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India and the Global Fund

Implications for Discussions on Transition and Sustainability

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Authors' Note

We originally published this paper in November 2014. We edited it to address comments received and to provide updated and additional information. Since this recent editing, there have been significant changes in India, including substantial shifts of funding and programmatic responsibility for HIV, tuberculosis, and malaria programs from the national government to states. In addition, the Global Fund's relationship with the Indian government has changed.

Introduction

India, home to 1.2 billion people, is both a country and subcontinent. Its 29 states, often larger in size and population than many countries in the world, provide a study in contrasts. Through a health lens, India is a priority for most international campaigns, as it represents a huge percentage of global burden of disease. Few global strategies for health can succeed without progress in India. Yet, high rates of malnutrition and child mortality stand in stark contrast to its financial, intellectual, and industrial riches. India presents a huge conundrum for global health funders, anxious to see it succeed but wanting the government to play a larger role in managing and financing improvements in health.

In this short paper, we offer a middle-ground approach for one of India's last remaining health donors, the Global Fund to Fight AIDS, Tuberculosis, and Malaria. We argue that the Global Fund should engage with the Indian government and other relevant stakeholders to agree on a long-term, detailed transition plan that includes a substantial reduction in funding. At the same time, we also argue that this plan must acknowledge the need for sustained external funding for those services not likely to be financed by the Indian government in the short term (but that must be maintained to ensure the continued success of the AIDS, tuberculosis, and malaria programs in which the Global Fund has so heavily invested). We also argue for a focus on some of India's largest and poorest states.

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The relationship between the Global Fund and India is important in and of itself, but also provides lessons for ongoing discussions about sustainability, transition, and graduation for other countries. As with most other countries receiving Global Fund support, the status quo is not an option, but neither is a hurried exit.

Background

India is the second-largest recipient of grant assistance from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, with a three-year allocation under its new funding mechanism of US\$850 million.² This reflects the magnitude of India's contributions to the global burden of disease—India has the highest number of tuberculosis (TB) cases (2.6 million) and the third-highest number of HIV cases (2.1 million) in the world,³ as well as 77 percent of malaria cases in Southeast Asia (estimated at 24 million).⁴

Other leading health and development indicators demonstrate significant challenges:

- Malnutrition is more common than in sub-Saharan Africa, with one in every three malnourished children in the world living in India.
- While the infant mortality rate in India has been halved over the past two decades, it remains more than 10 times the Organization for Economic Cooperation and Development (OECD) average.
- One in four newborns has low birth weight, a key contributor to childhood mortality.
- Over 400 million Indians live below the international poverty line, comprising roughly one-third of the world's poor.⁵
- In 2012, India had only 0.7 physicians per 1,000 people, well below the OECD average of 3.2.^{6,7}
- The majority of health care is provided through private-sector outlets, with 69 percent of health expenditures paid for out-of-pocket.⁸

² Global Fund, "Allocations," 2014–2016, <http://www.theglobalfund.org/en/fundingmodel/allocationprocess/allocations>.

³ Kaiser Family Foundation, "Global Health Facts," <http://kff.org/globaldata/>.

⁴ World Health Organization, "World Malaria Report: 2014," http://who.int/malaria/publications/country-profiles/profile_ind_en.pdf?ua=1. There is widespread assumption that rates of malaria infection are dramatically underreported in India. While the Indian Bureau of Vector-Borne Disease most recently reported just over 1 million cases, the WHO estimates the actual number of malaria cases in India to be around 24 million per year.

⁵ World Bank, "India Overview," <http://www.worldbank.org/en/country/india/overview>.

⁶ UNICEF, "India: Nutrition," http://www.unicef.org/india/children_2356.htm.

⁷ OECD, "Country Programmable Aid: Partner Countries," 2012, http://webnet.oecd.org/dcdgraphs/CPA_recipient/.

India's 1.2 billion population and expansive geography make addressing these and other health and development challenges enormously difficult and expensive. They also mask acute disparities in income and disease burden within its 29 states: just seven of India's poor northern states⁹ have a population greater than the United States, United Kingdom, France, and Germany combined, and have per capita incomes well below the World Bank's criteria for low-income status.

At the same time, India is a lower-middle-income country with the world's fourth-largest economy—its 2013 gross domestic product is estimated at US\$1.9 trillion.¹⁰ It has a space program with a budget exceeding US\$1 billion¹¹ (which recently sent a probe to Mars), as well as a foreign assistance program estimated at US\$1.3 billion.¹² It is also home to pharmaceutical manufacturers that supply many other low- and middle-income countries with generics, purchased in large part by other Global Fund-eligible countries.

As a result, international donors to the Global Fund are questioning ongoing support to India and other middle-income countries. Most bilateral health donors have already left, with only Japan, United States, United Kingdom, France, and Germany offering aid to India, totaling US\$2.3 billion in 2012.¹³ That figure has since decreased, with France and Germany shifting toward loans and the UK moving to end direct financial assistance by 2015. The World Bank remains active in India, including in the health sphere, but because India is no longer eligible for concessionary lending or grants, its future funding will largely consist of market-based development loans (and so are rightly described by Indian officials as equivalent to domestic funding). That leaves the Global Fund as one of the few remaining donors, for which India presents a stark dilemma: since it is home to a predominant share of the global burden of disease, the Global Fund's strategic targets for HIV, TB, and malaria cannot be achieved without success in India. Yet India's national and state governments dedicate too little of their own budgets to meet the health needs of the country's poorest, with about 1 percent of GDP spent to finance the public sector. In its 2015 budget, the national government even reduced health spending by 20 percent. While poorer countries are struggling to even maintain current programs, by comparison **India has the ability to take on a greater share of funding for its health initiatives. So what should the Global Fund do?**

⁸ A. K. Shiva Kumar, "Fixing India's healthcare system," LiveMint, May 13, 2014, <http://www.livemint.com/Opinion/pl58bANi9zaFOAR2MkUYuN/Fixing-Indias-healthcare-system.html>.

⁹ Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, and Uttar Pradesh. See "Map of Potential Priority States" at end of this paper.

¹⁰ World Bank, "India Overview."

¹¹ Government of India, "Expenditure Budget Vol. I, 2014–2015," <http://www.indiabudget.nic.in/ub2014-15/eb/stat02.pdf>.

¹² Rani D. Mullen, "India's Development Assistance: Will It Change the Global Development Finance Paradigm?" (paper prepared for workshop on Innovation in Government of Development Finance, New York University School of Law, New York, NY, April 8–9, 2013), <http://www.iilj.org/newsandevents/documents/mullen.pdf>.

¹³ OECD, "Country Programmable Aid," http://www.oecd-ilibrary.org/development/data/detailed-aid-statistics/country-programmable-aid-cpa_data-00585-en.

Findings

To answer this question, CSIS researchers traveled to India and interviewed a wide spectrum of stakeholders, including national and state government officials; international, national, and local nongovernmental service providers; civil society groups and advocates; finance and policy experts; and bilateral and foundation donors. There was broad agreement on the following observations:

- 1. The time is right for the Global Fund to plan its “exit” from India.** The government needs to take greater ownership of its burden of disease, given its ability to increase investments within the public health sector. However, there was great emphasis that the process of transition needs to be methodical, with explicit timelines, deliverables, and budget, and must be validated by government, the Global Fund, and other primary stakeholders. Keys to a successful departure include prior agreement on a clear transition pathway, early planning, alignment with government at each stage, and post-transition support. The Global Fund’s strategy can be informed by previous donor transitions, particularly the graduation of the Gates Foundation’s Avahan program to India’s National AIDS Control Organization (see box). Notably, those experiences demonstrate the likely need for a longer “tail” of funding to support civil society organizations as they work to address the needs of marginalized populations and advocate on their behalf.
- 2. The Indian government has strong national strategies for HIV, TB, and malaria, as well as well-intentioned schemes for universal health access and poverty alleviation, but these are stymied by poor implementation and insufficient accountability.** Investments are needed to strengthen India’s capacity to manage its own health programs: to train and retain qualified health workers, to purchase and distribute medicines and other health products, and to maintain international prevention and treatment standards. While there are

Lessons from the Avahan Transition

Avahan, funded by the Bill & Melinda Gates Foundation, was launched in 2003 to reduce the spread of HIV in India. Targeting high-risk populations in six states, the government of India signed a memorandum of understanding (MoU) committing to transition in 2006. Now in its third phase, the program has been successfully transitioned to the National AIDS Control Organization. The Global Fund can benefit from some of the lessons learned:

- Early planning and allocation of funds for transition
- Continued alignment with government at each stage of transition, including signed formal agreements (MoUs)
- Provision of technical and managerial support to build domestic capacity, and institutionalization of support mechanisms
- A phased approach to provide space for course correction
- Provision of post-transition support to maintain quality
- Continued engagement with program, and flexibility in funding

notable success stories within specific programs or states, most are attributed to exceptional leadership and less to systemic or bureaucratic capacity.

3. **Major challenges in the public and private health sectors prevent access to quality care for India's poorest.** While government-provided health care is almost entirely free, it is often of poor quality and difficult to access. As a result, the majority of Indians often turn to the private sector, which is largely unregulated, highly variable in quality, and very expensive, yet has grown tremendously in recent years, accounting for more than 90 percent of all hospitals and 80 percent of all doctors.¹⁴ Despite this, most of current discussion focuses on improving care in the public sector and not enough on leveraging private-sector capacity to extend and complement what government can provide directly (working with the private sector could have the ancillary benefit of improving oversight and shutting down unlicensed practitioners who harm patients and threaten expansion of disease incidence and drug resistance).
4. **Civil society organizations play a critical role in reaching key populations, but often lack capacity and are unlikely to receive adequate funding or support from the government.** Community groups provide vital services that government cannot or is unwilling to provide, so external donor assistance must be maintained over the medium and long term. While government programs should be held responsible for delivering primary preventive and curative care, civil society should attempt to move away from service provision, work to complement the public sector, and focus on holding government to account.
5. **While the Global Fund's support is valued by government health officials, the current relationship with the Fund's grant management team has deteriorated,** especially on the subject of funding for HIV. Pressure by the Global Fund to shift funding away from AIDS drugs purchases may be based on the admirable goal of increasing support for targeted interventions addressing vulnerable populations, but seems inconsistent with its mandate to let countries determine how to best use funds so long as that spending supports a strong national strategy. The Global Fund also seems to be missing huge leveraging opportunities given the scale of India's programs. For example, India has the world's highest TB burden but seems overly focused on purchasing medicines to treat drug-resistant tuberculosis. The Global Fund could help shift India's focus toward working to improve the overall quality of care for patients with drug-sensitive TB and testing new, differentiated care models that might improve outcomes for all patients while reducing costs.

While there were variations on these observations among those interviewed, the degree of consensus was surprising given the variety of organizations consulted. India seems ready for a new, smarter relationship with the Global Fund.

¹⁴ Kumar, "Fixing India's healthcare system."

State-Level Indicators

In India, provision of health services is a responsibility of states, financed in part with support from the national government. Many of these states are larger and more populous than most countries, and have per capita income levels that would classify them as low-income. There is tremendous diversity of capacity and need among India's 29 states, and examining disaggregated data for seven of India's poorest and largest states helps to better conceptualize the inequitable distribution of the country's recent economic and development gains.

Table 1: Potential Priority States with Low Per Capita Income and High Unmet Health Needs¹⁵

State	Population Size (2011)	Per Capita Income (2012–2013)	Disease Burden*
Bihar	104 million	\$444	100,000 HIV cases 77,000 TB patients on treatment
Uttar Pradesh	200 million	\$522	100,000 HIV cases 286,000 TB patients on treatment
Jharkhand	33 million	\$681	39,000 TB patients on treatment
Madhya Pradesh	73 million	\$689	91,000 TB patients on treatment
Odisha	42 million	\$777	25% national malaria burden** 49,000 TB patients on treatment
Chhattisgarh	26 million	\$827	13% national malaria burden, 27,000 TB patients on treatment
Rajasthan	69 million	\$843	113,000 TB patients on treatment
India	1.2 billion	\$1,271	2.4 million estimated HIV cases 1.5 million TB patients on treatment 2 million reported malaria cases, 24 million estimated malaria cases

*HIV statistics as of 2012, TB statistics as of 2011, and malaria statistics as of 2007.

**Odisha also represents 40 percent of India's *p. falciparum* malaria cases and 30 percent of its malaria-related deaths.

¹⁵ Table compiled from the following sources: Government of India Ministry of Home Affairs, "2011 Census," <http://www.censusindia.gov.in/>; Government of India Press Information Bureau, "Annexure: State-wise Per Capita Income and Gross Domestic Product at current prices," <http://pib.nic.in/archieve/others/2013/dec/d2013121703.pdf>; Revised National Tuberculosis Control Programme, "Tuberculosis Control—India," <http://www.tbcindia.nic.in/>; World Bank, "HIV/AIDS in India," <http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india>; and Ashwani Kumar, Neena Valecha, Tanu Jain, and Aditya Dash, "Burden of Malaria in India: Retrospective and Prospective View," in *Defining and Defeating the Intolerable Burden of Malaria III: Progress and Perspectives*, Supplement to Volume 77(6) of *American Journal of Tropical Medicine and Hygiene* (Northbrook, IL: American Society of Tropical Medicine and Hygiene, 2007), <http://www.ncbi.nlm.nih.gov/books/NBK1720/>.

These seven states are home to nearly 575 million people, roughly half of India's total population (46 percent). They all rank among India's 10 poorest states in terms of per capita income, with Bihar, Uttar Pradesh, and Jharkhand in the top five. **If considered as individual countries, any of these states would likely be classified as low income and eligible for Global Fund resources without restrictions.**^{16,17}

In terms of disease burden, the included states represent more than half of India's TB treatment population and 40 percent of its malaria cases. Furthermore, they are home to a growing percentage of new HIV infections as transmission rates have stabilized in the higher-burden southern states of Tamil Nadu, Andhra Pradesh, Maharashtra, and Karnataka. If run through the Global Fund's eligibility criteria for disease burden, six of the seven states above have TB notification rates classified as severe.¹⁸ Odisha's malaria burden, which contributes one-third of India's malaria-related deaths and 1 percent of total global malaria deaths, would be designated severe as well.¹⁹

Recommendations

CSIS offers the following recommendations to respond to the findings identified above:

1. **Global Fund leadership needs to systematically negotiate a transition plan with the Indian government**, while also working to engage key stakeholders. This agreement should establish a pathway for substantially reducing the amount of Global Fund grants while increasing national government funding to ensure that overall resources for health are maintained or increased. To be successful, a framework needs to be negotiated with senior officials from the health and finance ministries, and will ultimately need approval from Prime Minister Modi if it is to be politically viable. The United States, United Kingdom, and other major Global Fund donors active in India should use their missions to facilitate this process. There are a few themes that should guide these negotiations:
 - a. The Global Fund should focus on India's alignment with regional goals. Given its tremendous size and the regularity of cross-border migration, a focus on India's health objectives in relation to its neighbors could help to strengthen and synergize regional action. For instance, achieving the goal of a malaria-free Asia Pacific by 2030 will be impossible without strong Indian leadership, as it represents 77 percent of Southeast Asia's malaria burden and migrant workers often export the disease to surrounding

¹⁶ As of July 1, 2014, low-income economies are defined as those with a GNI per capita of \$1,045 or less. According to the World Bank Atlas Method, India has a GNI per capita of \$1,570, classifying it as a lower-middle-income country. See World Bank, "Updated Income Classifications," <http://data.worldbank.org/news/2015-country-classifications>.

¹⁷ Global Fund, "Eligibility," <http://www.theglobalfund.org/en/fundingmodel/single/eligibility/>.

¹⁸ Defined as higher than 100/100,000—Uttar Pradesh, Jharkhand, Madhya Pradesh, Odisha, Chhattisgarh, Rajasthan.

¹⁹ Global Fund, "The Global Fund Eligibility and Counterparts Financing Policy," November 2013, [file:///C:/Users/KPeck/Downloads/Core_EligibilityAndCounterpartFinancing_Policy_en%20\(1\).pdf](file:///C:/Users/KPeck/Downloads/Core_EligibilityAndCounterpartFinancing_Policy_en%20(1).pdf).

countries.²⁰ By more actively engaging India in regional discussions on malaria elimination, such as through the Global Fund-supported Regional Artemisinin Initiative, and by strengthening its internal leadership and implementation capacity, the Global Fund can enhance its overall investments in Southeast Asia.

- b. The Global Fund should push for greater collaboration between the public and private sectors. Given that the majority of Indians utilize the private health sector,²¹ as well as glaring gaps in coverage for low-income and key populations, the Global Fund should encourage the Indian government to promote scale-up of public-private partnerships, to improve the overall quality of care and better leverage existing resources. It should also consider investments that might directly leverage that private-sector capacity using its flexibility (and mandate) to utilize non-state actors as grantees. Recent legislation requiring corporations to make “corporate social responsibility” contributions holds promise to bring some of India’s business wealth forward, though few of the richest companies currently have a significant presence in the country’s poorest states.

2. **Over the next funding cycle, the Global Fund should consider a subnational approach that focuses resources on India’s poorest states.** While health is regarded as their responsibility, states such as Bihar lack the technical, financial, and political capacity to develop and implement effective responses to HIV, TB, and malaria. Federal support is limited and waning. Other donors have already moved to state-level programming, including the Bill & Melinda Gates Foundation, World Bank, and UK’s Department for International Development (DFID). This will require the Global Fund to evolve its grant management approach, which up until now has engaged primarily at the national level, as well as to consider if and how it interacts with India’s single national country coordinating mechanism (which is often criticized as conflicted and ineffective).

3. **The Global Fund board should consider carefully lessons from India as it debates its role in other middle-income countries.** While some of the issues raised here are unique to India, others have broader applicability:

- a. Transitions require advanced planning and must be confirmed by clear, detailed agreements between the Global Fund and key in-country stakeholders. These must include financial sustainability plans that include domestic and international sources, and that are agreed with ministers of finance or heads of state. Speed is essential so that the Global Fund can redirect its resources to countries that lack the financial capacity to confront their epidemics, but precipitous exits will jeopardize investments

²⁰ Richard Feachem, e-mail message to author, December 15, 2014.

²¹ Lawrence Loh, Cesar Ugarte-Gil, and Kwame Darko, “Private sector contributions and their effect on physician emigration in the developing world,” *Bulletin of the World Health Organization* 91, no. 3 (March 2013): 227–33.

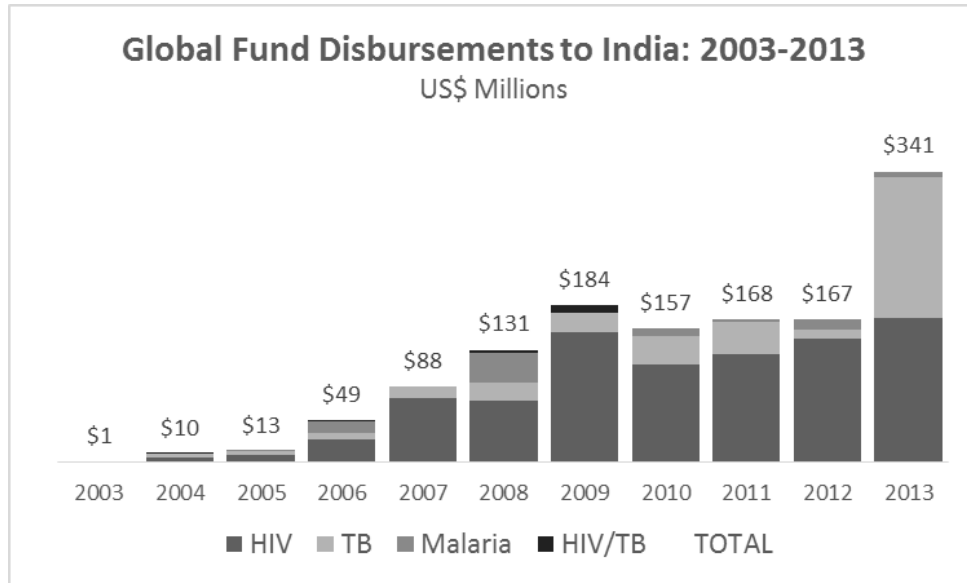
made with Global Fund resources and harm those the Global Fund has committed to serve.

- b. Successful transitions require senior-level political engagement that usually goes beyond ministries of health, which serve as the Global Fund's primary governmental interlocutors. More active partnering with the World Bank could prove a smart solution as its teams typically work closely with finance ministries, helping to develop medium-term expenditure frameworks that guide overall budget allocations. Bilateral and technical partners should be pressed to use in-country political clout to facilitate the process.
 - c. Large, federated states like India, Nigeria, and Pakistan require approaches that are respectful of national authorities and mandates but more actively engage state and even substate actors. This may require the Global Fund to staff up in these countries, and therefore staff down or move out of less complex countries.
 - d. The long-term role of nongovernmental groups as implementers and advocates needs fuller consideration. Through the Global Fund's "dual track financing" approach, it has invested nearly half of grant funds through nongovernmental organizations, yet it has no clear strategy for what happens to that capacity once its grants come to an end. Ensuring that most-at-risk populations are served and that civil society advocates are able to hold government to account seems essential and widely agreed. Further discussion is needed on how to finance that capacity. Another area yearning for attention is NGO implementation capacity, which many governments seem to consider as competition for resources rather than as a useful complement. Helping government leaders value and manage that capacity would be a worthwhile investment.
 - e. Each country's situation is different, so the Global Fund should find ways to expand the tools available to middle-income countries to allow (or even require) its secretariat to negotiate country-specific transition agreements. Figuring out this more flexible, differentiated approach will take time as well as negotiation between the Global Fund secretariat and board. Priority for implementing more flexible approaches must go to the largest grant recipients, including India and Nigeria, but eventually should apply to all countries.
4. **The Board should insist that all countries receiving grants have quality, sustainable, and equitable programs in place.** A "readiness index" could complement economic criteria that currently guide eligibility and coinvestment determinations, and reorient discussions with countries toward a path to sustainability. Global Fund investments could then target areas where readiness reviews reveal challenges to long-term sustainability. This approach could also identify the most catalytic types of support the Global Fund can provide or identify other

partners better suited to addressing these challenges. If there are significant systemic weaknesses in the health system, for example, this represents a challenge better suited for the World Bank, or if the issue is cost of drugs or other health products, perhaps the Global Fund can help negotiate access to concessionary pricing arrangements rather than paying for drug procurement.

As the first five review “windows” under its new funding model allocations have made clear, the Global Fund has inadequate resources to fully finance proposals from all eligible countries. The future does not look especially promising for increases in funding, and there is a good chance that the Global Fund will have to work hard just to maintain level pledges at its next replenishment cycle. This makes the discussion by the Global Fund’s board of directors on the issues of transition and sustainability both timely and perilous. It is timely because the Global Fund needs to find a way to increase the percentage of funding it gives to poorer countries that simply cannot afford to fight the three diseases without their support. It is perilous because precipitous action in countries like India, while perhaps politically appealing to some, will most certainly set back global efforts to fight HIV, TB, and malaria. For India especially, it is critical that the Global Fund confront this challenge head on, and move quickly to develop a sound transition strategy.

Additional Data



GLOBAL FUND SUPPORT TO INDIA	Signed Grants	Disbursed
HIV/AIDS	1,102,119,864	945,998,558
TB	443,531,556	344,109,880
Malaria	132,891,402	78,930,019
HIV/TB	14,819,772	14,819,772
Totals	\$1,693,362,594	\$1,383,858,229

Map of Potential Priority States with Low Per Capita Income and High Unmet Health Needs



Organizations Consulted

We benefited greatly from discussions with many wise people working in India, and thank them for sharing their perspectives. However, views expressed are those of the authors.

Aastha Parivar	Maharashtra State AIDS Control Society
Amaltas	National AIDS Control Organization
Bill & Melinda Gates Foundation	Oxford Policy Management
Brookings India	Project Concern International
CARE India	Public Health Foundation of India
Caritas India	UNAIDS India
Emmanuel Hospital Association	UK Department for International Development
FHI 360	U.S. Agency for International Development
Gateway House India	World Bank
Global Fund	World Health Partners
India HIV/AIDS Alliance	World Vision
International Finance Corporation	

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