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Call for evidence on impact of UK aid cuts: Médecins Sans Frontières/Doctors Without Borders submission to International Development Committee

For 50 years, Médecins Sans Frontières/Doctors Without Borders (MSF) has provided medical humanitarian assistance in low-resource settings and humanitarian emergencies. We currently run projects in 72 countries around the world. We work alongside ministries of health to ensure those most in need can access integrated child health and nutrition services, and deliver care for people living with HIV, hepatitis C, tuberculosis and many other long-term conditions. MSF is often one of the only actors caring for patients with neglected tropical diseases (NTDs) in remote areas where resources are scarce and health systems are fragile.

The COVID-19 pandemic exacerbated existing healthcare issues everywhere. Yet, while COVID-19 was ever present, it was a secondary problem for many people in the countries where MSF works who continued to suffer and die from other diseases, often because of a lack of available healthcare and prevention services.

In responding to the Call for Evidence by the International Development Committee (IDC), MSF considers that there are critical measures the UK government must put in place to reduce the impact of the dramatic reduction in ODA, particularly as it relates to affected health programmes and partners. The UK government must ensure that access to lifesaving health services and efforts to advance global health goals are not further eroded. Current UK efforts to 'combine aid with diplomacy' cannot overlook the importance of ensuring tangible access to quality health services and products for the most vulnerable communities around the world.

Impact of the changes

- Impact upon communities in lower income countries
- Impact upon organisations implementing UK ODA programmes

Process

- The FCDO's approach to the process of implementing in-year changes to the aid budget during the 2020-21 financial year, including its communication with stakeholders

Summary of key issues:

- In November 2020, the UK government announced a temporary reduction of ODA from 0.7% of GNI to 0.5%, representing a reduction of about £4 billion in real terms. This included reductions at a shocking scale to funding streams which critically support health programmes and services, as well as lifesaving assistance for the world's most vulnerable, in the middle of a global pandemic.
- The cuts in funding to global health partners, programmes and product research initiatives were enacted in an appalling fashion; opaquely, almost overnight, unconditionally and with no transition period or impact mitigation planning. The cuts reflect a complete lack of awareness or lack of concern regarding the years taken to build essential programmes, and the need to maintain gains against global health and humanitarian goals and prevent further deterioration into disease and disaster.
- The cuts have affected key programmes, including those focused on the treatment and prevention of life-threatening NTDs, such as visceral leishmaniasis (VL). On the global stage, the UK has assumed responsibility for several key programmes in this area since 2014, enabling actors such as MSF and WHO to reduce their contributions. Historically, other governments and donors have not been as engaged in the response to NTDs.

- In April 2021, the FCDO alerted its implementing partners of a 90% reduction to NTD programme funding. Partners were left adrift, unsure which NTD programmes were to be cut, what the remaining 10% was for, and if this cut was permanent. They were only told that the programmes must stop working immediately.
- Any gains made in controlling the spread of VL over the past decade, thanks to the UK's investments, will be reversed. VL control programmes in East Africa support over 10,000 patients each year and are fully dependent on UK funding for diagnostics, drugs and other support. They will collapse entirely following the withdrawal of funds. With such sudden cuts, there are no new partners able to take on this responsibility in the short term.
- Stocks of VL diagnostics and drugs are running low in endemic countries. Without the planned support of ASCEND, WHO cannot place new orders in time for the upcoming peak season. The resulting supply gaps will increase levels of transmission, infection and mortality, as well as likelihood of outbreaks. In several countries, including Ethiopia, South Sudan and Sudan, MSF will be the only actor left to respond to an outbreak of VL. We are looking into ways to provide more support, but will not be able to fill the gap that the ODA cuts have left.
- The continued failure to provide concrete strategies to safeguard programmes, communities and countries against the impacts of these drastic cuts could be considered negligence. COVID-19 has made needs even more acute and other governments and donors are unable to fill the gaps left due to similar economic contractions and on such short timelines.

Case study: Impact of cuts on visceral leishmaniasis

VL, also known as kala azar, is a vector-borne tropical disease, endemic in 78 countries, that is fatal if left untreated. In 2018, 45% of globally reported VL cases were in East Africa[i]. VL is a severely neglected and under-reported disease, which has catastrophically impoverishing effects on some of its most vulnerable communities. An annual average of 11,000 cases were reported in East Africa over the last five years[ii]; however, it is so commonly under-reported that there are likely to have been many more people suffering with VL than that. Large-scale outbreaks occur frequently, especially in Ethiopia, Kenya, Sudan and South Sudan[iii] [iv]. These are often only detected at a late stage due to poor surveillance or because they are initially mistaken for malaria or other acute febrile illnesses, since VL is mostly unknown outside endemic areas. If not addressed in a timely manner, these outbreaks can have very high mortality rates. Early diagnosis and treatment are the only option to reduce morbidity and mortality[v] [vi]. As such, robust surveillance programmes and sufficient health facilities that are able to provide these in remote endemic areas are crucial.

The UK has previously invested strongly in preventing and treating NTDs, including VL. Between 2014 and 2019, the UK funded KalaCORE, a programme that supported the control and elimination of VL in six of the most endemic countries: India, Nepal and Bangladesh in South Asia, and Ethiopia, Sudan and South Sudan in East Africa. This was first dedicated programme to support VL control in East Africa. As an organisation with decades of experience caring for patients with VL in East Africa, MSF was part of KalaCORE. This was first dedicated programme to support VL control in East Africa. The programme made remarkable progress. It supplied VL drugs and diagnostics, grew technical capacity, significantly improved access to diagnosis and treatment, and helped establish functional national surveillance systems in Ethiopia, Sudan and South Sudan.

In 2019, the UK government launched ASCEND (2019-2022), its flagship programme for the sustainable control and elimination of NTDs. Led and managed by a consortium of UK charities, academic institutions and companies, the programme was set to tackle six NTDs (intestinal worms, lymphatic filariasis, river blindness, trachoma, schistosomiasis and VL) in 25 countries across Africa and Asia. Under ASCEND, VL funding expanded to include Kenya and Uganda, but overall amounts compared to KalaCORE were reduced. Much less or no funding was given for surveillance, training and other activities, and, with the onset of COVID-19, access and response capacity were further reduced. Nevertheless, ASCEND crucially supported WHO in supplying essential drugs and diagnostics for VL country programmes.

The immediate worst-case scenario for East African countries dependant on UK-funded ASCEND programming is a prolonged supply gap of VL drugs and diagnostics. In this region, VL peak season starts in the third quarter of the year and reaches its highest point in the fourth quarter. WHO has already raised the alarm that, following the loss of UK support, only three to four months of VL supplies remain for East Africa, with no prospect of another donor. The lead times for these drugs and diagnostics are often very long, and new orders need to be placed as soon as possible. If a new donor is not identified immediately, it will be too late and at-risk countries will face shortages of drugs and diagnostics during the peak season. VL is a deadly disease, which can kill quickly, so these shortages may cause a dramatic increase in rates of mortality.

In Ethiopia, an estimated 2,500 people contract VL each year. MSF and the Drugs for Neglected Diseases initiative (DNDi) are the only external actors responding this disease. We currently support a small number of VL treatment facilities across the country. Some of these are in Tigray, where future access may not be guaranteed, as a result of the ongoing regional conflict. Thirty-eight VL diagnosis and treatment facilities and 28 diagnostic and referral facilities are managed by the Ministry of Health and are fully dependent on ASCEND and WHO for drugs, diagnostics and other support. MSF was asked to increase support to the control programme; however, we do not have the capacity to address the needs for the entire country.

In **South Sudan**, some years can see over 10,000 VL patients. VL control has been jointly managed by IMA World Health and MSF, which treats roughly 50% of patients. IMA World Health is the recipient of VL funding through ASCEND, and previously received support through KalaCORE. During KalaCORE, IMA received sufficient funds to upgrade 32 treatment centres in South Sudan's vast endemic area to a status of 'readiness' for delivering VL treatment, and then distributed drugs and diagnostics to these facilities. Most sites provided very basic care and were located in areas with no infrastructure, only accessible by boat, plane, helicopter or by foot from airstrips. Two mobile teams ran outbreak investigations, ad hoc training and mentorship, collected surveillance data, provided drugs and diagnostics in case of stock outs, carried out behaviour change communication and distributed health education material. IMA paid incentives to health workers in centres in rebel-held areas who would otherwise have not received a salary. Even with this support, the challenges were significant. Under ASCEND, funding was substantially reduced, and IMA has only been able to support 21 health centres and one mobile team in recent years. As in KalaCORE, all VL drugs and diagnostics were provided by ASCEND/WHO.

South Sudan has a fragile health system, which is entirely donor-dependent, and, without ASCEND, there will be no VL drugs or funding to distribute them to the health centres, no surveillance or training. Without IMA's incentives, there will most likely be no health workers left in many of the remote facilities, as they will have to look for paid work elsewhere. MSF will be the only actor left and is looking into possibilities to provide more support, but will not be able to fill the gap.

In **Sudan**, there are up to 4,000 VL patients each year. There are 44 VL treatment facilities in Sudan, all fully dependant on ASCEND drug donations and other support. Until 2020, MSF supported two VL treatment facilities, but we were able to hand both back to the Ministry of Health thanks to ASCEND support. MSF currently only provides VL treatment in refugee camps near the Ethiopian border, but has now been requested by WHO Sudan to scale up support again.

The UK government must:

1. Urgently and immediately ensure that funds remain available for the next two to three years to support WHO's purchase and supply of VL drugs and diagnostics for the 10,000 to 15,000 VL patients treated each year in East Africa. Support should include extra funding to ensure their distribution to remote endemic areas and to strengthen outbreak surveillance.
2. Urgently and immediately ask alternative donors to step forward and provide all necessary support to NTD control programmes and implementing partners as soon as possible.

3. Not completely withdraw from supporting global health programmes, to keep lifesaving programmes going, including budget lines for the acquisition of lifesaving medicines, even at a reduced level, until the UK returns to its 0.7% commitment.
4. Commit to a transparent, managed timeline of temporary reductions, urgently and immediately help to secure alternative global health funding and partners for gaps left by the cuts in ODA, and ensure there is proper monitoring and evaluation of their real-time impact.
5. Seek a return to previous funding levels as soon as possible in 2022 and beyond.
6. Provide space for partners to counter-propose key programmes or activities that must be kept going in 2021 in order not to result in loss of lives or baseline programme momentum.

NB. The impacts of UK ODA cuts on global health programmes and partners extend beyond VL to a diversity of health themes. We are in the process of assessing and collecting evidence for these, which will be available at a later date.

Strategy

- The strategic targeting of UK aid spending, including the focus areas set out by the FCDO's seven global challenges and their alignment with the conclusions of the Integrated Review
- Whether these focus areas address the most pressing global development challenges

Administration

- Changes to the administration of UK ODA, including the FCDO assuming responsibility for deciding the final departmental allocation of ODA and administering the majority of UK ODA
- The split between bilateral and multilateral ODA spending, and the effectiveness of these channels for the delivery of UK aid

Process

- The FCDO's approach to setting ODA budget allocations for the 2021-22 financial year, including its communication with stakeholders

Summary of key issues:

- The 2021 FCDO budget has broadly assigned £1.3 billion to 'COVID and Global Health'.[1] While this represents the largest allocation among the FCDO thematic priorities, and there have been cuts across departments, the government's implementing partners do not actually know what is included in this by-line that could potentially encompass an enormous range of issues and programmes.
- Decisions related to the 'COVID and Global Health' budget line came from outside the FCDO Global Health Directorate. High-level political commitments to three key multilateral global health actors, WHO, GAVI: the Global Vaccine Alliance, and the Global Fund for AIDS, TB and Malaria (GFATM) have been preserved as part of the 2021 budget.[2] This has left very little to cover the funding needs of all other global health issues and programmes, most notably bilateral programming, and some key multilateral actors.
- Aid cuts have forced the UK to renege on many important commitments to global health, at the same time as it assumes leadership of several international platforms with agendas dedicated to the same issues. The UK government's choices for the 'COVID and Global Health' budget appear to expedite a vision and

[1] https://www.gov.uk/government/speeches/uk-official-development-assistance-oda-allocations-2021-to-2022-written-ministerial-statement (26/05/2021)
[2] Written statements - Written questions, answers and statements - UK Parliament (26/05/2021)

approach to overseas global health that fortifies systems-level mechanisms, but disadvantages important targeted bilateral actors and programmes, including health product development.

- Smaller bilateral partners and issue-driven consortia are less resilient than large multilateral actors. Many will collapse without the political and financial backing of the FCDO. This support enables partners to attract interest from other donors and supporters, and its loss will severely hinder their ability to effectively build and progress programming and research.
- Cuts to UK ODA will reduce access to medical care for people in remote regions where its partners have been forced to stop their programmes. This includes health services that serve as critical 'touchpoints' with communities, providing insight into population health and needs. These are often the source of information that proves crucial to preventing late responses to outbreaks or issues of food insecurity.
- The current approach of the UK government invests impressively in the global health system, but increasingly keeps individual health issues and the experiences of people affected by them at arm's length. Without a FCDO global health strategy to guide UK cross-governmental investment in global health, the UK is on track to lose touch with the realities of individuals who are the essence of global health action.

In 2021, the UK is president of the G7 and COP26, and whilst being a permanent member of the UN Security Council was also president in February. The UK has written and promoted agendas for these platforms that heavily emphasise the intersecting areas of global health security, pandemic preparedness, action on climate change, sustainable food systems, famine prevention and nutrition, and financing for anticipatory action. Promising to 'combine aid with diplomacy' to deliver maximum impact even with a smaller global health budget, the UK has favoured tactical political proposals and eye-catching financial commitments to prompt others to follow suit. For example, supporting the ACT-A and its CoVax pillar, the G7 famine prevention and humanitarian crises compact,[3] the Pandemic Preparedness Partnership, and, most recently, the Action Review Panel for Child Wasting. In parallel, yet in complete contradiction, the government has decimated its funding for global health actors and programmes, both bilateral and multilateral, pursuing a campaign of staggering reductions, strategic non-renewals and early exits from funding streams for all but the three largest multilateral actors, WHO, GAVI and GFATM.

While cuts have been made across the board, the way global health resources have been distributed speaks to a vision and approach to foreign aid and global health that fortifies systems-level mechanisms, but does not do the same for targeted bilateral actors and programmes, including health product development. The current approach invests impressively in the global health system, but increasingly keeps individual health issues and the experiences of people affected by them at arm's length. The government has stated its intention to move away from bilateral programming to allow states to lead their own health responses. Instead, it favours core funding to multilateral organisations, while solutions to global health problems are seen to lie in the creation of another public private partnership (PPP) or global financing facility. Contracts to help achieve state-led responses are often offered to private British third-party institutions (sometimes for-profit), who act as middleman to implementing partners. Aid is heavily supplemented by diplomacy, largely through highly visible ambassadors or state-led plurilateral entities that seek to mobilise global interest and attention.

While the current UK approach to global health has shown results in some areas, there are important drawbacks that must also be highlighted. Where there have been achievements, these are increasingly through multilateral actor pathways that remove the UK from direct responsibility for programme quality and outcomes, shifting the focus on to 'high-level' structures and policies instead. The move away from direct bilateral action" distances the UK from the realities of at-risk countries and communities and unintentionally encourages global health monopolies. The same heavyweight actors are always at the table, while national actors from at-risk countries and civil society are conspicuous by their absence. As a side effect, large multilaterals have begun to grow beyond their mandates, sometimes at a cost to vertical programming, whether or not they are best suited to take on new focus areas. Big political initiatives to respond to health crises often have hefty price tags and the need to mobilise private sector interests to succeed, but this is often done without funding conditions, quality assurance monitoring, or mandatory commitments to equity and

transparency. As a result, these initiatives run the risk of not achieving their stated goals, and, in the end, diverting attention and resources away from other essential health programming. These large multistakeholder models have become a template that is reproduced for successive global health challenges. Yet, without transparent auditing or evaluation after the fact, problems are repeated.

In the process of the creation of the FCDO, through the merger of FCO and DFID, a Directorate of Global Health was welcomed by many. With the hope that the directorate would provide greater structure and cohesion among different technical and diplomatic teams working for the UK on issues of global health, and a much-needed departmental and cross-Whitehall strategy for UK investment in global health, which has been sorely lacking since 2015. As of now, the promised strategy has yet to come to fruition. Its existence might have ensured that ODA allocations within the FCDO 'COVID and Global Health' budget line were determined by the expertise housed in this department, and based on a pre-determined set of needs, priorities, and performance indicators. It would have also ensured a better equilibrium between UK support to multilateral and bilateral programming that does not disadvantage and irreparably damage programming and product development from smaller bilateral partners.

Multilateral programmes and PPPs have diversified sources of funding, which bilateral partners often lack. The UK's choice to preserve multilateral programmes and PPPs, at the expense of smaller targeted bilateral partners, is far from ideal as the latter will collapse without the political and financial backing of the FCDO. They need funding predictability; UK support enables partners to attract interest from other donors and supporters. The absence of both will have a devastating impact on their ability to effectively build and progress programming and research. These setbacks will significantly affect vital product development and reduce access to care in remote regions where many partners work. By choosing to deprioritise these types of bilateral aid, the UK risks dramatically reducing access to essential health services and removing critical health 'touchpoints' with communities, which enable visibility over a greater cross-section of a population's health and needs. The insights from these points provide information which guides interventions and is often crucial to preventing late responses to outbreaks or issues such as food insecurity.

The UK government must:

- Ensure that the FCDO Global Health Directorate has control and oversight over strategic decisions related to ODA funding to programmes and partners that fall within its remit.
- Ensure that a FCDO and cross-Whitehall strategy for global health guides smart and balanced decision-making relating to priorities and funding in the future.
- Provide transparent oversight of the issues and programmes included in the FCDO budget for 'COVID and Global Health', with explanations of recent changes in portfolio and distribution funding between multilateral and bilateral partners.
- Ensure UK support to large multilateral programmes and plurilateral partnerships is not at the expense of smaller targeted bilateral support. The UK must commit to creating an environment that is conducive to their continued role in overseas global health programme implementation and research and must monitor the impacts of reductions in these because of aid cuts.
- Empower a non-partisan watchdog entity to systematically transparently audit and review UK foreign aid support to multistakeholder initiatives, specifically scrutinising their efficacy, equality, and inclusivity, to guide future models developed and ensure they make a tangible difference for the lives and health of at-risk populations.

[i] World Health Organization. Global leishmaniasis surveillance, 2017−2018, and first report on five additional indicators. Wkly Epidemiol Rec 2020; 25: 265–80.

[ii] *Ibid*

[iii] Argaw D, Mulugeta A, Herrero M, et al. Risk factors for visceral Leishmaniasis among residents and migrants in Kafta-Humera, Ethiopia. PLoS Negl Trop Dis 2013; 7: e2543.

[iv] Seaman J, Mercer AJ, Sondorp E. The epidemic of visceral leishmaniasis in Western Upper Nile, southern Sudan: Course and impact from 1984 to 1994. Int J Epidemiol 1996; 25: 862–71.

[v] Argaw D, Mulugeta A, Herrero M, et al. Risk factors for visceral Leishmaniasis among residents and migrants in Kafta-Humera, Ethiopia. PLoS Negl Trop Dis 2013; 7: e2543.

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