Statement on middle-income countries (MICs) at the Organisation for Economic Co-operation and Development (OECD) 4th High Level Meeting October 2017

My name is Mike Podmore and I am director of STOPAIDS, a network of 70 member organisations in the UK, which are working together on the global HIV response. I have been working on the issue of development aid in middle- and high-income countries, and the impact of the exit of bilateral and multilateral donor funding from an HIV perspective for over five years.

More recently, in my role as the Alternate Board Member of the Developed Country NGO Delegation of the Board of the Global Fund to Fight AIDS, TB and Malaria, I have been part of critical discussions around this issue – to fundamentally answer the central question of where and how the Global Fund should be working in order to achieve its goal of ending the three pandemics by 2030.

My background is in HIV and global health, but my experience of these issues has made clear that the fundamental assumptions and questions at their heart speak to the very structure of international development work as a whole, and how we need to change our approach to have a chance of reaching the ambitious global goals we have set ourselves.

This presentation will draw on these experiences to do three things:

- The first will be to highlight some of the changes to the global situation that we need to recognise, and some of the old assumptions that need to be overcome.
- The second will be to outline some of the problems with the current development co-operation approach, specifically in relation to transitions in relation to global health.
- The third will hopefully help you avoid indigestion by ending on a positive note, suggesting five key steps that need to be taken to address the issue more effectively.

1) What are the facts of our changing world and some of the assumptions we need to overturn?

The international development project has seen some huge successes, for example huge reductions in poverty and disease. At the state level, we are seeing convergence on a global scale, recipients are catching up with donors, and new power blocks are emerging.

As Jonathan Glennie writes in a recent article, there have been three shifting geographies:

a. The first geography is that of wealth: towards the BRICs and a second tier of middle-income countries (MICs)

b. The second geography is that of poverty: this means that more and more of the poorest and most marginalised people that are the focus of our development work are to be found in what are now termed middle-income countries. 80% of the world's poorest people – those who live on less than US $2 per day – are now found in MICs.

For STOPAIDS and the HIV sector, we see the same dynamic. Whereas in 2000, two thirds of all people living with HIV resided in low-income countries (LICs), by 2020 an estimated 70% will live in MICs. The same is true of TB.

c. The third geography is that of power and knowledge: with these economic shifts come changes in geopolitical power, leading countries to demand a seat at the table and in decision-making, requiring shifts in global governance. This leads to less western-centric and more heterogeneous approaches.

But with these changes, so many of our old assumptions about development have been exposed as either simplistic or just not true. Some of the assumptions we have to debunk are as follows:

- The first assumption is that countries can be plotted along a 'development continuum'. What we now realise of course is that countries are on multiple development continuums and progress in one aspect of society does not necessarily mean progress in another.
- The second assumption is that progress along what we might understand as multiple development continuums is neither steady or in one direction. Countries move back and forth in terms of progress and sometimes quite rapidly.
- The third assumption is that economic growth, and its measurement using gross national income per capita, can act as a meaningful main proxy on its own for knowing where to direct ODA. Its limitations are becoming clearer in a number of ways:

    - The historical focus of ODA on low-income countries is becoming ever more limiting as more countries find themselves in the MIC 'classification'. There are now only 31 LICs, compared to 63 in 2000.
    - In the SDG world, the new focus on 'leaving no one behind' means understanding *how* to address inequality within countries as much as it does inequality *between* countries. GNIpc does not tell us anything about the level of inequality in a country.

- Within the health sector, it is assumed that an increasing GNI will automatically result in increasing domestic health resources and services for the poorest and most marginalised. As a result, many donors are pulling their funding out of MICs, particularly upper-middle income countries UMICs). While there is evidence that increasing domestic health resources do correlate with increasing GNI, there is sadly no direct correlation between increasing GNI and increasing services for the poorest and most marginalised in society. Put simply, inequality can happily thrive in a growing economy. If GNIpc continues to be used as the sole eligibility criteria, many millions will be left behind.

This brings me to the second part of my presentation:

2) What are some of the problems with the current development cooperation approach, specifically in relation to countries transitioning into higher income levels in the health sector?

From a health perspective – using GNIpc and income classifications to direct funding to fight AIDS, TB or Malaria is causing some problems. For the Global Fund it has resulted in a focus of funding in countries that are low-income and have a high burden of disease. Of course this makes immediate common sense, but it is becoming increasingly clear that the over-emphasis on GNIpc as the primary criteria is leading to an imbalance.

We have targeted the majority of our funding to LICs in Africa, and have made very good progress in reducing AIDS-related deaths and new HIV infections – and this is to be celebrated.

However, we have seen funding fall dramatically and donors exit from MICs in regions such as Eastern Europe and Central Asia, Latin America, North Africa and the Middle East.

In many cases, countries were not ready to transition away from donor funding and to sustain HIV services. In some countries where it may have been possible, the only relatively recent adoption of the Sustainability, Transition and Co-financing policy meant that there was inadequate preparation and resources to ensure an effective transition.

This has led to HIV infections dramatically spiking not falling – for example, infections in Eastern Europe and Central Asia have increased 56% since 2010. This region also has the highest prevalence of MDR-TB with 8 of the 16 MDR-TB high-burden countries.

I think it would be helpful here to delve a little into the impact of transitions on civil society and key populations to understand the dynamics at play:

- Apart from countries like South Africa and Nigeria, in most MICs the HIV epidemic is what we call a concentrated epidemic – it is concentrated in a few specific groups in the population, particularly what we call key populations

(KPs) – people who inject drugs (PWID), sex workers (SW), transgender (TG) and men who have sex with men (MSM).

- As you know, most KPs face discrimination and stigma in society, and in many countries they are criminalised. It is therefore often external donor funding that supports services for the poorest and most marginalised in MICs, usually delivered through civil society organisations.
- With ineffective planning and preparation for exiting donor funding, the domestic government will not pick up services for KPs.
- Many governments either do not acknowledge that these groups exist or are not politically willing to fund services for them.
- Even if governments might be willing to fund services for KPs, they often lack the technical knowledge to deliver effective tailored services.
- It would be ideal for governments to channel funding to civil society to deliver services, but often no social contracting mechanisms have been put in place.
- All this means that many HIV services for KPs in MICs have been gutted, and the epidemics among these populations have become resurgent.

Example in Romania:

- The Global Fund's grant for HIV finished on 30 June 2010, six months prior to the ending of a major UNODC grant that provided technical support and innovative approaches for harm reduction in Romania. Both grants ended without proper transition process and without properly established government buy-in.
- Following the grant closure, there was no funding for HIV prevention programmes and HIV prevalence among PWIDs grew from 3.3% in 2010 to 29% in 2013.

Another current example is that of Venezuela:

- The case in Venezuela is a symptom of the failures of the global system – a gaping crack in the architecture of global health. The devastation faced by Venezuelans is mandated in part by the arbitrary rules and regulations that shape global health aid eligibility:
- Venezuela was classified by the World Bank as a high-income country in 2012, now an upper-middle income country, with national income levels dropping at dizzying speed. This makes Venezuelans ineligible for aid, thanks to over-broad national income measures that fail to capture the vast inequality, stagnant growth and soaring inflation within the country.

- Despite extensive documentation, Venezuela's government denies there is an emergency – so many other governments and some UN agencies look the other way.

- The Joti people of Venezuela must watch their children struggle through repeated bouts of malaria without adequate medicine. In its neglect, the international community has collectively doubled down on them and other victims of this rights violation. Aside from the ethical problems this poses to international aid agencies, as a global health strategy, it is absurdly short-sighted. Infectious diseases do not respect political parties or national borders. Health gains in neighbouring countries are now at risk: the states that are now experiencing a surge in malaria are on borders with Colombia and Brazil. Recovery from the Venezuelan crisis will take decades, and will cost millions in global aid. Swift action is in all our collective interest, and is urgently needed to save lives.

  Ensuring flexibility in our eligibility and allocation processes is essential if we are to direct funding *where* and *when* it is most needed.

3) What needs to change?

But, you will rightly ask, what would be envisaged to change in terms of domestic and international funding in order to find a solution to this issue?

There is broad agreement globally that an ever increasing portion of the global HIV and global health response needs to be financed by domestic financing in LICs, LMICs and UMICs if we are going to end AIDS by 2030 and reach our other health-related goals.

That said, my first recommendation is that donor financing is targeted in a more nuanced way at appropriate levels and using different types of support to achieve each of the SDGs – in my case that would be ending aids as a public health threat in each and every country and among every population.

To enable this, my second recommendation is to invest in and adopt the findings of processes such as the Equitable Access Initiative to find a better set of eligibility and allocation criteria that goes well beyond income classification to direct us towards our goals.

- In the context of the Global Fund this means using disease burden as the primary criteria for eligibility rather than GNI and looking at other factors such as fiscal space for health, political willingness to invest in health, and levels of inequality.

My third recommendation is that donors should only be transitioning out of a country when health or key development goals are achieved (for example, malaria is eliminated, HIV and TB are under control) or when a clear set of criteria necessary to sustain the health gains has been met. Otherwise previous investment is wasted and development gains are simply lost, leading to even greater expense in dollars and lives.

My fourth recommendation is that funding, and mechanisms for directing that funding for civil society, must be developed and scaled-up globally. It is civil society that is best positioned to hold their government to account; mobilise the most marginalised communities to access services; and to provide many of the most appropriate services for these communities, particularly those most marginalised and left behind.

My fifth and final recommendation is that all bilateral and multilateral donors should develop transition policies that have a consistent and long-term approach to developing transition plans with all key stakeholders. These transition plans should then be implemented over a long enough trajectory to allow meaningful development to create sustainable domestic responses. This may mean that the flow of donor exits from countries slows down and perhaps stops altogether.

But, ultimately the traditional system of ODA and process of allocating funding and support doesn't reflect the world as it is now. Cracks have not only appeared, but they are widening and sadly many people are falling in.

If we are to really focus our efforts and adjust how we work in order to achieve the SDGs, we will need to build a new development approach and narrative. This will include:

- focusing on overcoming inequalities between countries and people
- structuring global development governance around collaboration of equal partners – meaning *all* countries and *all* stakeholders
- moving from concepts of aid as 'charity' to concepts of 'international public investment', global solidarity and mutual benefit…

…to enable all to work to achieve Agenda 2030 together.

Thank you very much.

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