gaps per disease and areas of intervention

HIV attracts the most funding, almost two thirds of all available, with 21 per cent allocated for TB and 16 per cent for Malaria. For all three disease responses, the majority of expenditure and funding is focused on service delivery components, which generally accounts for 90 per cent of the budget for each disease. The GoUM funding for HIV accounts for 1 per cent of total cumulative funding, for Tuberculosis approximately 0.4 M and for Malaria around 0.2 M per year.

While there has been some growth in investment since 2006, current pledges forecast a reduction in investment in 2009-2010, resulting in considerable funding gaps in the different elements of the National Operational Pans, as shown in the following tables presented by disease.

HIV

Area of activities	Allocation operational budget	Forecast gaps 2009-2010
Prevention	40%	66%
Support, treatment and care	50%	90%
Enhancing health system capacity	9%	75%
Provision of leadership, strategic information and M&E	1%	50%

Tuberculosis

No planning or budgeting has taken place for TB since 2006, which inhibits accurate prediction of funding gaps beyond 2008. For the purpose of analysis, activity and their costing levels have been projected forward at the same levels as 2009.

Area of activities	Allocation operational budget	Forecast gaps 2009-2010
Sustain and improve quality of DOTS services	80%	90%
Treatment and support	6%	55%
Case Detection, Diagnosis	13%	92%
M&E and surveillance	1%	96%

Malaria

As with Tuberculosis, no planning or budgeting has taken place for Malaria since 2006, which inhibits accurate prediction of funding gaps beyond 2008. For the purpose of analysis, activity and their costing levels have been projected forward at the same levels as 2009.

Area of activities	Allocation operational budget	Forecast gaps 2009-2010
Prevention including bed nets	33%	90%
Diagnosis and treatment	25%	30%
Empowerment	15%	90%
Improve management capacity	20%	50%

Financial information gap

Although the reporting requirements of various stakeholders are being met, a fundamental gap exists in that there is no comprehensive system of financial information available which consolidates the overall financial activities involved in the implementation of the disease responses and from which the 3DF can draw the financial information required for decision making in resource allocation.

A strong, comprehensive system of financial management is required to deliver accurate, evidence based financial information that is necessary for economic cost analysis purposes.

Disease information gap

National information on the burden of each disease is not as accurate as desired for various reasons. For Malaria, information from the national surveillance system reflects hospital based data on aggregated malaria cases in Burma/Myanmar. The data is often in conflict with information from community based programmes, which is not captured in the national statistics and suggests under-reporting of malaria prevalence.

For TB, estimates of burden are based upon prevalence surveys carried out up to 1994 and incidence rate is assumed to be constant in the absence of information to the contrary. The prevalence survey carried out in Yangon in 2006 suggests three times higher rates than the results of the 1994 survey.

In the area of HIV and AIDS, the National AIDS Control Programme together with key partners and international experts carried out an exercise in 2007 to estimate the adult HIV prevalence rate in Burma/Myanmar. As a result, the previous estimation was corrected from 1.3 per cent to 0.67 per cent.

For this study, the consultant was not aware of the existence of any available information on the impact of the various interventions within each disease response, in either financial or physical terms. Performance data is not generally included in any current reporting requirements.

Required next steps

To ensure a high degree of prioritisation in the allocation of 3DF funds, it would be necessary to have evidence based recommendations on resource allocation between diseases and within each national strategic program, whilst considering the most cost-effective interventions in order to maximise impact on the three diseases.

The Fund Board would benefit from employing cost-effectiveness analysis to establish formulae for resource allocation, which reflect as precisely as possible the variation in need across the three diseases.

The consolidation of outcome based information and accurate financial information enables cost analysis to be carried out for better targeting of resources.

To proceed with such evidence based analysis for best resource allocation, the planning and budgeting capacity of the Technical Strategic Groups (TSG) needs to be stimulated to operate on a more dynamic basis to produce three year rolling plans which consider plans for the coming year in detail with indicative data for subsequent years.

Some pre-conditions are also necessary within the national responses before such systems of information can be fully developed:

- The planning and budgeting capacity of the TSG needs to be re-stimulated to operate on a more dynamic basis to produce three year rolling plans which consider plans for the coming year in detail with indicative data for subsequent years.

- The use of standard costing methodologies and budgeting tools should be encouraged for establishing unit costs of interventions. Unit costs are average costs and generally include assumptions of coverage, but for financial need estimation and resource allocation they are easy to compute and provide a basis for comparison.

- The planning and budgeting function, supported by strong information systems, will be capable of re-examining service delivery targets and activity levels required to address the national strategies. Operational plans and supporting budgets developed can thus present an accurate assessment of financial need.

As a result of the further efforts in establishing evidence based financial and disease information, and strengthening the systems of planning and budgeting recommended here, the Fund Board will be able to rely on the assessment of need presented in three year rolling plans and, together with the economic analysis of the costs of specific interventions and impact on disease, develop an approach to resource allocation which is evidence based, transparent and delivers stability to prioritized strategies.