

Patterns of funding allocation for tuberculosis control in fragile states

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SUMMARY

OBJECTIVE: To assess recent (2006–2010) tuberculosis (TB) funding patterns in conflict and non-conflict-affected fragile states to inform global policy.

METHODS: The Creditor Reporting System was analysed for official development assistance funding disbursements towards TB control in 11 conflict-affected states, 17 non-conflict-affected fragile states and 38 comparable non-fragile states. The amounts of funding, funding relative to burden, funding relative to malaria and human immunodeficiency virus (HIV) control, disbursements relative to commitments, sources of funding as well as funding activities were extracted and analysed.

RESULTS: Fragile states received on average more per capita for TB control relative to non-fragile states (US\$0.159 vs. US\$0.079). However conflict-affected fragile states received on average less per capita than non-conflict-affected states (US\$0.144 vs. US\$0.203),

despite worse development indicators. Conflict-affected fragile states also received on average only 70% of TB funds already committed. Analysis by burden revealed the least disparity in funding in highest prevalence settings. Analysis of funding activities suggests increasing importance of TB-HIV integration, multidrug-resistant TB and research in both fragile and non-fragile states. Relative to non-conflict-affected fragile states, conflict-affected fragile states received approximately two thirds the per capita funding for TB.

CONCLUSIONS: This study revealed disparities in TB control funding between fragile and non-fragile as well as between conflict and non-conflict-affected fragile states. Findings suggest possible avenues for improving the allocation of global TB funding.

KEY WORDS: TB; conflict; aid effectiveness; MDGs

FRAGILE STATES are of crucial concern in the areas of development and health. Although they comprise only 9% of developing countries, by 2015 they are projected to be home to half of the world's extremely poor.^{1,2} In almost every Millennium Development Goal (MDG), fragile states are faring disproportionately worse, as not a single fragile state has yet to achieve a single MDG.² Many fragile states are currently, or have been, conflict-affected, leading to even greater instability and breakdown of health service provisions.¹

As of 2010, tuberculosis (TB) was the tenth leading cause of death globally and accounts for 49 396 disability-adjusted life years.³ The negative effects of various crises on TB control are well documented. Increases in mortality and morbidity from TB have been shown during and post conflict.^{4,5} These increases have been attributed to population displacement, disruption of health programme services and poor nutrition.⁶ The effects of armed conflict on TB control can be offset by strong TB programme management,

as has been seen in Somalia and Timor-Leste.^{7,8} Sufficient funding has been cited as being key to programme resilience in these conflict-affected countries.⁹

Previous studies on funding of infectious disease programmes have found that funding for many disease programmes was not proportional to their burden.^{10,11} Despite a general global increase in funding for TB control in the last 25 years,¹² a significant gap in funding, particularly with regard to multidrug-resistant TB (MDR-TB) control, still remains.¹³ Generally, TB programmes have reported more difficulties in securing external donations than human immunodeficiency virus/acquired immune-deficiency syndrome (HIV/AIDS) and malaria programmes.¹⁴ Where funds have been disbursed in fragile states, they appear to have been inconsistent and based on donor preferences.¹

No study to date has systematically reviewed funding for TB control within the context of fragile states, including those also affected by conflict. We therefore attempted to fill this gap by analysing recent levels of

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TB funding (2006–2010) to inform global TB strategy. The specified time period was chosen to include the most recent full data available (2010) as well as to reflect short-term patterns of funding. Specifically, we aimed 1) to quantify the absolute amount of TB funding for fragile and non-fragile states and those experiencing conflict; 2) to compare levels of TB funding between fragile and non-fragile states; 3) to compare funding relative to burden and 4) relative to HIV/AIDS and malaria control; and 5) to describe the activities within TB control for which funding was requested and disbursed.

METHODS

Case definitions and ethics

Case definitions of fragile, non-fragile and conflict-affected fragile states are shown in Table 1. As all information was extracted from publically available, anonymous databases, ethics approval was not required.

Data collection

Funding information was extracted from the Creditor Reporting System (CRS) of the Organisation for Economic Co-operation and Development, which tracks official development assistance (ODA) by country. Previous studies have indicated the reliability of this database,^{17,18} and have used it to explore funding allocations for a number of health topics.^{13,19} The CRS database was consulted using labelled purpose codes (specifically, purpose code 12263: Tuberculosis Control, <http://www.oecd.org/dac/aidstatistics/49846064.doc>). Data on commitments and disbursements were extracted for all fragile states and non-fragile states serving as controls. The amount of funding disbursed for malaria control as well as for control of sexually transmitted infections (STI) and HIV infection was also extracted from the CRS. All funds were calculated using the 2010 US dollar as the base rate to account for the effects of currency exchange and inflation.

Table 1 Case definitions of fragile, non-fragile and conflict-affected fragile states

Case definitions using the World Bank Country Policy and Institutional Assessment (CPIA) indicator were developed.¹⁵ The CPIA is used to assess the quality of policies and institutions in countries who, because they met an annually determined common poverty threshold and were unable to borrow, were eligible for international development assistance.

Fragile states were included in the study if they scored ≤ 3.2 on the CPIA for a minimum of 3 of the 5 study years. In addition, countries where CPIA was unable to be conducted were included as fragile states, as inability to conduct CPIA was seen as a proxy for fragility. Countries that had scored >3.2 on the CPIA for all 5 study years were included as non-fragile controls.

Using the Uppsala University Conflict Database,¹⁶ we also defined a fragile state as conflict-affected if a minimum of 25 battle-related deaths had occurred in any year of the 5-year study period.

Data on prevalence of TB, chosen as the key indicator of burden, were extracted from the World Health Organization (WHO) global database.²⁰ The US Census International Database was accessed to collect year-specific country population estimates to perform per capita calculations of funding.²¹ Lastly, data on key development indicators were extracted from the open database of the World Bank.²²

Analyses

All analyses were conducted using Microsoft Excel (Microsoft, Redmond, WA, USA). Total funding disbursed for TB control was calculated for both fragile and non-fragile countries, and stratified by conflict status for the former. The percentage of commitments disbursed was calculated for each year to determine the pattern of disbursements relative to commitments. The mean funding disbursement over the 5 years of analysis was calculated. The estimated number of prevalent cases was calculated using the product of median population estimate and median prevalence. The amount of funding per prevalent TB case was then calculated using the 5-year funding mean as the numerator and the median population over the period as the denominator. The amount of funding per capita was calculated as the ratio of the 5-year mean disbursement and the median population estimate, and was again stratified by fragility and conflict status.

Per prevalent and per capita TB funding disbursements were further analysed by stratifying results by quintile of prevalence. This was to compare funding in fragile, non-fragile and conflict-affected states that had a similar TB burden. The sources of funding were compiled according to donor country, and the percentage of TB control funding each donor country disbursed was calculated and ranked relative to other donors. In analysing funded activities, each individual grant entry in the CRS was scrutinised for mention of a discrete programme activity or a particular target population and categorised accordingly. Initial categories of funding activities were taken from the WHO Global TB report,¹³ and subsequent categories were delineated during the grants review (see Results). The CRS does not report the budget breakdown of each grant into different activities. Lastly, total global and per capita funds disbursed for malaria and STI/HIV were computed using the same approach.

RESULTS

Twenty-eight countries met the inclusion criteria for fragility and 38 met the criteria for comparable non-fragile states (Table 2).^{*} Fragile states had a median TB prevalence of 384 cases per 100 000 compared to 178.5 in non-fragile and 393 in conflict-affected

^{*} A more detailed version of Table 2 and supporting data are available on request from the corresponding author.

Table 2 List of fragile and non-fragile states included in the analysis

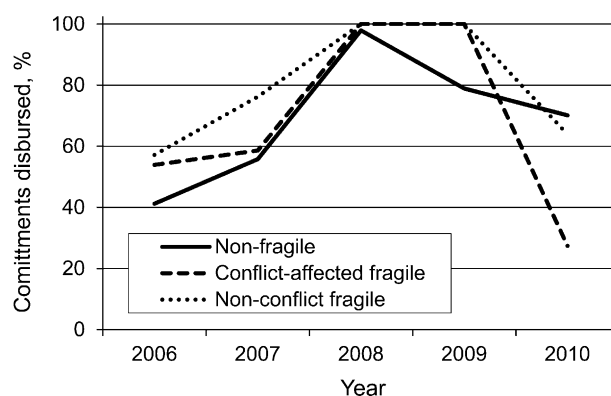
Fragile states	Non-fragile states
Afghanistan*	Armenia
Angola*	Azerbaijan
Burundi	Bangladesh
Central African Republic*	Benin
Chad*	Bhutan
Comoros	Bolivia
Congo, Democratic Republic*	Bosnia & Herzegovina
Congo, Republic of	Burkina Faso
Côte d'Ivoire	Cape Verde
Djibouti*	Dominica
Eritrea	Ethiopia
Guinea	Georgia
Guinea-Bissau	Ghana
Haiti	Grenada
Kiribati	Guyana
Laos	Honduras
Liberia	India
Myanmar*	Kenya
Sao Tome and Principe	Kyrgyz Republic
Sierra Leone	Lesotho
Solomon Islands	Madagascar
Somalia*	Malawi
Sudan*	Maldives
Timor-Leste	Mali
Togo	Moldova
Tonga	Mozambique
Yemen*	Nicaragua
Zimbabwe	Niger
	Rwanda
	Samoa
	Senegal
	Sri Lanka
	St Lucia
	St Vincent & Grenadines
	Tanzania
	Uganda
	Viet Nam
	Zambia

* Conflict-affected.

fragile states. Per capita calculations revealed that, on average, conflict-affected fragile states received approximately 30% less TB funding than non-conflict-affected fragile states but almost twice as much funding as non-fragile states. All states, irrespective of category, showed an increase in funding during the study period.

Despite the above, in 2010 all country categories experienced a sharp decline in the proportion of funding commitments that were actually disbursed after 3 years of growth (Figure 1). Relative to 2008, the proportion of commitments disbursed in 2010 declined by 76% for conflict-affected fragile states, 39% for non-conflict-affected fragile states and 28% for non-fragile states. Over the 5-year study period, non-conflict-affected fragile states received on average 81% of commitments, followed by conflict-affected fragile states (71%) and non-fragile states (69%).

Stratification by quintile of TB prevalence revealed large disparities in funding per prevalent TB case (Figure 2). With the exception of the highest prevalence quintile (5), proportionately far greater funding per TB case was provided to non-fragile states (quintile 1, i.e., lowest) or fragile states (quintiles 2, 3 and

**Figure 1** Percentage of per capita commitments disbursed.

4, with a more than 20-fold difference between fragile, non-conflict-affected and non-fragile states in quintile 3). Generally, the lowest levels of funding per case were found in the highest prevalence quintile. After comparing median funding levels among all countries within each quintile, these broad patterns remained (data not shown). The majority of funding during the study period to both fragile and non-fragile states was contributed by the Global Fund for AIDS, Tuberculosis and Malaria (the Global Fund), followed by the US Government and the World Bank (Table 3).

Overall, the number of individual grants awarded to non-fragile states shows an increasing pattern, while the number of grants to fragile states peaks in 2008 and declines thereafter (Table 4). However, the number of grants with multiple target activities shows an increase for both fragile and non-fragile states, suggesting that more activities are being consolidated into fewer grants. There do not appear to be large differences in distribution of activities between fragile and non-fragile states, particularly in the last 2 years. An increasing number of grants are targeted towards TB-HIV integration, MDR-TB control and research (Table 4). In fragile states, an increasing

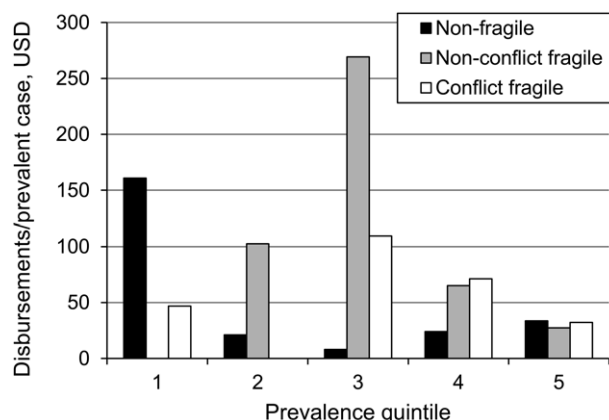
**Figure 2** Tuberculosis (TB) funds disbursed per prevalent case by quintile of prevalence (USD). Missing data: no funds were disbursed for non-conflict-affected fragile states in prevalence quintile 1; no conflict-affected fragile countries met the TB prevalence for quintile 2.

Table 3 List of TB donor sources by per cent of funds contributed

Donor	Fragile states				Non-fragile states	
	Conflict		Non-conflict		Absolute amount disbursed, million USD	Percentage of total non-fragile
	Absolute amount disbursed, million USD	Percentage of conflict	Absolute amount disbursed, million USD	Percentage of non-conflict		
Global Fund	113.1	67.9	92.0	86.3	493.6	68.3
United States	20.3	12.2	5.5	5.1	73.7	10.2
IDA, World Bank	12.4	7.4	5.3	5.0	102.4	14.2
Canada	7.5	4.5	0.0	0.0	0	0
Japan	5.7	3.4	0.1	0.1	2.7	0.4
Italy	3.8	2.3	0.1	0.1	5.6	0.8
Belgium	3.4	2.0	0.8	0.7	0.5	0.1
Norway	0.2	0.1	0.0	0.0	0.1	<0.1
Finland	0.2	0.1	0.1	0.1	<0.1	<0.1
Australia	0.0	0.0	2.2	2.0	<0.1	<0.1
European Union	<0.1	<0.1	<0.1	<0.1	2.1	0.3
France	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1
Luxembourg	<0.1	<0.1	<0.1	<0.1	25.6	3.5
The Netherlands	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1
Spain	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1
United Kingdom	<0.1	<0.1	0.1	0.1	2.4	0.3
Portugal	<0.1	<0.1	<0.1	<0.1	0.3	<0.1
New Zealand	<0.1	<0.1	<0.1	<0.1	0.3	<0.1
Austria	<0.1	<0.1	<0.1	<0.1	12.2	1.7
Korea	<0.1	<0.1	0.2	0.2	0.5	0.1
Greece	<0.1	<0.1	0.0	0.0	0.2	<0.1
UNDP	<0.1	<0.1	0.3	0.3	0.1	<0.1
Total	166.7	100	106.6	100	722.4	100

TB = tuberculosis; Global Fund = the Global Fund for AIDS, Tuberculosis and Malaria; IDA = International Development Association; UNDP = United Nations Development Programme.

number of grants included activities to strengthen the health system as time progressed, although the proportion remained below 10%. On a global scale, funding for STI/HIV, malaria and TB all increased over the 5-year study period (Appendix Table).^{*} However, globally, TB control received 56% less funding than malaria and 93% less than STI/HIV control. Over the analysis period, conflict-affected fragile states received less funding per capita for TB control relative to both malaria and STI/HIV control. Relative to non-conflict-affected fragile states, conflict-affected fragile states received approximately two thirds the per capita funding for TB, half that for malaria and one eighth that for STI/HIV control.

DISCUSSION

This study is the first to quantify the amount of official development assistance (ODA) funding for TB control in conflict and non-conflict-affected fragile states as well as comparable non-fragile states. Fragile states compared favourably to non-fragile states in terms of TB funding. However, conflict-affected fragile states were worse off than non-conflict-affected states. This supports previous studies that have shown that conflict-affected states have received less aid relative to their levels of poverty and less aid than non-conflict-

affected low-income countries.^{13,23} Previous reports have indicated that this inequity may be due to the lack of absorptive capacity in conflict-affected countries.¹³

Conflict-affected fragile states also fared the worst, with only 27% of commitments being disbursed in 2010. This could have potentially serious repercussions for control of TB, as a decrease in funding may lead to deterioration of socio-economic conditions in addition to a weakening of control efforts.²⁴ This is a particularly worrying trend as the funding gap for global TB control is projected at 21 billion by 2015.²⁵ Alternatively, the trend may be a result of multi-year projects such as dual phase Global Fund grants, in which funds are not dispersed annually but at the beginning of each budget cycle. Furthermore, because fragile states have a low per capita health expenditure, ODA may account for a large portion of total health care expenditure.²⁴ Indeed, for the majority of the sub-Saharan African countries, domestic TB funding makes up less than 50% of total TB funding, while in the 17 highest burden countries, excluding the BRICS (Brazil, Russia, India, China and South Africa), donor funding accounts for 50% of total TB funding.¹⁵

The World Bank, the United States and the Global Fund contribute 90% of TB ODA for both fragile and non-fragile states. They are also the three major donors for conflict-affected countries. Preliminary results by the Global Fund, which found that grant performance in fragile states was comparable to stable states, may explain its continued commitment to fragile states.²⁶ Nevertheless, this illustrates the heavy

^{*}The Appendix is available in the online version of this article at <http://www.ingentaconnect.com/content/ijltd/ijltd/2014/00000018/00000001/art00013>

Table 4 Number and percentage of TB grants according to mention of one or more TB control activities

Year, fragile	Grants <i>n</i>	TB-HIV*	Monitoring and evaluation	DOTS [†]	MDR-TB [‡]	Purchase of drugs, laboratory equipment and services	PPM/PAL/ACSM	Research [§]	Health systems strengthening	Vulnerable populations [¶]	Training and salaries [#]	Unspecified	Multi-activity grants <i>n</i>	Multi-activity grants %
2006														
Yes	27	11.1	0	25.9	14.8	7.4	3.7	0	0	7.4	0	0	8	30
No	59	11.9	1.7	8.5	3.4	3.4	3.4	5.1	6.8	13.6	0	3.4	15	25
2007														
Yes	50	32	4	32	22	8	4	0	2	8	0	40	17	34
No	127	40.2	6.3	15	28.3	5.5	7.9	3.1	8.7	14.2	5.5	26	59	46
2008														
Yes	227	17.2	0.4	5.3	14.5	0.4	1.3	13.2	0.4	0.9	0.4	10.1	36	16
No	153	47.7	3.9	9.2	42.5	3.9	6.5	41.8	5.2	5.2	5.2	26.1	78	51
2009														
Yes	74	66.2	4.1	17.6	55.4	10.8	6.8	50	5.4	10.8	14.9	13.5	56	76
No	195	63.6	4.6	15.4	56.9	8.7	14.9	47.2	7.7	12.3	7.7	10.3	133	68
2010														
Yes	102	63.7	5.9	24.5	49	14.7	9.8	40.2	5.9	14.7	8.8	15.7	74	73
No	315	68.9	3.2	8.3	65.4	8.9	11.4	53.3	4.1	7	11.4	7.9	226	72

*TB-HIV integration.

[†]Strengthening and expanding DOTS coverage.

[‡]Combating drug resistance.

[§]Both operational and primary research.

[¶]Children, women, inmates, the poor and hard-to-reach populations.

[#]Both local staff and external consultants.

TB = tuberculosis; HIV = human immunodeficiency virus; MDR-TB = multidrug-resistant TB; PPM = public-private partnership; PAL = Practical Approach to Lung Health; ACSM = advocacy, communication and social advocacy.

reliance of recipient countries on these donors and their documented potential vulnerability to any fluctuations in funding.²⁷

The increasing number of grants targeted at TB-HIV and MDR-TB and research reflects the growing recognition of the challenges of these infections, with 650 000 prevalent MDR-TB cases and 350 000 TB-HIV deaths in 2010.¹⁵ It also reflects the increasing importance of primary research as a key activity for reaching global targets,^{14,25} with further research on financing for TB research and development.²⁸

Funding for TB, HIV and malaria programmes all increased over the study period, whereas as noted previously TB receives substantially less funding.^{12,16} Relative to non-fragile states, fragile states did, however, receive more per capita funding for TB and malaria programmes. This may simply be a reflection of the higher burden of these diseases in these countries or due to the higher costs of treatment associated with the respective programmes.

Study limitations

The study was limited to ODA for TB programmes, which do not reflect the entirety of funding. Data on public or private TB expenditure within countries, as well as money sent by the Somali diaspora population to relatives in Somalia, could not be compiled as they are not available in open-source databases. This would have given a more accurate assessment of the TB funding situation within fragile states. Due to the large number of grants with uninformative short descriptions, narrative labelling was relied upon in which grants were labelled based on information extracted

from the long description. This has been shown to be inaccurate.¹⁷ As a result, it was not possible to determine the precise amount of funds allocated to each activity. Similar studies on reproductive and maternal health have used previously calculated allocation figures to estimate amounts of funding for specific reproductive health activities,^{13,29} but no such estimates could be found for TB control activities.

Country-level comparisons of funding levels for TB control activities could not be made with international recommendations, as no such guidelines are available. This is in large part due to the highly context-specific nature of TB control, with each country budgeting funding for TB control activities according to its own strategic plan. The strategic plan is a medium- to long-term plan detailing goals, strategies and budgets, and is dependent on current and future epidemiological projections.³⁰ Neither the strategic plans nor the previous year budgets were publicly available and they could not be traced in a timely manner for this study.

Furthermore, it was not possible to make a more precise comparison with HIV alone, as funding for HIV was included with that of funding for various STIs, and the coding in the CRS did not allow for disaggregation. However, it is possible that STI funding represented a small proportion of the total STI/HIV disbursements.

This study was limited to assessing funding at national levels and could not determine how it was allocated within country. This is especially relevant in conflict-affected countries, as these tend to occur in geographically distinct areas.

While funding per prevalent TB case does provide a crude measure of equity between different countries, it does not account for differing costs of diagnosis and treatment: for example, it is possible that in fragile states the true cost of managing a TB case might be higher than in non-fragile states due to difficult transport conditions and logistics, greater requirements for training and upfront investments in rehabilitating health structures.

Lastly, because only 24 members of the Development Assistance Committee (DAC) are obliged to report funding to CRS, only a portion of total ODA is available for analysis. This is due to the increasing amount of funding from non-DAC members not currently reporting to the CRS.¹³ This is significant, as some non-DAC countries, such as Saudi Arabia and China, contribute more ODA funds than many of the regular DAC countries.³¹

CONCLUSIONS

Fragile states receive comparable or greater funding for TB than non-fragile states. However, fragile states, and particularly conflict-affected fragile states, bear the greatest burden of TB compared to non-fragile states, and are the least financially able to mount an effective domestic response without appropriate aid. To reach the MDG goals and to make significant long-term development gains, TB control in fragile and conflict-affected states must continue to be strengthened through increased donor funding.

Conflict of interest: none declared.

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APPENDIX

Table A Funds (USD) disbursed according to disease and fragility status

Programme, funding category	2006	2007	2008	2009	2010	Annual average
Malaria						
Total*						
Global	494.50	508.22	893.06	1498.42	1607.44	1000.33
Fragile						
Conflict	40.72	72.66	134.40	163.84	186.61	119.65
Non-conflict	31.48	52.47	79.09	64.38	203.23	86.13
Non-fragile	327.76	221.82	438.74	695.63	754.73	487.74
Per capita [†]						
Fragile						
Conflict	0.16	0.28	0.52	0.63	0.72	0.46
Non-conflict	0.37	0.61	0.93	0.75	2.38	1.01
Non-fragile	0.18	0.12	0.24	0.38	0.42	0.27
Tuberculosis						
Total*						
Global	237.04	319.04	405.61	499.20	787.07	449.59
Fragile						
Conflict	23.22	27.42	26.65	23.65	64.16	33.02
Non-conflict	12.50	19.31	21.40	17.27	29.71	20.04
Non-fragile	93.77	117.66	137.16	157.04	215.33	144.19
Per capita [†]						
Fragile						
Conflict	0.09	0.11	0.10	0.09	0.25	0.13
Non-conflict	0.15	0.23	0.25	0.20	0.35	0.23
Non-fragile	0.05	0.06	0.08	0.09	0.12	0.08
STI/HIV						
Total*						
Global	4223.43	5201.77	6254.82	6675.77	7201.28	5911.41
Fragile						
Conflict	132.62	109.66	162.21	83.28	219.38	141.43
Non-conflict	248.92	299.95	343.13	367.99	435.94	339.19
Non-fragile	1342.50	2063.02	2407.90	2530.48	2947.43	1517.11
Conflict	0.51	0.42	0.62	0.32	0.84	0.54
Per capita [†]						
Non-conflict	2.91	3.51	4.02	4.31	5.10	3.97
Non-fragile	0.74	1.14	1.33	1.39	1.62	1.24

* Millions of USD (2010).

[†] USD (2010).

STI = sexually transmitted infection; HIV = human immunodeficiency virus.

OBJECTIF : Evaluer, pour servir d'information à une politique mondiale, les types récents (2006–2010) de financement de la tuberculose (TB) dans les pays fragiles avec ou sans conflits.

MÉTHODES : On a analysé le Creditor Reporting System concernant les dépenses de fonds de l'assistance officielle au développement visant la lutte contre la TB dans 11 pays fragiles affectés par les conflits, dans 17 pays fragiles sans conflits et dans 38 pays comparables mais non fragiles. On a extrait et analysé les quantités de financement par rapport au fardeau, le financement par rapport à la lutte contre la malaria et le virus de l'immunodéficience humaine (VIH) et les dépenses liées aux engagements financiers, les sources de financement ainsi que les activités de financement.

RÉSULTATS : En moyenne, les pays fragiles ont reçu des sommes plus importantes per capita pour la lutte contre la TB par comparaison avec les pays non fragiles (0,159\$US vs. 0,079\$US). Toutefois, les pays fragiles atteints par les conflits ont reçu en moyenne moins per

capita que les pays sans conflits (0,144\$US vs. 0,203\$US) en dépit de l'existence d'indicateurs de développement plus défavorables. Les pays fragiles affectés par les conflits ont reçu également en moyenne 70% seulement des fonds qui leur étaient destinés. L'analyse en fonction du fardeau a révélé que la disparité en matière de financement était la plus faible dans les contextes où la prévalence est la plus élevée. L'analyse des activités de financement a suggéré une importance croissante de l'intégration TB-VIH, de la TB multirésistante et de la recherche tant dans les pays fragiles que non fragiles. Par rapport aux pays fragiles sans conflits, les pays fragiles atteints par des conflits ont reçu approximativement deux tiers du financement par capita pour la TB.

CONCLUSIONS : Cette étude a révélé une disparité dans le financement de la lutte antituberculeuse entre les pays fragiles et non fragiles et aussi entre les pays fragiles avec conflits ou sans conflits. Ces observations suggèrent diverses possibilités d'amélioration de l'attribution mondiale du financement pour la TB.

OBJETIVO: Analizar la modalidad reciente de los financiamientos destinados a la tuberculosis (TB) del 2006 al 2010 en los países fragilizados por situaciones de conflicto o los países frágiles sin conflicto, con el fin de documentar las políticas mundiales.

MÉTODOS: Se examinó el Sistema de Notificación de la deuda de los Países Acreedores en busca de desembolsos en favor del control de la TB en el marco de la Asistencia Oficial para el Desarrollo, en 11 países frágiles en situación de conflicto y 17 países frágiles sin conflicto y 38 países sólidos comparables. Se extrajeron y analizaron la cantidad de fondos, los fondos en función de la carga de morbilidad, los relacionados con el control de la malaria y la infección por el virus de la inmunodeficiencia humana (VIH), los desembolsos correspondientes a los compromisos, las fuentes de financiamiento y también las actividades que se financiaron.

RESULTADOS: La ayuda que recibieron en promedio los países frágiles por habitante, destinada al control de la TB, fue mayor que la recibida por los países sólidos (US\$ 0,159 contra US\$ 0,079). Sin embargo, los países frágiles afectados por situaciones de conflicto recibieron en promedio una menor ayuda por habitante que los

países sin conflicto (US\$ 0,144 contra US\$ 0,203), pese a que exhibían indicadores de desarrollo más deficientes. Asimismo, los países frágiles en conflicto recibieron en promedio solo 70% de los fondos destinados a la TB que les habían sido destinados. Un análisis en función de la carga de morbilidad reveló que la menor disparidad del financiamiento por caso nuevo se encontraba en los medios con la más alta prevalencia. El análisis de las actividades financiadas indicó una importancia creciente de la integración de las actividades contra el VIH y la TB, la TB multidrogorresistente y la investigación en los países frágiles y también en los países sólidos. En comparación con los países frágiles exentos de conflicto, los países frágiles afectados por una situación de conflicto recibieron cerca de dos tercios del financiamiento por habitante destinado al control de la TB.

CONCLUSIÓN: Los resultados del presente estudio revelan una disparidad en el financiamiento del control de la TB entre los países frágiles y los países sólidos y también entre los países frágiles afectados por una situación de conflicto o países frágiles exentos de conflicto. Estos datos sugieren posibles vías de progreso en la asignación de los fondos mundiales a la lucha contra la TB.