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The Global Fund: What Next for Aid Effectiveness and Health Systems Strengthening?

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Table of Contents

Preface

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Executive Summary

Introduction

Having recently been through a triple crisis (fiduciary, financial and managerial), the Global Fund is undergoing a process of "transformation." Several reports and articles have been published about how the Global Fund should change. However, there has been generally little discussion about how the transformation of the Global Fund should accommodate its commitments and responsibilities towards aid effectiveness (AE) and health systems strengthening (HSS). This report changes that by first providing a detailed history of the Global Fund's engagement with AE and HSS, and by then discussing how AE and HSS should inform the Global Fund's transformation agenda.

History

The history of the Global Fund's engagement with AE and HSS is complicated – but it essentially charts a gradual though uneven journey from the Fund being established as a selective, vertical and disease-based funding agency towards the Fund being more aware of the need to contribute to the AE and HSS agendas. However, the short timeframe, coupled with a complex and changing global health landscape and insufficient arrangements for mutual accountability, has constrained and limited the Global Fund's AE and HSS efforts.

What now?

The triple crisis that has hit the Global Fund has left its various AE and HSS initiatives hanging in the balance. Three themes that are currently influencing the Global Fund's transformation agenda are shifting the Global Fund back towards becoming more vertical, top-down and donor-centric; even more concerned with the selective delivery of selective services; and increasingly concerned with being able to attribute results to itself. The three themes are: (1) financial austerity; (2) stronger performance-based funding; and (3) fiduciary risk and financial management.

Recommended actions

Reaffirm the relevance and importance of the AE and HSS agendas

The underlying rationale for AE and HSS has not diminished because of, or since, the Global Fund's triple crisis. If anything, many of the recent problems affecting the Global Fund require *systemic* solutions rather than *Fund-specific* solutions. The Global Fund must therefore affirm the relevance and importance of AE and HSS to its transformation agenda and declare its plans for optimising harmonisation and alignment, participating in the Health Systems Funding Platform (HSFP) and the International Health Partnership (IHP), and managing the tension between vertical programmes and horizontal health systems development.

Correct the imbalances in accountability

The Global Fund's accountability framework is being increasingly dominated by two lines of reporting: (1) from the Global Fund Secretariat to the Board; and (2) from grant recipients to the Global Fund Secretariat. There is too little emphasis on mutual lines of accountability between the Global Fund and other development partners and "downward accountability" from the Global Fund to ministries of health and local stakeholders.

However, a number of initiatives of the IHP and the HSFP could help remedy this imbalance in accountability and should be supported by the Global Fund. These include: (a) the use of joint assessment and financing agreements with other development partners; (b) embracing the independent monitoring of the policies and behaviour of individual organisations with regards to their adherence to the principles and commitments of the IHP; and (c) using "country compacts" to establish more detailed agreements with governments and development partners over how health aid can be better coordinated and integrated.

Transform the Global Fund but also shape the broader global health complex.

Effective AE and HSS is the responsibility of multiple institutions; the ability of the Global Fund to operate optimally is influenced by other institutions. Given its recent problems, the Global Fund has a reason for examining the policies and practices of other global health institutions, and how they interact with each other *and* the Global Fund. This should inform the Global Fund's transformation agenda and could also be used to improve the coherence and overall effectiveness of the global health complex. Such an examination could be commissioned as an independent study and focus on eight key institutions: the World Health Organization (WHO), the GAVI Alliance, the World Bank, the US government, the UK government, the European Union and the Gates Foundation.

Monitor health systems strengthening, not just health outputs and outcomes.

The Global Fund's performance is mainly measured against its impact on disease-related health outputs and outcomes. There is little emphasis on measuring the Fund's impact on the overall functioning of national health systems or against a broader set of national health priorities. Although it provides guidance on monitoring and evaluating HSS activities, this guidance suffers from three shortcomings: (1) it tends to reduce HSS activities to those that have a *direct* impact on disease-related indicators; (2) it over-emphasises the usefulness of quantitative indicators; and (3) it only covers the Global Fund's HSS activities (and not other HSS activities). Therefore, there is a need to design better approaches for how the Global fund should identify and prioritise HSS activities worth funding, and how it should evaluate the value and impact of HSS support.

Introduction

The last twelve months have not been easy for the Global Fund. They began with a media storm about corruption and fraud. This, in turn, triggered a High-Level Panel investigation into the fiduciary controls of the Fund that culminated in a report that severely criticised the Fund's leadership and management.[1] Soon after, a financial shortfall led to the cancellation of an entire funding round (Round 11). The Executive Director and a number of senior staff resigned soon after the appointment of a "General Manager," an ex-banker, who had been a member of the High-Level Panel.

This is a triple crisis: fiduciary, financial and managerial. The Global Fund's reputation has suffered. and the Fund is now being subjected to reform and restructuring. The direction of this reform raises concerns regarding the Fund's commitments to aid effectiveness (AE) and health systems strengthening (HSS).

This report describes how the Global Fund evolved and engaged with AE and HSS, and provides the historical context to current debates about the Fund's future. It identifies important issues that are missing from the current commentaries[2,3,4,5,6,7] and advances four recommendations that we believe should inform discussions about the Fund's challenges.

Our critique of the current discourse is based on two observations: First, in most discussions, the Global Fund is treated as a discrete, self-contained and autonomous organisation. In reality, it is a messy partnership of multiple organisations and stakeholders with different agendas and priorities. On top of this, the Global Fund and its constituent elements are part of a larger global health complex. Second, the commentaries have tended to portray the Global Fund more as a global organisation than a trans-national organisation with effects at both the global *and* country level.

As a consequence, there has been little discussion about how the Global Fund's current crisis relates to other global health actors and broader global health dynamics or to the priorities and needs of recipient countries. Of particular note is the lack of discussion about AE and HSS.

Joining the Dots: Aid Effectiveness, Health Systems Strengthening and the Global Fund

The concept of AE was codified at the 2005 High-Level Forum on Aid Effectiveness, which was held in Paris, France and was based on the following principles: There should be country ownership of strategies and plans for development; development partners should ensure alignment with country-based plans and systems, and harmonisation of their plans, procedures and reporting requirements with each other; and, finally, there should be a focus on measuring results and on developing a culture and system of mutual accountability.

These principles are especially important in the health sector where a rapid increase in development assistance for health (DAH) over the past decade has been coupled with an uncoordinated proliferation of funding streams, programmes and projects.[8,9] This growing complexity of the global health arena set the context for AE, which is designed to: (a) minimise health systems fragmentation and the duplication of health programmes and logistical systems; (b) reduce inefficiencies associated with unplanned and uncoordinated developments; (c) protect ministries of health from the burden of multiple donor-led demands and reporting systems; (d) prevent inappropriate "brain drain" from the public sector to donor-funded private and non-governmental organisations; and (e) enable a more balanced and holistic approach to resource allocation across the different health priorities of a country.

AE is therefore a pre-condition of HSS, especially in countries that experience a heavy burden of external, donor-funded vertical programmes. The Global Fund, with its fundamental disease-based orientation, has been at the centre of debates about the costs and benefits of vertical programmes compared to comprehensive and integrated health care; and about the trade-offs between needing to urgently expand coverage of life-saving services and needing to build sustainable and robust systems for the future. Therefore, it is surprising that there has been so little recent discussion about AE and HSS. Before discussing the Global Fund's present and future engagement with AE and HSS, it is helpful to start with the past.

A short history of the Global Fund, AE and HSS

2002

The Global Fund was launched in 2002, following endorsement by the UN General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001. Among other things, it emerged as a result of much public health activism, the support of Bill Gates (who arrived on the global health scene a few years earlier with financial support for vaccine development and supply), an impassioned plea by the then UN Secretary General Kofi Annan for the creation of a "war chest" to fight HIV/AIDS, and, to some extent, the convergence of American foreign policy and security interests with global health (epitomised by the launch of the President's Emergency Plan for AIDS Relief (PEPFAR) .

The Global Fund's birth occurred in the middle of the period 1990–2008, during which the volume of DAH increased four-fold and the global health landscape became transformed into a crowded and multi-nodal global health complex. The Global Fund itself would become the largest of about a hundred so-called "global health partnerships," many of which bring the UN, government donors, private foundations, big business and civil society organisations into a single structure.

Other developments in the two decades preceding the birth of the Global Fund were also significant. The debt crisis, structural adjustment programmes and health sector reform in the 1980s and 1990s all contributed to under-investment and a weakening of health systems in many low- and middle-income countries. The period also witnessed a shift in international health policy from comprehensive Primary Health Care to selective Primary Health Care, and the emergence of cost-effectiveness analysis as a basis for international health priority-setting. This informed the performance-based funding models that were adopted by organisations like the Global Fund.

Although the Global Fund's focus was designed to fight three diseases, the Fund had a mandate to do so "in ways that will contribute to strengthening health systems."[10] However, with the creation of the GAVI Alliance (GAVI) to promote vaccines and immunisation two years earlier and the emergence of other disease-based partnerships, the Global Fund's birth coincided with a new era of vertical and selective donor-funded health programmes.

2002–2004

The Global Fund's growth was rapid. In its first year, it awarded grants worth $378 million to 31 countries. Two further rounds of grants were approved in January and November 2003, by the end of which there were 121 recipient countries and about $200 million had been disbursed. A fourth round of grants was approved in 2004.

For Rounds 1–4, applicants could apply for heath systems expenditures through what was called a “cross-cutting” or “integrated” component of a grant application as long as the expenditures were directly relevant to the fight against the three diseases. Examples of allowable HSS activities included strengthening comprehensive commodity management systems, and supporting recruitment, training, deployment and supervision of health workers. However, only ten proposals with cross-cutting or integrated components were submitted in the four rounds, and only one was approved. Following Round 4, the Global Fund’s Technical Review Panel (TRP) raised concerns about the lack of clarity concerning the scope of HSS activities that could be included in a grant application.

In 2003, PEPFAR was established as a large vertical donor programme for HIV/AIDS, and the World Health Organisation (WHO) and UNAIDS announced the “three by five” target for expanding antiretroviral therapy (ART) coverage to three million people before the end of 2005. Both PEPFAR and the Global Fund were at the heart of attempts to achieve these ambitious targets.

Recognising that there was insufficient coordination of HIV/AIDS programmes, in 2004 UNAIDS, in cooperation with the World Bank and the Global Fund, established the “Three Ones” Principles: (1) one plan to coordinate the work of all partners; (2) one national coordinating authority with a multi-sectoral mandate; and (3) one national monitoring and evaluation system.

At the same time, results from multi-country studies evaluating the impact of the Global Fund and other initiatives like PEPFAR and the World Bank Multi-Country AIDS Program (MAP) became available.[11] They highlighted, among other things, the lack of alignment between global initiatives and national policy, plans and priorities, including efforts to strengthen health systems.

2005

For Round 5, the Global Fund introduced a separate and specific funding component for HSS. As in Rounds 1 to 4, only HSS activities directly related to achieving disease-specific goals could be funded. Only three out of 30 HSS applications were approved. According to the TRP, there was still insufficient guidance about what HSS activities were eligible for funding, and an inadequate system for generating strong HSS proposals and evaluating them effectively.

In 2005, the Paris Declaration on Aid Effectiveness was announced and the (US) President’s Malaria Initiative was launched. The Gates Foundation had become another major player in the field of malaria. Meanwhile, GAVI created a new HSS financing ‘‘window’’ to address system-wide barriers to expanded immunisation coverage, and recommended that applicants focus on: health workforce capacity and incentives; district level management and supervision; supply and maintenance systems and increased engagement of civil society.

2006

For Round 6, amidst much debate, the Global Fund reversed its decision to have a specific HSS funding component. Instead, requests for funding HSS activities were to be included within disease-based applications. Global Fund guidance described eleven examples of “allowable” HSS activities. According to the TRP, however, the overall quality of Round 6 HSS proposals remained low. Proposals were too broad, ambitious or vague. Many of them failed to locate strategies within the broader national context and some were thought likely to undermine some aspects of the health system.

There was growing international and donor recognition of the need to strengthen health systems during this period. Advancing its earlier 2000 framework on the critical functions of health systems, the WHO promoted a model for health systems evaluation that would eventually form the 2007 Framework for Action that identified "six building blocks" or essential functions of health systems: service delivery, health workforce, information systems, medical products and technologies, financing, and governance and stewardship. GAVI further strengthened its HSS funding remit by creating a dedicated budget (15–25 percent of its total programme expenditures).

The Shakow report published findings of a study of the comparative advantage of the World Bank and Global Fund in supporting HIV/AIDS programmes.[12] It typified growing concern over the need to improve coordination and to implement the principles of the Paris Declaration.

2007

Round 7 of the Global Fund used the same approach as Round 6, but introduced the notion of a health system "strategic action" within a disease-specific component. Applicants were also requested to conduct a health systems analysis and to have thought through the implications of grant proposals on *other* health services and needs.

Elsewhere, the World Bank published a new 10-year health strategy and warned that the world risked squandering the recent increases in DAH unless coordination, harmonisation and HSS are improved. The strategy called on the Bank to establish itself as the lead global agency for health systems policy development, and suggested that the WHO and UNICEF focus on "the technical aspects of disease control and health-facility management."[13]

The International Health Partnership (IHP), which was designed to apply the principles of the Paris Declaration in the health sector, was launched in 2007. The Global Fund, GAVI, the World Bank, the WHO, the Gates Foundation and a number of bilateral development agencies (with the US government being a notable exception) signed up to the IHP's "Global Compact," committing signatories to adhere to the principles of AE and to an independent evaluation of their performance. Shortly thereafter, the IHP became the IHP+ after incorporating a range of other related initiatives such as the activities of the Global Health Workforce Alliance. An IHP+ Secretariat was established and staffed jointly by the World Bank and the WHO.

2008

For Round 8, the Global Fund allowed cross-cutting HSS activities to be built into disease-specific proposals or to be submitted as part of a discrete HSS section within a disease-based grant application. Out of 45 proposals with discrete HSS sections, 25 were approved. The TRP recommended that the Global Fund work more closely with the WHO and other relevant organisations to assist countries in planning cross-cutting HSS activities. In addition, in Round 8, the Global Fund explicitly encouraged applicants to include measures to strengthen community systems on a routine basis.

By this time, there was more attention being paid globally on HSS. An NGO Code of Conduct for Health Systems Strengthening was launched,[14] and the World Bank announced that it would double the number of "health systems experts" for Africa. A High-Level Taskforce for Innovative International Financing for Health Systems, chaired by the Prime Minister of the UK and the President of the World Bank, was also established.

Ethiopia signed the first "country compact" of the IHP+. The World Bank and the WHO were signatories. But the Global Fund and GAVI only sent letters of support.

Despite such developments, participants at the Third High-Level Forum on Aid Effectiveness held in Accra, Ghana heard that more than two-thirds of all commitments for health aid were for amounts of less than $500,000 – resulting in large numbers of small and fragmented projects.[15] They also heard that relatively little was being provided directly into country budgets and that there were marked disparities in the allocation of health aid among countries.

2009

In 2009, the Global Fund piloted a new funding approach called national strategy applications (NSAs), which was designed to align Global Fund grants with national disease strategies. Five countries were invited to participate in a First Learning Wave. An early review concluded that while NSAs had enhanced consultation and country ownership, they were still too disease-specific and had too many transaction costs.[16] However, a subsequent review found evidence that NSAs enhanced progress towards AE, albeit within the context of single diseases. [17]

In Round 9, 17 out of 34 proposals with a cross-cutting HSS component were approved. The TRP recommended that the Secretariat provide better guidance and forms for submitting proposals for HSS activities.

The final report on the independent five-year evaluation of the Global Fund was published. Among other things, it recommended strengthening country health information systems as part of an HSS strategy, particularly given the critical impact of information deficits on the Global Fund's performance-based funding model. It also suggested the Global Fund work with partners to support and monitor HSS in countries, but implied that the Global Fund focus on health systems components related to the three diseases.

Global attention on HSS continued to increase. The G8 published a "Global Action for HSS," a report that signalled high level geo-political interest in health systems policy and development. This coincided with what academics termed a growing "securitisation of health aid," which included a stronger alignment of health aid towards the foreign policy and security interests of donor countries.[18]

IHP+ continued to develop, with several more countries announcing the signing of "country compacts." The first ministerial review of the IHP+ identified six areas where more effort was required: (1) improving in-country collaboration; (2) developing a common approach to the in-country assessment of national health strategies; (3) translating commitments described in "country compacts" into real changes in behaviour; (4) strengthening mechanisms for mutual accountability; (5) increasing civil society engagement; and (6) harmonising procurement policies.

IHP+ also developed the Joint Assessment of National Health Strategies (JANS) – a tool to allow donors and governments to jointly assess the quality of national health plans, and thereby to strengthen national strategies and secure more predictable and better aligned donor funding. It also aimed to reduce the need for parallel systems, improve mutual accountability and strengthen government leadership in sector coordination.

Two working group reports of the High-Level Taskforce for Innovative International Financing for Health Systems were published in early 2009. One report noted that the existing global "architecture" for health needed "a radical simplification of the overall funding landscape."

Research coordinated by the WHO on the interaction between global health initiatives and country health systems reported a mixed picture of positive and negative synergies.[19] The findings were deemed controversial and revealed considerable tensions between and within different global health institutions over the appropriate balance between vertical programmes and HSS, as well as over money, turf and authority.

Anticipating a new and dedicated source of global funding for HSS, GAVI and the Global Fund jointly declared an interest in working together to bring about a more coherent and effective platform for the funding of HSS activities. The final report of the High-Level Taskforce recommended establishing a new joint platform for health systems financing that would involve GAVI, the Global Fund and the World Bank. It suggested that the three agencies should receive funds from traditional DAH sources, as well as from new and innovative sources, and work under a new collaborative agreement.[20]

Eventually, a Health Systems Funding Platform (HSFP) was established as a joint endeavour of GAVI, the Global Fund, the World Bank and the WHO. An inter-agency working group was set up to develop frameworks for enabling joint HSS programming and funding, especially between GAVI and the Global Fund. But by the end of the year, hopes that the HSFP would mobilise and attract new and dedicated funding for HSS were dashed. This was mainly because of the global financial crisis and scepticism about the credibility of HSS strategies, interventions and measurements of progress.

Within countries, the rhetoric around AE and HSS was still not fully translated into significant and tangible improvements. Many HSS activities were highly selective and remained linked to vertical programmes.[21] A report on health aid in countries of the Organisation for Economic Co-operation and Development (OECD) noted uneven progress in harmonisation and alignment and a substantial gap between commitments and practice on the ground.[22]

2010

The Global Fund made significant steps in the direction of AE by encouraging a process of grant consolidation and single-stream funding (per disease, per principal recipient ([PR]). These proposals would reduce the transaction costs involved in managing multiple grants within a country and make it easier for Global Fund grants to be better aligned to national plans and programmes. While optional for Round 10, consolidated proposals were expected to be compulsory in Round 11. A number of non-governmental organisations produced a practical toolkit to encourage and support countries to build HSS activities into their grant applications.[23] The Global Fund announced that for Round 11, countries could submit stand-alone proposals for cross-cutting HSS activities.

The HSFP developed two “tracks” of support for HSS. Track 1 would cover “existing modalities” and included many elements of IHP+ such as: promoting joint M&E frameworks and Joint Financing Agreements (JFAs); as well as single fiduciary and procurement systems. Track 2 consisted of “new modalities” for accessing HSS funding from the Global Fund and GAVI. One option was for countries to use a common proposal form for HSS which could be sent to either GAVI or the Global Fund, or to both (but stipulating what funding was requested from which funder).[24] A second option was for countries to submit funding requests following a JANS process. The Platform itself was therefore not a source of pooled funding for HSS, but had become limited to merely coordinating and rationalising the separate HSS funding processes and technical support of the Global Fund, GAVI, the World Bank and the WHO.

Support for HSS in general, and for the HSFP in particular remained ambivalent. As one analysis noted, stark differences between GAVI board members regarding HSS had existed since its inception and remained a core tension. While for some, the “primacy of

immunisation is non-negotiable" and financing HSS was viewed with suspicion, other Board Members wanted to see immunisation "integrated with, and subordinated to broader systems objectives".[25] A later analysis noted that certain donors of both GAVI and the Global Fund believed that the HSFP risked diluting the mandate, competence and respective "brands" of both organisations.[26] Eventually, the head of GAVI (a strong proponent of HSS) resigned, which provided an opportunity for donors sceptical of financing HSS to realign GAVI activities towards more focused immunisation investment, with future financing of HSS tied to immunisation indicators. By contrast, the Global Fund Board decided in principle to strengthen its investment in maternal, new-born and child health (MNCH) and explore expanding the Global Fund's mandate to cover MNCH, possibly through a dedicated channel of funding.[27]

The 3rd IHP+ Country Teams meeting took place in Belgium in December 2010 and concluded that "the aid effectiveness agenda matters as much – if not more – today as it did five years ago." The meeting noted that getting alignment was a messy business which required leadership and compromise. Furthermore, new ways of working through joint action and collective responsibility still needed to be consolidated with more focus on effective monitoring platforms and mutual accountability.

2011

A report on the lessons learnt from the Global Fund's First Learning Wave of NSAs found that disease control strategies and national disease strategy budgets were still inadequately linked to health sector strategies, national health budgets and other macro-economic frameworks.[28] In order to press ahead, the Fund announced that 11 countries were eligible to apply for the second wave of NSAs. Meanwhile, all countries were expected to transition to consolidated proposals and single stream funding arrangements in Round 11.

The Global Fund Secretariat, working closely with colleagues from GAVI, the WHO and World Bank encouraged and supported a number of countries to access HSS funds through a joint Global Fund/GAVI funding proposal and build on the JANS assessment tool.

However, for the Secretariat, much of 2011 was consumed with concerns about fraud and corruption, generated by a series of reports from the Global Fund's Office of the Inspector General (OIG) and negative media publicity. The Fund began to experience a weakening of financial support from donors and other uncertainties about its future budget. Eventually, Round 11 was cancelled and funding for HSS through the HSFP was suspended.

Meanwhile, GAVI announced that even though its preferred option for supporting HSS was to use the JANS process and to base proposals on national health strategy documents, grant applications still had to demonstrate strong links to immunisation outcomes.

By this time, IHP+ covered 25 development partners and 27 developing countries. By early 2011, five countries (Nepal, Ethiopia, Uganda, Ghana and Viet Nam) had completed formal joint assessments of their new national health sector strategies or plans (i.e., the JANS process). Other countries were developing "joint M&E roadmaps." The second formal and semi-independent evaluation of IHP+, covering 2009, was published and showed some progress, but there was still much to be done to promote the coordinated and efficient use of international and domestic resources for health.[29]

The fourth High-Level Forum on Aid Effectiveness took place in Busan, South Korea. Highlights included signs of a greater involvement of non-traditional donors in AE deliberations, a special focus on fragile states and stronger emphasis on the roles of civil society and the private sector. The tension between donors indicating a preference for selective "results" and a more bottom-up and country-led process remained unresolved.

Although the meeting produced stronger language on systems approaches and the use of country systems, there was little mention of harmonisation and alignment. Few, if any, specific time-bound commitments emerged.

What now?

The history described above, though not comprehensive, provides important historical context to current discussions about the Global Fund's future. Looking back over the past ten years, one sees an organisation that was set up to finance selective and disease-based vertical programmes and to bypass or work around the weaknesses of local systems in recipient countries, but that then began to "bolt on" HSS support, partly to mitigate the problems arising from its original design.

As the problems associated with uncoordinated DAH became more obvious, the Global Fund worked to rationalise its own system of grants and to align itself more with national strategies and plans – by, for example, encouraging NSAs and adopting a policy to move towards grant consolidation and single-stream funding. It also signed up to the IHP+ and, from 2010 onwards, actively participated in the HSFP and processes for conducting joint assessments of national strategies.

Thus, the Global Fund's ten-year history describes an uneven but gradual shift in the direction of AE and HSS. However, it is worth noting that ten years is not a long time for an organisation that was itself a new model of multi-stakeholder governance and that grew rapidly from scratch to having hundreds of grants in more than a hundred countries. On top of this, the Fund was operating in a complex and changing global health landscape and had to work with (and through) other global health institutions such as the WHO, UNAIDS, Stop TB, PEPFAR and Roll Back Malaria. Ten years is also a short time for any organisation to come to grips with the unique contexts, needs and demands of more than a hundred countries.

This historical and wide-angle perspective on the Global Fund is important because it shows how some problems and deficiencies were inevitable and even predictable. The vertical nature of the Global Fund, in its drive to ensure that commodities were delivered quickly, was bound to have negative side-effects on comprehensive health systems development. The pressure to quickly raise and spend money implied risk-taking and was bound to lead to sub-optimal fiduciary control. Predictably, the demand-driven model of grant-making led to an imperfect match between expenditure and burden of disease. The partnership model of the Global Fund was always going to be characterised by internal dissonance and ambiguity around certain policy issues such as the mandate of the Fund to support HSS. The lack of coherence, coordination and mutual accountability across the multi-nodal global health complex was guaranteed to strain the Fund's narrow mandate as a global-level financing agency because it would always be reliant on other actors to help develop sound, efficient and effective in-country systems.

In many ways, the Global Fund was given an impossible juggling act by its founders and funders. Many of the problems that now make up its current crisis are the result of inevitable tensions and trade-offs, and internal contradictions within its operating model. In one paper, donors who helped set up the Global Fund, and then criticised it for not adhering to AE principles, were described as being schizophrenic.[30] Consequently, any solutions or recommendations for the Fund's future must be directed not just at the organisation, but also at the actors who shape the conditions, rules and expectations under which it operates both at the country and global level.

But while the Global Fund took a number of steps to progressively "de-verticalise" its operations and disease-based structure, HSS mostly remained a secondary concern. More often than not, support for HSS was in the form of selective "health services support" that was deemed necessary for achieving the goals of the Fund's disease-based programmes. HSS activities supported by the Fund were often just vertical infrastructural or health service components of HIV, TB and malaria programmes.

However, in a few cases, the Global Fund did support cross-cutting HSS plans that were not linked to a disease-specific programme. A notable example was Malawi, where a Global Fund grant, combined with bilateral aid from the UK government, supported a five-year comprehensive Emergency Human Resource Programme that included salary increases for generic health workers.[31,32] Another was Rwanda, where the Fund contributed to cross-cutting health sector financing. While such examples are relatively few, they make two important and generalizable points. First, the Global Fund can "do" HSS. Second, the Fund can collaborate with countries and other development partners to tackle the more fundamental and intransigent problems associated with weak health systems.

By 2010, consideration was given to expanding the mandate of the Global Fund to include more specific and comprehensive HSS support. Two suggestions were advanced: (1) a dedicated funding platform for HSS which would be co-administered by the Global Fund, GAVI and the World Bank; (2) expansion of the scope of the Fund to include MNCH priorities or become a more open-ended and general Global Fund for Health.[33]

These ideas were soon swept away. The global financial crisis dashed hopes for a new HSS funding platform. The Fund's own storm of financial, fiduciary and leadership crises forced it into crisis management mode and it needed to prioritise avoidance of any disruption to essential prevention, treatment and care services. More significantly, it precipitated the construction of a new narrative for the Global Fund.

This new narrative is built on three themes. The first is "financial austerity" and the need for the Fund to do more with less. The second is an enhanced version of performance-based funding characterised by concepts such as increasing "purchasing efficiency," improving "return on investment," and "cash-on-delivery aid." The third theme is "fiduciary risk" and the Fund's association with corruption and financial mismanagement. Significantly, many commentaries about the Fund's future have been silent about the AE and HSS agendas.

While in principle the Global Fund continues to support AE and HSS,[34] this new narrative risks shifting it towards becoming more vertical, top-down and donor-centric, concerned with the delivery of selective and attributable outputs and overly focused on its own financial and fiduciary concerns. There are few concrete commitments or plans for enhancing AE and HSS. Neither the Global Fund's Consolidated Transformation Plan nor its 2012–2016 Strategy mentions the IHP+. The HSFP is mentioned only once in each document.

The apparent lack of appreciation for the inseparability and inter-connectedness of HSS activities with disease-based or vertical programmes, or for the evidence on the benefits of harmonisation and alignment,[35] is a concern because AE and the need for sustainable health systems development remain important. It can even be argued that the problems facing the Global Fund should push it more towards finding *systemic* solutions rather than *Fund-specific* solutions. For example, the squeeze in donor budgets demands quicker and better harmonisation and alignment in order to maximise the efficient use of scarce resources. And concerns about fraud and fiduciary control should prompt a redoubling of HSS efforts because corruption and financial mismanagement are more likely when systems are weak, fragmented and uncoordinated.

For these reasons, the apparent shift away from AE and HSS needs to be debated, if not challenged. But in the process, we should examine not just the Global Fund's policies, plans and preferences, but also those of other stakeholders. While some players (e.g., ministries of health, the WHO and civil society advocates of comprehensive Primary Health Care principles) will want the Global Fund to continue to improve harmonisation, alignment and synergy between disease-based funding and health systems development, others may favour it becoming more selective and vertical.

The latter could include the large number of non-governmental recipients of grants who may want the Global Fund to maintain or expand a vertical, project-based approach to health care delivery. It could also include a corporate sector that may want the Fund to maximise the purchase, supply and distribution of medicines and other commodities instead of strengthening local supply and distribution systems or HSS more generally.

The Gates Foundation, being keen on technological and market-led solutions and sceptical about the value of HSS, may want the Global Fund to focus on a selective and vertical approach to disease management. Although the US government under the Obama administration has expressed greater support for HSS, the central role the government played in shaping the composition and outlook of the High-Level Panel suggests that it supports the Fund adopting a more vertical and selective approach. Other donors of significance such as France, Japan, Germany, the UK and the European Union, may have other views and preferences but could be persuaded – in the context of financial austerity, media reports about corruption and growing public cynicism toward foreign aid – to push the Global Fund towards being more selective and vertical.

Finally, the ability of the Global Fund to engage effectively with AE and HSS will depend on the plans and actions of bilateral aid programmes and other global health institutions. The World Bank, the WHO and GAVI are especially important. All three are part of the HSFP, and the first two also coordinate the IHP+ and have a mandate to promote AE and to support HSS. The WHO, the World Bank and bilateral aid agencies have in-country staff that could play a role in helping to integrate Global Fund grants into a more coherent and comprehensive country-based framework for health systems development.

Recommended actions

Set a different tone to the current narrative.

The Global Fund Board should actively raise the profile and importance of the Global Fund's support for the AE and HSS agendas. It could do this by instructing the Secretariat to produce a report on the Fund's plans for optimising harmonisation and alignment, participating in the HSFP and IHP+, and managing the tensions between vertical programmes and HSS. Although this will re-hash many old debates, those debates remain relevant and important.

Such a report should be accompanied by a number of commissioned country case studies, so that a discussion about AE and HSS can be rooted in the concrete realities of countries and health systems and not be limited to conceptual and abstract arguments. Specifically, these country case studies should examine four sets of tensions. The first is between being disease-specific and having an impact and stake in the functioning of the broader health system. The second is between having to justify and promote its own unique contribution to "results" while also being signed up to the principles of harmonisation and alignment. The third is between being established as a global financing agency and being pushed towards having a more in-country presence and operational function. The fourth is between needing

to act urgently to expand the coverage of life saving treatments and supporting a slower and more solid process of health systems development.

Correct the imbalances in accountability.

The Global Fund's accountability framework is dominated by two lines of reporting. The first is from the Global Fund Secretariat to the Board, and the second is from grant recipients to the LFA and Secretariat. There is little emphasis on "horizontal" (and mutual) lines of accountability between the Global Fund and other donors and global health institutions. Equally lacking in emphasis is downward accountability from the Global Fund to ministries of health and local stakeholders. This imbalance in accountability, which also applies to other development partners, contributes to the lack of harmonisation, alignment and effective support for health systems development.

A number of practical and positive steps encouraged and supported by the IHP+ and the HSFP have been taken to develop remedies for the current imbalance in accountability. However, these developments are fragile and need to be nurtured and protected from sudden shifts in policy and priorities, including those of the Global Fund.

One development is the adoption of joint processes and systems to promote better harmonisation and alignment. These include JANS and JFAs, and the development and use of shared M&E, procurement and audit systems. Periodic progress reports on the incorporation of Global Fund grants into these processes and systems across all recipient countries would provide a useful means of monitoring the Fund's contribution to this agenda.

A second development is the structured monitoring of the policies and behaviours of development partners and recipient countries in adhering to the principles of AE and to their commitments to HSS. This has been conducted under the auspices of the IHP+ and includes the production of individual scorecards for participating organisations. The Global Fund could support and participate more actively in this initiative.

A third development is "country compacts" through the IHP+. There are eleven such compacts which are designed to establish more detailed agreements between governments and development partners over how they intend to better cooperate and collaborate to improve health. Although the Global Fund is a signatory to the IHP+ "global compact," it has not signed any country compacts because it claims to only be a demand-driven financing mechanism with no in-country offices. However, with the Fund adopting a more top-down and hands-on approach to managing grant applications and performance, it should now participate in the signing of "country compacts." Not only would this enhance mutual accountability, it could help the Global Fund to develop cooperative agreements with the WHO, the World Bank and bilateral donor agencies to support the in-country implementation of Global Fund grants.

Transform the Global Fund but also shape the broader global health complex.

Effective AE and HSS is the responsibility of multiple institutions; the ability of the Global Fund to operate optimally is influenced by other institutions and the overall shape and cohesion of the broader global health complex. Thus, the crises that have affected the Global Fund should not just prompt thoughts about how the Global Fund should change, but should also precipitate proposals for making the global health complex more effective, strengthening mutual accountability and improving the division of labour.

Given its recent problems, the Global Fund has a reason for examining the policies and practices of other global health institutions, and how they interact with each other *and* the Global Fund. This should inform the Global Fund's transformation agenda and could also be

used to improve the coherence and overall effectiveness of the global health complex. Such an examination could be commissioned as an independent study and focus on eight key institutions: the WHO, GAVI, the World Bank, the US government, the UK government, the European Union and the Gates Foundation.

Monitor health systems strengthening, not just health outputs and outcomes.

The Global Fund, established as a performance-based funder, is itself now being subjected to performance-based funding. However, its performance is mainly defined in terms of the impact that Fund-supported programmes and projects have on a set of disease-related health outputs and outcomes. There is much less emphasis on measuring the Fund's contribution to improving the performance of national health systems or national health strategies. This needs to change. However, we foresee some challenges.

Health systems are complex, open and multi-dimensional. As a consequence, HSS activities and investments are rarely concrete and fixed. Usually, they are diffuse, multi-faceted and adaptive. In addition, their impact on health is often indirect and delayed. This makes HSS activities and investments difficult to measure and evaluate. Critically, countries need to build local monitoring, evaluation and research capacity to inform and improve health sector policy development and strategic sector-wide management.

Although the Global Fund has produced guidance on how to monitor and evaluate HSS activities, the guidance contains three shortcomings. First, it tends to reduce HSS activities to those that have a *direct* impact on selected service or disease-related output and outcome indicators. Second, it over-emphasises the utility of quantitative indicators. Third, it only covers the monitoring and evaluation of HSS activities that the Global Fund finances.

Therefore, there is a need to design better approaches for how the Global Fund should identify and prioritise HSS activities worth funding, and how it should evaluate the value and impact of HSS support. But it should do this in concert with countries and other organisations.

Post script

It should be noted that the recommendations made above are based on three premises. The first is that the Global Fund's role, focus and mandate do not change. The second is that donors provide development assistance as a *voluntary* act of charity to poor countries and therefore have a right to place conditionalities and to demand strict reporting on a pre-determined results framework. The third is that "financial austerity" and budget cuts to development assistance are unavoidable.

However, each of these premises can be challenged. The Global Fund's scope and mandate could still be broadened; development assistance can be reconfigured along the lines of international duties and obligations (as argued by the Joint Action and Learning Initiative on National and Global Responsibilities for Health[36]); and the Global Fund's budget could be expanded given the political will. While the principles of AE and HSS would remain relevant, arguing for a different set of premises would require another discussion paper.

Endnotes

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