The Global Fund to Fight AIDS, Tuberculosis and Malaria and Support for Middle Income Countries

In November 2011, the Global Fund Board decided that 55% of its funding commitments in any given year should be allocated to low-income countries. The Board had previously instated a range of measures to guide resource allocation to middle income countries including capping funding to upper middle income countries at 10%; counterpart financing, and a MARPs channel. In order to implement the 55% funding allocation decision, the Board Chair announced in February 2012 that he had decided to cap phase two renewals at 75% of TRP-approved totals for all upper lower-middle income countries and upper middle income countries.

Using country income categories as the main guidance for deciding whether or not to allocate resources to specific vulnerable populations may ultimately be counterproductive as income alone is not indicative of countries' ability to pay for the cost of their disease responses. In making previous decisions about who is eligible for funding and how funding should be prioritized, the Global Fund board has carefully considered both disease burden and country income category. According to the Center for Global Development, the Global Fund's former eligibility requirements (before the 2011 update) led to high correlation between grant size and disease burden (0.84). Given this shift in policy with even greater emphasis on country income category, it is doubtful that this new criteria will lead to nearly such an effective funding distribution. In fact, the 55% rule may inadvertently prevent the Global Fund from investing adequately in countries with the highest disease burdens and greatest need. In order to achieve impact and the new strategy's targets, the Global Fund Board should therefore revoke the 55% rule at its 26th Board meeting.

- **Many countries are transitioning from low to middle income, but poverty in middle income countries remains high**. Poverty in middle income countries is exacerbated by rising income inequality. At the World Economic Forum in Davos in 2011 income inequality within countries was recognized as one of the most serious challenges facing global development. As of 2011, there were only 35 low income countries left, compared to 110 middle income countries. Middle income countries still have high rates of poverty that contribute to negative health outcomes. In fact, 60% of the world's poor live in five populous middle-income countries: Pakistan, India, Nigeria, China and Indonesia. Of the top ten countries by contribution to global poverty, only four are low income.

- **Middle-income countries have higher burdens of HIV and TB than low-income countries.** LICs continue to have significant needs for support to finance their responses to the three diseases, furthermore, they require investments in basic infrastructure, for instance through investments in health and community systems strengthening. However, measured in disability adjusted life years (DALY), low-income countries have approximately one-third of the overall disease burden of middle-income countries for all causes. For HIV, DALYs are roughly equal between low income and middle income countries, but low-income countries have only one-third of the TB DALYS compared to middle-income countries. Income-level funding allocations make even less sense when specific countries are considered. Three of the top five countries with the highest HIV burdens are middle income; while eight of the ten countries with the highest TB burdens are middle income. Middle-income countries have far lower rates of ARV coverage for people living with HIV than low-income countries and much higher rates of multi-drug resistant tuberculosis.

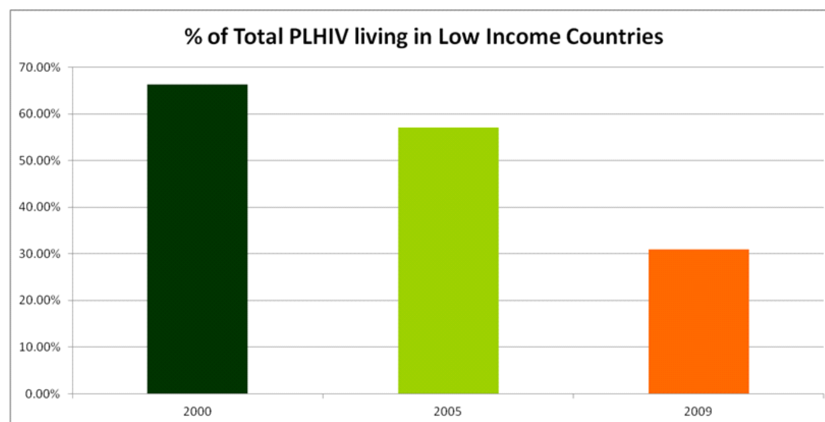
  The table and graph below illustrate the landscape of HIV and TB burdens according to country income specification. Both examples demonstrated that shifting funds from middle-income countries would be a poor strategy for controlling these epidemics.

Highest Burden HIV and TB Countries (in DALYs)					
HIV			TB		
Rank	Country	Income	Rank	Country	Income
1	South Africa	UMI	1	India	LLMI
2	Zimbabwe	LI	2	China	UMI
3	Nigeria	LLMI	3	Indonesia	ULMI
4	India	LLMI	4	Nigeria	LLMI
5	Kenya	LI	5	Bangladesh	LI
6	Tanzania	LI	6	Pakistan	LLMI
7	Uganda	LI	7	Ethiopia	LI
8	Ethiopia	LI	8	South Africa	UMI
9	Mozambique	LI	9	Philippines	LLMI
10	Democratic Republic of the Congo	LI	10	Russian Federation	UMI

Key:

LI= Low Income LLMI= Lower Lower Middle Income

ULMI= Upper Lower Middle Income UMI= Upper Middle Income



- **The capacity of middle-income countries to pay for health and their disease responses varies.** While transitions in income status may indicate that economic conditions are improving, this does not necessarily translate into a capacity to substantially increase health expenditure. In Zambia, a new lower middle income country, Results for

Development Institute has estimated that fully funding its HIV response would require an investment of more than 6% of GNI; which is beyond the government's capacity in the short or even longer term. Countries such as the emerging powers of China and India may have low need for ODA generally and a growing capacity to take over a larger share of their health responses, but this is in a context where the absolute number of poor people in these countries may be increasing. In yet other cases, fiscal space policies and constraints may limit how much additional funding can be allocated to the health sector. However, increasing public health expenditure is also heavily influenced by political will; in many middle income countries health and social development do not rank as highly in terms of country priorities as public infrastructure and defense. Where there is capacity and willingness among countries to provide more public funds for their HIV and health responses, the money is often targeted at building health systems and paying for ARVs rather than for often controversial or unpopular interventions such as those for key populations etc. For example, in Eastern Europe, the Global Fund's added value may be particularly through relatively modest investments in marginalized and criminalized communities, while national governments take over funding for less controversial issues such as HIV treatment. In all cases, a more nuanced approach to funding is needed that takes into account disease burden, income levels, the distribution of wealth within countries, ability to pay, and the sustainability of the responses.

- **The Global Fund will only achieve its targets if investment is proportionate to disease burden.** The Global Fund's new strategy 'Investing for Impact' outlines ambitious targets for the reduction of the disease burden globally by 2016 aiming to save 10 million lives and to prevent 140-180 million new infections. The strategy places a specific focus on highest impact countries, interventions and populations. In line with the High-Level's Panel's observation that the Global Fund should be more targeted to be more effective, the strategy identifies the global distribution of disease as one of the main considerations of potential for impact of the investment approach. However, the 55% contradicts these strategies and directly jeopardises the achievement of the new targets. As outlined above, MICs carry 2/3 of the disease burden for TB, 3 of the top 5 countries with the highest HIV burdens are middle-income and 8 of the 10 countries with the highest TB burdens are middle-income. Given that the implementation of the Global Fund's strategy between 2012 and 2014 depends entirely on programming supported through phase 2 renewals and reprogramming, it is these processes that will need to be leveraged to achieve the strategy's targets. The Chair's decision to cap phase

two renewals at 75% for all upper lower-middle income countries and upper middle income countries in fact puts the achievement of the targets directly at risk.

- **Investing according to disease burden will maximize donor contributions and maintain the principle of additionality.** Given its track record as a global funding mechanism for the three diseases, the Global Fund has been considered as the strategic channel through which to provide resources to MICs. Significant donors, such as the UK, have focused funding provided bilaterally on low-income countries and consider their obligations towards middle-income countries as met through their contributions to the Global Fund. Limiting the Global Fund in similar ways to low income countries would indeed duplicate efforts and channel bilateral as well as GF resources to the same countries.

Recommendation:

The International HIV/AIDS Alliance therefore urges the Global Fund Board to revoke the 55% rule immediately and therefore stop its application to existing grants, grant renewals and future new grants.