

## **The Global Fund: Institutional Innovation or Same Old, Same Old?**

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Louise Walker

PhD Candidate

Politics and International Studies

The University of Warwick

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[louise.walker@warwick.ac.uk](mailto:louise.walker@warwick.ac.uk)

### **Abstract**

This paper examines the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) as a form of institutional innovation among traditional multilateral institutions. It argues that the Global Fund has developed new sources of legitimacy which distinguish it from the ‘doctrine of sovereignty’; however, as the Global Fund has matured, its authority has expanded challenging its country ownership ethos and its external accountability to those whose lives it affects. The first section of the paper describes the Global Fund’s legitimacy and how it differs from that of traditional multilateral institutions, even though its legitimacy is held primarily in the eyes of wealthy and powerful states. The second section of the paper discusses the Global Fund’s adoption of ‘country ownership’ and, using the case of Malawi’s failed National Strategy Application to the Global Fund in 2009, explores its limits and ambiguities including the challenge of external accountability. The final section of the paper explores the Global Fund’s expanded authority that has accompanied its maturation and how it has exacerbated its external accountability gap. The paper concludes by observing that the pressure created by the increasing need and competition for resources to address MDG 6 may be causing the discursive global public goods tide to recede towards the ‘doctrine of sovereignty’ and the responsibility of individual states. This challenges the Global Fund to acknowledge the growth in its authority and power beyond that of a financing mechanism for three diseases towards that of a global health policy maker and develop its accountability to keep step.

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# 1 Institutional Innovation among Traditional Multilaterals

## 1.1 Change at the Millennium

...the old formulas of Westphalian governance have failed and a new generation of innovation from many actors is emerging to take its place. But while the new vulnerability provides and increasingly powerful driver, a new world of institutionalised innovativeness and multi-centred sovereignty has yet to replace the Westphalian order of old (Kirton and Cooper 2009, p. 309).

By the beginning of the new millennium, the United Nations' (UN) approach to global public health concerns had undergone transformation. Globalisation and its effects including the relationship between infectious disease, global security and poverty required international cooperation beyond the confines of traditional multilateralism<sup>1</sup> (Held and Koenig-Archibugi 2004, p. 127; Bartsch 2007, p. 3; Zacher and Keefe 2007, p. 16, 2008, p. 19; Kickbusch 2009, p. 323) and donor governments sought new mechanisms and models of governance in order to address devastating epidemics like HIV/AIDS (Buse and Walt 2001, p. 551; Forman and Segaar 2006, p. 216; Kickbusch 2009, p. 323). In its final communiqué from the 2001 Summit, the G8 described what would become the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund):

“...we have launched with the UN Secretary-General a new Global Fund to fight HIV/AIDS, malaria and tuberculosis. We are determined to make the Fund operational before the end of the year. We have committed \$1.3 billion. The Fund will be a public-private partnership and we call on other countries, the private sector, foundations, and

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<sup>1</sup> For the purposes of this paper, ‘traditional multilateralism’ refers to a state-centred form of global governance which perpetuates “the dominance of states at the top of the hierarchical state system (Knight 2001, p. 15 ),” such as the WHO whose governing body is the World Health Assembly comprised of delegations from 193 member states.

academic institutions to join with their own contributions - financially, in kind and through shared expertise (G8, 2001).”

This paper argues that the Global Fund is a form of institutional innovation among traditional multilaterals, with sources of legitimacy and accountability distinct from those of the “doctrine of sovereignty (Keohane 2006, p. 11)”; however, as the Global Fund has matured, its scope and authority have expanded challenging its country ownership ethos and its own external accountability to those whose lives it affects. This paper is in three sections. The first describes the Global Fund’s legitimacy and how it differs from that of traditional multilateral institutions, even though its legitimacy is held primarily in the eyes of wealthy and powerful states. The second section of the paper discusses the Global Fund’s adoption of ‘country ownership’ and, using the case of Malawi’s failed National Strategy Application to the Global Fund in 2009, explores its limits and ambiguities including the challenge of external accountability. The final section of the paper explores the Global Fund’s expanded authority that has accompanied its maturation and how it has exacerbated its external accountability gap. The paper concludes by observing that the pressure created by the increasing need and competition for resources to address MDG 6 may be causing the discursive global public goods tide to recede towards the ‘doctrine of sovereignty’ and the responsibility of individual states. This challenges the Global Fund to acknowledge the growth in its authority and power beyond that of a financing mechanism for three diseases towards that of a global health policy maker and develop its accountability to keep step.

The Global Fund is one among a number of Global Health Initiatives (GHIs) that have emerged since the late 1990s. Initially referred to as Global Public Private Partnerships (GPPPs), they were defined as “a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or

industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour (Buse and Walt 2000, p 550).” While some GHIs meet Buse and Walt’s GPPP criteria, many do not. GHIs vary in their missions and models and in the range and interests of partners—some advocate, some fund, some develop products, some conduct research and others address market weaknesses by creating supply chain and purchasing mechanisms. What GHIs have in common is their role in delivering what Kaul and her associates at UNDP (Kaul, Grunberg and Stern 1999; Kaul, Conçeição, le Goulven, and Mendoza 2003) characterise as a global public good<sup>2</sup>, whose financing and delivery is no longer exclusively a function of the public domain, but an undertaking of both public and private actors, an opening up of traditional multilateralism.

As reflected in seminal reports at the new millennium including then UN Secretary General Kofi Annan’s *We the Peoples: The Role of the United Nations in the 21st Century*, the notion of private sector participation in the UN had gained a foothold (United Nations 1999; United Nations 2000a; United Nations 2000b). It is not surprising then that the concept of partnership between public and private actors was embedded in the Global Fund from inception (G8 Communiqué 2000). In establishing the Global Fund, the UN and donor governments sought to create a new type of global organisation, one that was a “genuinely international entity and a partnership between the public and private sectors” which would “make more efficient use of donor resources, with lower transaction costs for all involved (WHO 2002, p. 1).” At the new millennium the public health agenda had become the object

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<sup>2</sup> The Global Fund’s mandate to attract, manage and disburse resources to achieve Millennium Development Goal (MDG) 6, to combat HIV/AIDS, malaria and other diseases, is a provision of a global public good. According to Kaul, Grunberg and Stern (Inge Kaul, Isabelle Grunberg and Marc A. Stern (1999) ‘Defining Global Public Goods’, Inge Kaul, Isabelle Grunberg and Marc A. Stern, eds., *Global Public Goods: International Cooperation in the 21st Century*. Oxford: Oxford University Press, pp. 1-19.) “We have defined global public goods as outcomes (or intermediate products) that tend towards universality in the sense that they benefit all countries, population groups and generations. At a minimum, a global public good would meet the following criteria: its benefits extend to more than one group of countries and do not discriminate against any population group or any set of generations, present or future.” Global public health lies on what Kaul et al. describe as a continuum between purely private and purely public goods.

for international cooperation, the domain of actors beyond states<sup>3</sup>, and what Chen, Evans and Cash (1999, p. 297) described as the locus for an “institutional space for organizational renovation and innovation.”

## 1.2 Institutional Innovation and New Sources of Legitimacy

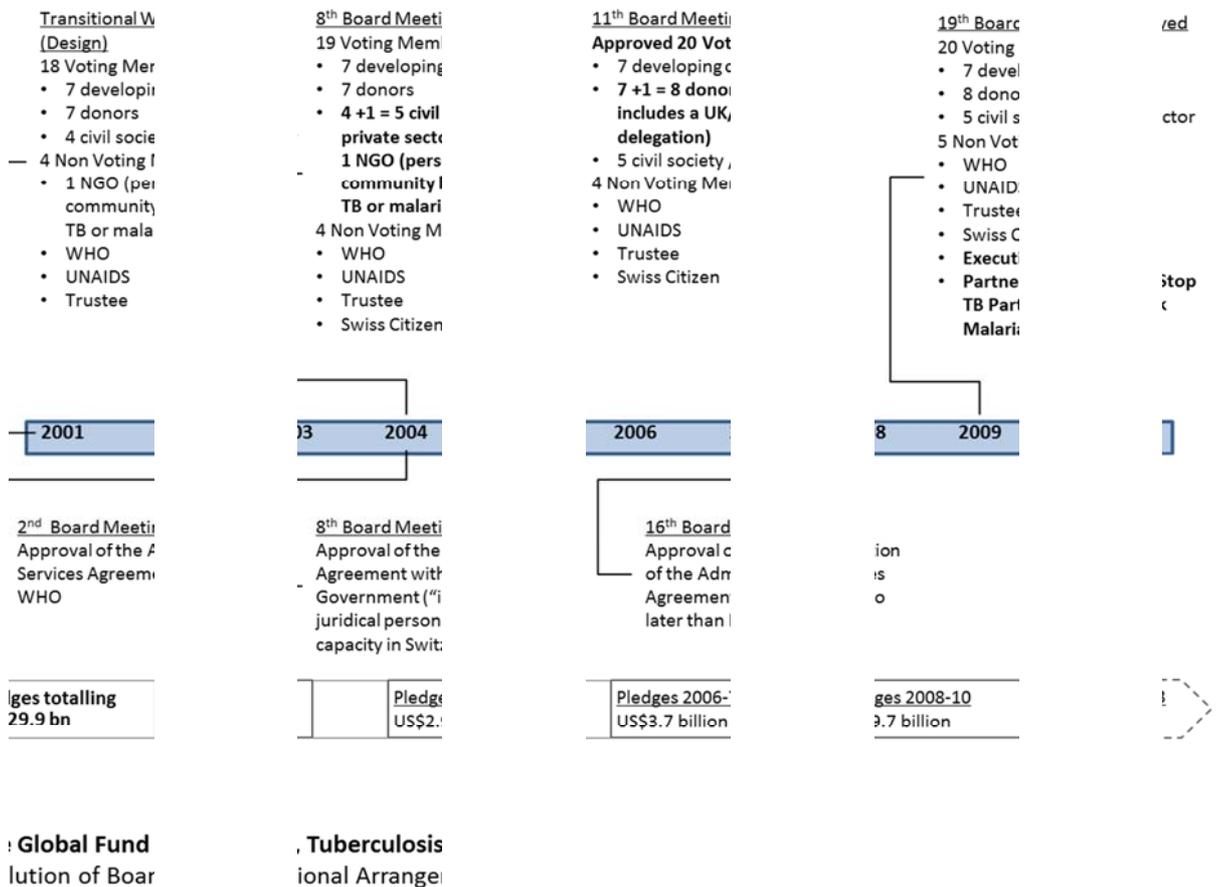
The Global Fund’s inclusive governance model, its transparent and performance-based modus operandi and the scale of its resource mobilisation and distribution are features of its design which broke from “business as usual (WHO 2002, p. 1)” and distinguish it from traditional multilateral organisations. These features are also new sources of legitimacy. For this argument, legitimacy is seen as both normative and rational. Suchman evokes a normative definition describing legitimacy as “...a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions (Suchman 1995, p. 574).” Scharpf on the other hand evokes a rational definition, describing legitimacy as both “input-oriented” or reliant on democratic processes “by the people” and “output-oriented” or reliant on demonstrating outcomes “for the people (Scharpf 1999, p. 2).” For the Global Fund, both the normative and the rational are important—the belief in its legitimacy and mechanisms that make it so.

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<sup>3</sup> This paper considers private actors to include a range of non-state actors such as civil society organisations (CSOs), non-governmental organisations (NGOs) and for-profit corporations and businesses. Civil society as it is used in this paper follows Hadenius and Ugglá’s definition (which also forms the definition used by the WHO (World Health Organization (2001) ‘Strategic Alliances: “The role of civil society in health’ *Civil Society Initiative, Discussion Paper 1*. Geneva: WHO.): “A common way of clarifying the concept of civil society is to say that it denotes (a) a certain area of society which is (b) dominated by interaction of a certain kind. The area in question is the public space between the state and the individual citizen (or household). Civil society is further distinguished by the fact that the activities contained therein take an organized and collective form. When we speak of civil society, it is to groups arranged in social networks of a reasonably fixed and routinized character that we refer.” (Axel Hadenius and Fredrik Ugglá (1996) ‘Making Civil Society Work, Promoting Democratic Development: What can States and Donors Do?’, *World Development*, Vol. 24 (10), pp. 1621-1639).

The Global Fund's inclusive governance model at global level is a departure from the governance by states model adopted by multilaterals like the World Health Organization (WHO). When the Global Fund was originally constituted as a private foundation in 2001, the 18 voting members of its board were comprised of seven donor country delegations, seven developing country delegations, and four delegations representing civil society and the private sector (see Figure 1). In 2004, the Global Fund acquired "international juridical personality and legal capacity" (The Global Fund 2004, p. 2), status as an international organisation, and by 2005, its board composition had changed to one where donor country delegations dominated. By 2009, its board had 20 voting members comprised of eight delegations representing donor countries, seven representing recipient countries, one representing a developing country Non-governmental Organisation (NGO), one representing

**Figure 1: Evolution of the Global Fund's Board and Institutional Arrangements**



a developed country NGO, one representing the private sector (in this case meaning for-profit business and corporations), one representing private foundations and one representing people living with or in communities affected by HIV/AIDS, tuberculosis and malaria. In addition, non-voting members included the WHO, UNAIDS, the World Bank (the Global Fund's trustee), a representative of the Global Fund's partner constituency, its Executive Director and as required to maintain its legal status in Switzerland, a Swiss law firm.

Given this inclusiveness and diversity, the Global Fund's board exhibits the "equivalence principle" where those affected by a global public good have a say in its provision (Kaul et al 2003, p. 36; Held 2004, p. 371). Nevertheless the dominance of donor governments raises the question of whether inclusion and 'having a say' is enough to serve as a legitimising force if the balance of power either functions as or is perceived as a "colonisation of power and wealth (Wallace Brown 2010, p. 530)." Although the board's inclusiveness is a significant departure from the model of traditional multilaterals, rather than a source of input-oriented legitimacy providing a form of global deliberative equality (Slaughter 2004, p. 175), the Global Fund's board can better be understood as a source of output-oriented legitimacy. The balance of voting power in favour of donor governments supports the Global Fund's business model-- its capacity to solve the problem of infectious disease and provide a collective solution to MDG 6--through mobilising and distributing funds. As at the end of 2010 (which includes the third replenishment cycle), the countries comprising the donor government delegations on the Global Fund's board had contributed 88% of the total pledges to the Global Fund, or just over US\$26 bn.<sup>4</sup> This suggests that despite its diversity, the Global Fund's board may not be immune to the "realities of power politics (Keohane 2006, p. 5)", one where donor governments can dominate.

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<sup>4</sup> Analysis by author based on pledge data extracted from the Global Fund's website. Accessed February 17, 2010.

The Global Fund's country level governance model with its 'country ownership' ethos might more readily be seen as a form of input-oriented legitimacy. Unlike most multilaterals the Global Fund does not have in-country presence or representation. Instead, it relies on a model where a Country Coordinating Mechanism (CCM) develops proposals, Principal Recipients (PRs) receive grants and oversee implementation and a Local Fund Agent (LFA) contracted by the Global Fund provides an in-country monitoring function. None of these mechanisms is part of the Global Fund organisation proper. Guidelines developed by the Global Fund encourage CCMs "to be broadly representative of all national stakeholders in the fight against the three diseases (The Global Fund, no date(a), p. 3)" creating a forum which includes national and international private actors such as local and international NGOs and CSOs in addition to government.

The engagement of civil society in country-level public health harkens back to neo-liberal structural adjustment policies which were seen to by-pass government in favour of the "thousand points of light" which civil society provided (Boone and Batsell 2001, p. 13). Practically, the engagement of civil society has been a critical element of many countries' scaled up response to their HIV/AIDS epidemics, featuring strongly not only because CSOs offer capacity and community reach in environments with typically weak infrastructures but also because they advocate for the rights of those affected by the epidemic (Teixeira, Vitoria and Barcarolo 2004, p. S6; Piot 2005, p. 13; The Global Fund (no date (b)), p. 39; Piot, Bartos, Larson, Zewdie and Mane 2008, p. 854; Doyle and Patel 2008, p. 1931). As one executive at a multilateral observed, "The Global Fund would insist that they deal with the country, not the government. Most of the institutional space where health policy is negotiated is dominated by government and they have shifted that space in a helpful way I believe (Research Interview Geneva 2009)."

Beyond governance, the Global Fund has recognised civil society's implementation role by flowing significant funds to CSOs: 40% of its grants have been to civil society and private sector organisations.<sup>5</sup> On the one hand the inclusion of private actors in an independent, country level governance mechanism could be seen to undermine the authority of government (Doyle and Patel 2008, p. 1935). On the other hand inclusiveness and independence at country level can be seen as a basis for a new source of legitimacy through the creation of a "national public (Keohane 2006, p. 16)" which is involved in designing and implementing far reaching programmes of prevention, treatment and care for the three diseases. Beyond providing a forum for governance 'by the people', giving voice to actors beyond the state, the Global Fund's country level model also serves a highly practical purpose. It's a strategy to support the scaled up responses to the three diseases in weak infrastructure environments and is therefore also a form output-oriented legitimacy, or governance 'for the people'.

The Global Fund's modus operandi of transparency together with its performance-based funding model was intended to distinguish it from that of more bureaucratic multilateral organisations in which some donor countries had lost faith (Buse and Walt 2001, p. 551; Kickbusch 2009, p. 323). If the Global Fund was to be a departure from an UN organisation (The Global Fund 2003, p. 6; The Global Fund 2003b, p. 3) then it needed to establish its legitimacy without the distinctive social form of authority provided by traditional bureaucracies (Barnett and Finnemore 2004, p. 3). For the Global Fund, transparency and performance-based funding serve two, mutually reinforcing, purposes. First, they are the foundation for a compelling communication and advocacy function, particularly to donors which strengthens the output legitimacy associated with its grants. Second, the Global Fund's transparency and performance-based funding strengthen, if not fully address, its

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<sup>5</sup> Analysis by author based on grant portfolio data extracted from the Global Fund's website. Accessed November 10, 2010.

accountability.<sup>6</sup> As one executive of a global institution observed, “The Global Fund achieves concrete results which are easier to communicate to donors and to the media. It’s something that every [donor] ministry can easily communicate to the public... it is a success story that you may want to be associated with... This is quite significant for donors (Research Interview 2009).”

Transparency, like inclusive governance, has a normative dimension to the extent that it contributes to the belief that organisational decision-making processes are deliberative and democratic particularly where the inclusion of NGOs and CSOs is concerned (Woods and Narliker 2001, p. 575; Moravcsik 2004, p. 342; Nanz and Steffek 2004, p. 321; Slaughter 2004, p. 169; Sridhar, Khagram and Pang 2008, p. 9). As a tool for ‘better’ governance, transparency is a form of input-oriented legitimacy, where it is seen to strengthen participation by non-state actors and diversify the discourse beyond the natural boundaries of state-centric representation.

Performance based-funding on the other hand is an important output-oriented, legitimising force for the Global Fund because, in theory at least, it forms the basis for the Global Fund’s capability to measure and report results achieved through its grants. Increasingly the Global Fund is not unique among international institutions in its drive to make ‘value for money’ arguments, particularly to donors, but it was among the first to adopt a “Raise it. Invest it. Prove it.”, model as core to its operations.

Together, transparency and performance-based funding support what Keohane describes as “internal accountability (Keohane 2002, p. 14)”, by providing information for donor governments to hold the Global Fund to account. There are of course many others to whom

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<sup>6</sup> Like legitimacy, accountability can be conceptualised as both normative and rational (Bovens 2009). This paper will focus on the rational or mechanistic form of accountability with its two dimensions as described by Keohane: internal and external.

the Global Fund could be held to account, including private actors involved in its governance and the ‘national publics’ and those these publics serve who are directly affected by the Global Fund’s decision-making and actions. In the case of the latter constituency, the Global Fund experiences what Keohane describes as an external accountability gap, where its transparency and performance-based funding facilitate its ability to “give an account” but not to be “held to account (Bartsch 2007, p. 11-13).”

The output-oriented nature of the Global Fund’s governance at global and country levels and its transparency and performance-based funding underpin the unprecedented success of the Global Fund’s resource mobilisation for three diseases. By the end of 2009 the Global Fund had mobilised more than US\$21 bn in commitments and approved US\$19.3 bn in grants to 144 countries (The Global Fund 2010, ‘Resource Mobilization’), making more resources available to combat HIV/AIDS, tuberculosis and malaria than any other UN or Bretton Woods institution. To calibrate, the World Bank through its Multi-Country AIDS Program (MAP) is estimated to have contributed more than US\$1.5 billion to 40 low and middle-income countries between 2000 and 2010 (Lisk 2010, p. 78). Only PEPFAR (the President’s Emergency Plan for AIDS Relief—the U.S. bi-lateral initiative) operates at the scale of the Global Fund distributing just over US\$20 bn of the US\$24.8 bn available between 2004 and 2009 including US\$3.8 bn to the Global Fund (PEPFAR 2010, ‘Summary Financial Status By Appropriation As Of June 30, 2010’). Although the Global Fund describes itself as a public/private partnership, from a resource perspective it relies heavily on public sources. Since its founding, donor governments have contributed 96% of the Global Fund’s pledges (The Global Fund 2010c, ‘Our Resources’) which lends legitimacy, that conferred by wealthy and powerful states. The aspect of the Global Fund’s resource mobilisation that is a new legitimising force is a type of output-oriented legitimacy separate from that associated with its source of funds: the unprecedented scale of resources the Global Fund has made available

particularly to high need countries where outcomes such as lives saved or the number of people with access to ART (anti-retroviral therapy) would not have otherwise been possible before the Global Fund's creation. For some countries, the magnitude of these resources is significant (Bernstein and Sessions 2007). In Malawi as an example, in 2008-09 the Global Fund was the third largest donor across all sectors (not just health), providing 14.6% of *all* aid after the European Union (EU) at 18.1% and the UK's Department for International Development (DfID) at 14.7% (Government of Malawi Ministry of Finance 2009, p. 5). The effectiveness with which the Global Fund has made significant resources available to countries for MDG 6 including HIV/AIDS, in particular low-income, high need countries like Malawi, is a source of legitimacy not replicated elsewhere among multilateral institutions. The source of these funds may be traditional, but their scale and the effectiveness of their distribution is evidence of the "break from business as usual" that the Global Fund's creators intended.

As one among a number of GHIs that emerged around the new millennium, the Global Fund was a new type of institution occupying the space that Chen, Evans and Cash described as one of "organization renovation and innovation" necessary for the provision of a global public good. It is the Global Fund's inclusive governance model, its transparent and performance-based modus operandi and the scale of its resource mobilisation and distribution which are distinct aspects of its design and new sources of legitimacy from those found in traditional multilateral institutions. While the Global Fund's sources of legitimacy are a form of institutional innovation, they do share an important characteristic with that of traditional multilaterals: despite its public/private nature and the normative perceptions of inclusive and deliberative decision-making processes, the Global Fund's legitimacy is held in the eyes of wealthy and powerful states.

## 2 The Limits of Country Ownership and the External Accountability

### Challenge

When the ‘country’ in country ownership includes state and non-state, public and private and global and national actors, accountability—for what and in whose interests—defies neat conceptualisation and definition. This section of the paper explores the concept of country ownership and looks at how Malawi’s failed National Strategy Application to the Global Fund in 2009 tests the limits of country ownership and at the same time heightens the challenges for external accountability.

The Global Fund advocates for ‘national ownership’ in its Framework Document, but does not provide a definition for what is meant by national and what it is that is owned (The Global Fund, no date (c), ‘The Framework Document’, p. 1). It is signatory to the Paris Declaration and the Accra Agenda (The Global Fund 2010b, ‘Improving Aid Effectiveness’, p. 1) the latter of which describes the ‘who’ of country ownership as developing country governments and ‘what’ is owned as the policies and the processes of democratic engagement and accountability for them (OECD 2008, p. 15). In practice, the Global Fund’s in-country governance model broadens the concept of ‘country’ beyond the state to include a range of global, national and private actors. Concepts of accountability (Held and Koenig-Archibugi 2004, p.127; Bartsch 2007, p. 11-13) fail to accommodate the ambiguity inherent in this practice of country ownership, where the roles of stakeholders versus that of decision-makers may be unclear or inconsistent and subject to forms of authority other than the democratic engagement of citizens by the state.

If accountability as it relates to country ownership only concerned itself with what Keohane describes as “internal accountability (2002, p. 14)”, the Global Fund’s performance-based

funding approach—the technocratic linking of the Global Fund, its donors and its recipients by monitoring and reporting of country results to demonstrate ‘value for money’—fits well. However, accountability in the context of country ownership becomes much more difficult to divine when considering what Keohane refers to as “external accountability: ...accountability to people outside the acting entity whose lives are affected by it (Keohane 2002, p. 14).” Keohane gives the problem over to political philosophers, but the Global Fund’s fostering of a broad conception of country ownership makes the challenge of external accountability not one of high thought but one with real and practical implications for the Global Fund, the independent, decision-making ‘national public’ it has created and those whose lives are affected by its deliberations.

## **2.1 Country Ownership and Malawi’s HIV/AIDS Epidemic**

Malawi has the ninth highest HIV/AIDS prevalence rate in the world (UNAIDS 2008, ‘Adult (15-49) HIV prevalence percent by country, 1990-2007’) which has profound short and long term economic, social and psychological implications for the envisioned development of the country and the well-being of its population. The first HIV/AIDS case was diagnosed in Malawi in 1985 and prevalence at that time was estimated at 2% (Government of Malawi 2004, p. foreword). By the 1995, HIV prevalence in antenatal women was estimated at over 30% in urban areas, HIV/AIDS was the leading cause of death in the most productive age group (20-48 years) and it accounted for over 40% of all in-patient admissions (Government of Malawi no date; p. 4). Despite the magnitude of its epidemic, in recent years Malawi has made gains, dramatically scaling up the number of people on ART by 2009 to almost two thirds of adults and children in advanced stages of AIDS (Government of Malawi Office of the President and Cabinet 2010, p. 202) and reducing the overall HIV/AIDS prevalence in the adult population from 14.6% in 2000 to just under an estimated 12% by 2007 (World Bank

2010, Health Nutrition and Population Statistics). The resources provided by the Global Fund have played a significant part in enabling Malawi's ability to respond to a devastating epidemic.

Malawi is highly dependent on aid and it follows that its response to its HIV/AIDS epidemic requires significant donor resources. In 2008/09 Malawi's health sector received almost 32% of total donor support provided to the country. By June 2010, the Global Fund had cumulatively disbursed to Malawi US\$136 mm for HIV/AIDS through its Round 1 and Rolling Continuation Channel grants representing approximately 82% of its funding for all three diseases.<sup>7</sup> The history of Malawi's relationship with the Global Fund tells a meaningful good news story in human terms. Between 2005 and 2009 an estimated total of 200,000 adults and children who otherwise would not have access to life-saving drugs, were registered on ART of which 170,000 remained alive (Maida, Schouten, Njala 2009, p. 13). It is also a story of influence and reliance that comes with the magnitude of resources the Global Fund contributes relative to the level of Malawi's need. The Global Fund's funding of ART provision almost in its entirety in Malawi implies a long term commitment, or a 'treatment mortgage' considering that drugs are needed for a patient's lifetime and the number of new infections are estimated at 90,000 per year which continues to outpace the number of people starting ART (National AIDS Commission 2009, p. 8). Malawi's dependence on aid and on the Global Fund in particular to address its HIV/AIDS epidemic is as much about current response as long-term commitment.

## **2.2 The Limits of Country Ownership**

In 2009, Malawi was one of seven countries invited to submit an application to the Global Fund's 'learning wave' for its first round of National Strategy Applications (The Global Fund

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<sup>7</sup> Analysis by author based on Global Fund Grant Performance Reports extracted October, 2010

2010g, 'Rolling Out National Strategy Applications' p. 4). The national strategy approach is arguably the biggest reform in the Global Fund's history (Research Interview 2009) because it entails moving away from vertically focused emergency response interventions to the national health agenda. This implies a broader system and policy scope, greater coordination with other donors, less control over tracking the value for money impact of Global Fund investment and, for the country, a more predictable funding relationship. It has the potential to expand the Global Fund's scope of influence at country level well beyond vertical health system interventions focused on three diseases. It places the Global Fund among multilateral and bilateral global health leaders with the capacity to influence the national health agenda, expanding the Global Fund's remit from that of financing towards that of policy maker.

The visit to Malawi by a Strategy Review Team designed to help the country develop its National Strategy application and Malawi's successful history of Global Fund applications set expectations among CCM members for success (Research Interview Malawi 2010). The application's failure came as a shock and the Technical Review Panel (TRP), the Global Fund body which decides which proposals are funded, cited three main reasons for its decision: Malawi's failure to take meaningful action to rectify the shortcomings of the Central Medical Stores (CMS) which has had longstanding procurement and supply chain challenges; the need for more Principal Recipients (PRs) in addition to Malawi's National AIDS Commission (NAC), and weaknesses in the prevention strategy. One critique of the prevention strategy was its lack of focus on men having sex with men (MSM), a high risk population which had been a focus of the International AIDS Conference in Mexico City in 2008 and the subject of a global consultation by the WHO and UNDP that same year (WHO 2009, p.35). Those who had participated in developing Malawi's prevention strategy disagreed with the TRP's assessment and defended its credible and evidence based approach to Malawi's epidemic:

“I know the difference between how you focus on the general population and how you focus in concentrated epidemics. I was appalled by the TRP’s comments...I feel like there is a very, very small vocal voice advocating [for a focus on MSM in Malawi]. Go ahead and advocate, but it’s not evidence based...it’s not the crux of the epidemic here... I thought that we had a very, very strong, evidence based, national prevention strategy and we had experts from all over the world working on it. We have a very evidence based National Action Framework which is what the National Strategy Application was based on...[it] goes against everything in terms of evidence based programme implementation. It’s activism (Research Interview Malawi 2010).”

The TRP’s feedback was perceived by some as imposing a global human rights agenda on Malawi’s HIV/AIDS response (Research Interviews Malawi 2010) and exemplifies a tension inherent in ‘country ownership’ when country agendas, especially those where a range of stakeholders in addition to government are engaged, depart from global level interests.

This example [the TRP’s feedback to Malawi on the lack of focus on MSM in its prevention strategy for its failed National Strategy Application] points to real tensions between country ownership and global principles and principles of human rights. What do we do if women are minors but gender and equality drive the epidemic? It’s very delicate and difficult, not black and white. It’s the responsibility of AIDS advocates and normative agencies to work with countries to point to vulnerable groups...In the Malawi case it was devastating for the country because the partners had worked together hard on the proposal (Research Interview Geneva 2010).”

When the interests of a ‘global public’ are brought to bear, the authority of country ownership, particularly in the context of the dynamics of influence and need inherent in a donor/recipient relationship, fades.

### 2.3 The External Accountability Challenge

The magnitude of funds granted by the Global Fund to Malawi and the influence that comes with this provides the basis for the Global Fund's exercise of its internal accountability through its performance-based funding, monitoring and reporting. The Global Fund can assess Malawi's results against its grant proposals and indicators, set conditions precedent for the release of funds and report successes and failures to its board and donors. Closing the internal accountability gap is possible largely because of the boundaries set by the donor/recipient relationship. However, external accountability, for example to those whose lives are affected by the validity and effective implementation of a prevention strategy, requires that a complex range of decision makers be held to account. If indeed the TRP's feedback was influenced by the politics of activism rather than epidemiological evidence, the accountability of a 'global public' adds another dimension to this already unwieldy collection.

“The whole definition of accountability needs to be turned on its head in terms of donors. We always write this into programme agreements—all partners will be accountable—but what does this mean? What are the indicators? There is a missing link that we are not able to have legally enforceable accountability system that holds accountable the Global Fund, the WHO and [International NGOs] for that matter. The population has no way to ensure their rights... (Research Interview Geneva 2010).”

The challenge of external accountability is broader than Malawi's prevention strategy. As Stone (2008, p. 23) observes in relation to transnational policy communities, “One outcome of this disjuncture [that economic globalisation and regional integration are proceeding at a much faster pace than processes of global government] is that the power of the nation-state has been reduced or reconfigured without a corresponding development of international institutional cooperation. This is one of the major causes of a deficiency of public goods at

global levels.” It can be argued that this disjuncture could also cause a deficiency in the delivery of global public goods at county level, where accountability for developing and implementing an effective, evidence-based prevention strategy remains ambiguous including ‘who’ should be held to account and ‘how’ this might happen. As the Global Fund expands its role beyond disease focused interventions towards national strategies, it expands the breadth of its influence. The limits of country ownership and the extent of the external accountability challenge raise the question as to whether the Global Fund’s governance is sufficient to keep pace with its expanding scope of authority and the power that comes with it.

### **3 The Global Fund: Maturation and the Persistent External Accountability Challenge**

As a GHI, the Global Fund was conceived with a well-defined, functional purpose; however it has matured as an organisation, building its legitimacy and expanding its authority to take its place in a landscape which had been the domain of multilateral institutions. This section of the paper argues that the Global Fund’s process of organisational maturation and increasing bureaucratisation have been accompanied by an expansion of its scope and authority. Its increasing power exacerbates the Global Fund’s external accountability gap “to people outside the acting entity whose lives are affected by it (Keohane 2002, p. 14).” Rather than evolving into the ‘same old, same old’ traditional multilateral institution, the Global Fund’s unique sources of legitimacy and its evolving authority continue to distinguish it; however, it’s uncertain where this experiment in institutional innovation will lead.

#### **3.1 The Global Fund: Growing Bureaucracy, Authority and Power**

The Global Fund's increasing bureaucratisation and expanding mandate signify the growth of its authority. As described by Barnett and Finnemore, "[b]ureaucracy is powerful and commands deference, not in its own right, but because of the values it claims to embody and the people it claims to serve...(Barnett and Finnemore 2004, p. 21)." Between its founding in 2002 until the end of 2010, the Global Fund has received approximately US\$29.8 bn in pledges (The Global Fund 2010d, 'Resource Mobilization') and grown its secretariat to over 500 staff (The Global Fund 2010e, 'Secretariat'):

"Originally it [the Global Fund] was just to be a financing organisation. I think we were all naïve in terms of its size. Not in terms of money, but in terms of staff. The first concept note talked about 15 people. We were totally off the wall. But as it has grown so has its ambition in terms of policy and not just in AIDS, TB and malaria but now there is this big debate on health systems strengthening (Research Interview Geneva 2010)."

The Global Fund is included among the 'Health Eight' (H8) the other members of whom are the WHO, the World Bank, UNICEF, UNFPA, UNAIDS, GAVI and the Bill and Melinda Gates Foundation. The H8 is associated with the International Health Partnership (IHP+), co-chaired by the Honourable Gordon Brown, former Prime Minister of the United Kingdom and Robert Zoellick, President of the World Bank, which endeavours to align global health institutions, developed and developing country actors and civil society towards fulfilling their respective commitments to the health MDGs. Relative to the H8 and the work of the IHP+, the Global Fund has made two significant global health leadership claims. First, in 2007 the Global Fund's board endorsed a move to fund national strategies to align its investments with that of other donors (The Global Fund 2007, 'Fifteenth Board Meeting'). In 2009 the Global Fund and the GAVI Alliance wrote to the IHP+ Co-Chairs, then Prime Minister Brown and

Mr. Zoellick, advising of their intention to underpin their leadership in health system investment with a joint programming approach for health systems strengthening (Lob-Levyt and Kazatchkine, 2009). The maturing of the Global Fund speaks to the effectiveness of its legitimisation and sets the stage for the expansion of scope of authority from that of a financing mechanism for three diseases towards that of global health policy maker.

The Global Fund is reluctant to claim itself as a policy maker; nevertheless, it influences policy at country level. Although the Global Fund argues that it is a financing mechanism, not a policy maker, because of the scale of funding it provides to individual countries and in sum globally, it is a policy enabler. For example, the Global Fund's support for the technical policies developed by the WHO, such as the adoption of preferred drug regimens means that they can be implemented on a large scale:

“It's one thing to say that the WHO thinks these are the three drugs that should be used for first line [Anti-retroviral – ARV] treatment. Would the country then introduce [them] at scale because [the WHO recommends them]? It's only when the Global Fund says it will make the money available for these three drugs and suddenly it becomes national policy and...[the country] develops programmes to test, counsel and put people on treatment. So it's an interesting balance. [The Global Fund is]...not making policy but... [it is] influencing policy at country level (Research Interview Geneva 2010).”

The Global Fund's deference to the WHO's technical policy role in part retains the purity of its mandate to “attract, manage and disburse resources (The Global Fund 2009, p. 2)”, in part avoids muddying the division of labour among health actors at global level, and in part avoids contention associated with a GHI rather than a state-centric multilateral making global public health policy. However, as the case of Malawi's failed National Strategy Application and the

TRP's feedback on the country's prevention strategy indicates, the decision making and communication tied to Global Fund grants is an authoritative voice in the national sphere.

The interests reflected in or the implications of its decisions are not always a neat and straightforward business, particularly when global and country priorities collide (Walt and Gilson 1994, p. 355; Stone 2008, p. 29; Okuonzi and MacRae 1995, p. 131; Kickbusch 2000, p. 980; Buse, Drager, Fustukian and Lee 2002, p. 253).

The Global Fund's authority appears similar to that of multilaterals: at global level its claim to global leadership in health systems strengthening and its participation in the H8 include it among multilateral actors. At country level its authority lies in the donor/recipient relationship practiced by multilaterals, governments of wealthy nations and private foundations alike; however the Global Fund brings a scale more akin to that of powerful states than private wealth and its national strategy approach has expanded its scope beyond three diseases to the broader health agenda. This evolution is evidence that the Global Fund's authority is not only expanding but also changing, becoming a form of political authority, a "fusion of power with legitimate social purpose (Ruggie 1982, p. 382)."

The distinction between authority and power has been claimed by some to lie in the former relying on trust achieved through legitimacy and the latter relying on obedience achieved through coercion (Krieger 1977, p. 259; Cutler, Haufler and Porter 1999, p. 334; Hall and Biersteker 2002, p. 4). The nature of 'coercion' exercised by the Global Fund, rather than being insidious as the term might imply, comes not just from the scale of resources it distributes to countries, but also from the reliance of many countries on these resources to provide prevention, treatment and care to their populations for the three diseases. In other words its 'coercive power' is at the heart of the Global Fund's mandate, supported by its legitimacy and inherent in the donor/recipient relationship. This is evidenced by the aftermath

of Malawi's failed National Strategy Application and the TRP's feedback on its prevention strategy when concern was expressed about how to strategically position the country's next application:

“For this Round 10, there is a lobby to focus more on treatment, because there is a concern in the Malawi Government that they will get another rejection. So they said let's leave out some of the very sensitive areas with these vulnerable groups like men having sex with men and prison populations. It's all in the prevention strategy but maybe they will not include it as much in Round 10. Because there are concerns about issues that are not yet resolved for Malawian society and there is a concern that if you make it too ambitious that you will get rejected again. There is a lot at stake for this proposal. People are nervous about it (Research Interview Malawi 2010).”

Malawi's reliance on Global Fund resources and consequently its willingness to conform to priorities identified by the TRP reveals a coercive force at work. However, this 'coercion' should also be recognised in concert with the role of the Global Fund in countries' ability to respond to MDG 6 and as a result the significant improvements in mortality and morbidity for millions of poor and disadvantaged people. It's unthinkable to imagine the circumstances in countries like Malawi which had a 14.6% HIV/AIDS prevalence rate in 2000 without the scaled up response that Global Fund resources have enabled. That said, what is troubling about the Global Fund's exercise of authority at global and country levels, particularly where there is an expansion beyond its original financing mandate is that its authority has none of the accountability that accompanies state-centric forms of authority with this reach and scope. Its internal accountability remains focused on proving performance to donor governments for a financing mechanism for three diseases.

The Global Fund was a form of institutional innovation when it was created at the beginning of the millennium and in a very short period it has grown in size and scale to become like the bureaucracies associated with traditional multilateral organisations. Despite its growing resemblance to these institutions, the Global Fund is not the ‘same old, same old’. It remains a form of institutional innovation owing to its distinct sources of legitimacy and its particular form of internal accountability. The Global Fund’s expanding mandate, and its growing authority and power at global and country levels suggest that it is evolving from a financing mechanism towards that of a global health policy maker with significant influence on country level health agendas.

### **3.2 The Persistent External Accountability Challenge**

At country level in particular the notion of country ownership can be seen as softening the coercive nature of the donor/recipient relationship (Khan and Sharma 2001, p. 14); however, despite benefits such as strengthened in-country leadership capacity and stewardship of health programs (Atun and Kazatchkine 2009, p. S68), the inclusive definition of ‘country’ beyond the state and the creation of a ‘national public’ only serves to complicate the challenge of external accountability:

“There is little doubt that mechanisms of accountability have not kept pace with the power and reach of international organizations. Such developments become all the more troubling when it is recognized that IOs [International Organisations] have autonomy and can develop in ways that are not sanctioned by their creators...As international organizations grow in power and scope, more populations are vulnerable to their policies than ever before ...(Barnett and Finnemore 2004, pp. 170-1).”

For low income, high need countries like Malawi this vulnerability is likely to become increasingly palpable. Consider that in 2009, there were 1.8 million adults and children newly infected with HIV/AIDS in Sub-Saharan Africa (UNAIDS 2010, ‘UNAIDS Report on the Global AIDS Epidemic 2010’). In Malawi, despite the scaled up response to the epidemic, in 2009 279,000 adults and 27,000 children were estimated to be in need of ART (Maida, Schouten, Njala 2009, p. 23). Need in the most endemic countries is not declining, yet resources since the 2008 global financial crisis are under considerable pressure. At its third voluntary replenishment cycle for 2011-2013, the Global Fund received US\$11.7 bn, failing to meet its lowest target scenario of US\$13 bn which would have allowed for the continued funding of existing programmes, but significantly lower funding for new programmes than in the past (The Global Fund 2010f, ‘Second Meeting of the Third Voluntary Replenishment (2011-2013)’). As noted in a recent report with the indicative title *Sharing the Responsibility* by the Institute of Medicine (IOM) to the U.S. Government (the single largest government funder of HIV/AIDS globally),

“[n]o single strategy will offer a magic bullet to meet the challenge of HIV/AIDS; countries will need to adopt multipronged approaches. In particular, African nations—where the burden of HIV/AIDS is the greatest in the world—should plan now for how to respond to this rapidly growing epidemic. Shared responsibility between the United States and African nations will empower these nations to take ownership of *their* [emphasis author’s] HIV/AIDS problem and to work to solve it (Institute of Medicine 2010 ‘Sharing the Responsibility: Report Brief’).”

In resource constrained times, the global public goods nature of achieving MDG 6 may be shifting from a problem addressed through cooperation to one that is the responsibility of affected states. This implies that accountability can only move away from the inclusive but

messy notion of country ownership as practiced by the Global Fund back towards the domain of sovereignty. This does not make the external accountability gap go away, but rather heightens the necessity to answer the questions who is accountable to those whose lives are affected and how are they held to account. The challenge for the Global Fund is to evolve its accountability to more accurately reflect its expanded authority and power as an organisation which has matured beyond a financing mechanism for three diseases.

## **4 Conclusion**

The Global Fund was a form of institutional innovation created at the new millennium to facilitate the attainment of MDG 6, to combat HIV/AIDS, malaria and other diseases. It was conceived as a public/private partnership that was intended as a “break from business as usual” meaning it would operate differently from traditional multilateral institutions even though it was charged with the provision of a global public good. The Global Fund’s design provided new sources of legitimacy which distinguish it from “the doctrine of sovereignty” associated with traditional multilateral organisations. These were its inclusive governance model, its transparent and performance-based funding modus operandi and the scale of its resource mobilisation and distribution. While the Global Fund’s internal accountability which ties the results achieved in countries to investments by donors in a value for money argument is in place, its external accountability to those affected by its decisions, remains elusive.

The Global Fund’s promotion of country ownership, a broad conception of ‘country’ beyond the traditional domain of government, further complicates the Global Fund’s external accountability challenge. As the case of Malawi’s failed 2009 National Strategy Application and the feedback from the TRP on Malawi’s prevention strategy demonstrated, the influence

of the 'national public' in the face of the power of the donor/recipient relationship fades. The Global Fund's expansion from its initial function as a financing mechanism for vertical, disease focused interventions towards national strategies and health systems strengthening has not been accompanied by an accountability function that keeps pace with its increased influence.

Since its inception, the Global fund has grown its bureaucracy, its authority and its power. However, it is not evolving into the 'same old, same old' multilateral institution; rather, its unique sources of legitimacy and its donor government focused internal accountability retain its institutionally innovative character. The Global Fund's expansion into global leadership for health systems strengthening and funding of national strategies demonstrates its evolution beyond a financing mechanism for three diseases.

The Global Fund's external accountability gap is more apparent as its power grows. This gap is exacerbated as country needs, particularly in the most HIV/AIDS endemic countries like Malawi, where needs show no signs of abating and competition is strong for constrained donor government resources. This pressure is beginning to erode the global public goods ethos and the broad conception of country ownership as the notion of a state's ownership of its problems particularly for recipient countries begins to re-assert itself. The challenge then for the Global Fund is to evolve its accountability, particularly its external accountability to those whose lives it affects to reflect its maturation beyond a financing mechanism towards global health leadership and policy making.

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