

# The Global Fund to Fight AIDS, Tuberculosis and Malaria: 10 years on

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## ABSTRACT

The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund or GFATM) is a private public partnership aimed at leveraging and providing funding for the three focal diseases outlined in its title. Set up in 2002, the fund was part of a new 'breed' of players in the field of global health, combining skills from bilateral and multilateral agencies with private sector and civil society. Highly innovative in its structure and funding model, the Global Fund's secretariat in Geneva provides grants directly to one or more organisations – not just governments – in recipient countries. Despite great successes, including scaling up treatment for AIDS to reach 4.2 million people, the fund has been the subject of intense debate. This includes discussion of its impact on health systems and allegations of financial irregularities among recipients in four countries. The organisation has now emerged with a new strategy, funding model and executive director. This paper charts its history, discusses some of the challenges faced, drawing on fieldwork conducted by the author in 2007–08, and reflects on recent changes and the road ahead.

**KEYWORDS:** Global Fund, global health, health financing, public private partnerships

## History and model

The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund or GFATM) is a private public partnership aimed at leveraging and providing funding for the three focal diseases in its name. It was launched in 2002 following recommendations from the Group of Eight (G8) in 2001<sup>1</sup> and subsequent reiteration of these recommendations at the United Nations' General Assembly Special Session on HIV and AIDS a year later. Its intention was to raise significant new funding to address and improve outcomes in these three major global diseases – a move that was considered pivotal in achieving the United Nations' Millennium Development Goals.<sup>2</sup>

During the first 10 years, the Global Fund disbursed more than \$19 billion and provided grants for programmes aimed at tackling the three diseases in 151 countries. By 2013, in addition

to providing \$10 billion for HIV/AIDS-related activities, the organisation was the world's largest funder of harm-reduction programmes supporting people who use drugs and the leading external funder of tuberculosis (TB) programmes globally.<sup>3</sup>

This paper examines the key features of the Global Fund's model and reviews milestones in its 10-year history. It highlights some of the debates around its structure and operations, focusing specifically on its impact at the national and sub-national levels, as observed in the literature, and drawing on evidence from research focused on the rollout of antiretroviral treatment for HIV/AIDS in Zambia and South Africa. The paper concludes by outlining recent changes to the Global Fund's model and discusses the extent to which these are likely to alleviate challenges facing global organisations.

## The Global Fund's business model

At the time of its creation, the Global Fund was part of a new 'breed' of players in global health – global health initiatives (GHIs) – which rely on a common blueprint or strategy that is implemented across a range of countries to target a specific disease, group of diseases or global health challenge. The GHIs vary widely in focus (from disease orientated to intervention, eg vaccination orientated) and institutional model. However, as innovative mechanisms, GHIs all share the aim of addressing a major health issue across different countries. Some GHIs – notably the US President's Emergency Plan for AIDS Relief (PEPFAR) – are bilateral, but GHIs are often seen as an opportunity to combine the skills and resources of traditional multilateral organisations, such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF) and World Bank, with bilateral agencies and the private sector in order to utilise the energy and country-level experiences of non-governmental organisations (NGOs).<sup>4,5</sup>

At the time of its inception, the Global Fund's model presented several innovations<sup>6</sup> compared to previous models of development assistance for health. For example, it did not seek to become an implementing agency and, to this day, has no presence or offices in countries where funding is provided. The fund provides resources directly from a central secretariat in Geneva to a number of principal recipients and sub-recipients within countries on the basis of their performance. Principal recipients are not limited to government agencies but can be the local office of a multilateral organisation or a civil society organisation, including universities and NGOs.<sup>6</sup>

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The fund is led by demand. Countries previously submitted proposals for funding on the basis of specific calls issued on a periodical basis. Each 'round' of funding was targeted to specific types of interventions – eg for prevention of HIV – or to strengthen health systems. Yet the overall content of proposals was shaped by countries through a process designed to maximise countries' ownership of funded interventions. Proposals to the fund have to be developed through country-coordinating mechanisms (CCMs), which are intended to bring together a range of different stakeholders at the country level – crucially including civil society as a partner in this process.<sup>6–8</sup> Submitted proposals are then reviewed by technical review panels made up of experts, who make recommendations to the board on whether funding should be awarded. Civil society, private sector and multilateral agencies are represented on the Global Fund's board, with full voting rights.

In the past, countries submitted proposals for funding on the basis of specific calls issued on a periodical basis. Each 'round' of funding was targeted at specific types of interventions – for example HIV prevention or health systems' strengthening. However, the overall content of proposals was shaped by countries through a process designed to maximise countries' ownership of funded interventions. The mechanism for this, which is retained in the revised Global Fund model, are country coordination mechanisms (CCM). These are intended to bring together a range of different stakeholders at the country level – crucially including civil society in this process.

### Debates and controversies

By early 2013, the Global Fund had provided resources for the treatment of 4.2 million people with AIDS and 9.7 million people with tuberculosis and for the supply of 310 million insecticide-treated nets for the prevention of malaria.<sup>3</sup> Taken at face value, this would indicate success; however, the organisation has faced claims of abuse of its funding in several countries over the past 3 years.<sup>9,10</sup> The fund, with its emphasis on accountability, had discovered these irregularities itself through a report by internal auditors and published the results on its website.<sup>11</sup> The subsequent full investigations revealed that only a small amount of funding had been misappropriated and that this was mainly confined to two countries.<sup>12</sup> However, as the story broke in international news media, several donor governments, including Germany, suspended funding to the organisation.<sup>10</sup> Due to the resulting shortfalls, the fund announced in November 2011 that it was suspending all new funding until 2014, while embarking on a restructuring process.<sup>13</sup>

### How to (or not to) strengthen health systems

Predating the crisis resulting from financial irregularities were discussions among implementers, researchers, funders and other global health actors on the effects of large scale funding by the Global Fund and other GHIs on countries' health systems. Within the first 5 years of the fund's operation, it became apparent that the scale up of disease-specific programmes was affected and potentially limited by weak health systems in recipient countries. This included lack of physical health facilities, lack of health workers, limited appropriate skills of health workers, weak procurement systems and poor health information systems, all of which posed a challenge to meeting and monitoring the fund's results.<sup>14,15</sup>

Although the GFATM began funding some health system-related activities in the fifth round of its funding in 2007, much debate following its initial 5 years of work centred on whether the organisation should retain its focus on the initial three diseases, explicitly open a funding stream to strengthen health systems or, in a potentially more radical departure, change its mandate to become (or become part of) a global fund for health.<sup>16</sup> These discussions resulted in the creation of a joint platform for health system strengthening, in which the Global Fund, Global Alliance for Vaccines and Immunization (GAVI) Alliance, World Bank and WHO work together to harmonise funding and support at national level in an effort to strengthen health systems.

Evidence highlighted the need to invest in health systems rather than disease-specific interventions and programmes, as was then the norm for the Global Fund and other GHIs such as PEPFAR and the World Bank's Multi-Country AIDS Program.<sup>17</sup> This transition was spurred on due to concerns regarding negative system-level effects as a result of GHIs – for example, the negative impact on availability of public sector human resources, influences distorting country priorities, lack of harmonisation of programmes funded by two or more organisations, and the creation of parallel structures leading to inefficiencies and 'doubling up'.<sup>8,17</sup>

Furthermore, research conducted between 2007 and 2008 on the implementation of rollout of antiretroviral treatment for HIV/AIDS in Zambia and South Africa revealed some unintended consequences of financial support from the Global Fund.<sup>18</sup> This included an impact on or potential displacement of human resources for health. Health workers sought to work on programmes funded by the Global Fund and other GHIs rather than other public sector programmes, as these were perceived to provide better chances for career and financial advancement due to enhanced training, allowances and overtime payments. Indeed, the most far-reaching impact on human resources observed was through the recruitment of health workers – doctors, nurses and administrators – from within the public sector to NGOs funded by the Global Fund and others, who were able to provide higher salaries.<sup>19</sup> Moreover, the administration of resources provided by the Global Fund and their monitoring represented a real opportunity cost in terms of time and energy spent by public health managers within ministries of health.<sup>18</sup> This burden and the inefficiencies resulting from parallel governance structures have been corroborated by others in a number of settings.<sup>20, 21</sup>

These challenges were not confined to the Global Fund but reported as common across different GHIs, and their exact impact remains contested despite the common themes identified.<sup>22</sup> Evidence also underlines that, despite these potentially negative system-level effects, the Global Fund created momentum in terms of health-systems issues within focal countries, highlighted the need for activities to strengthen systems, which otherwise may not have come to the fore, and provided resources that would otherwise not have become available.<sup>17,23,24</sup>

### Country-coordinating mechanisms

The CCMs – envisaged as bodies to facilitate greater country ownership, including through the participation of civil society organisations – have also been the focus of research and discussion.<sup>17</sup> Evidence has pointed to CCMs providing

space for greater participation of civil society in policy processes, including giving visibility and a seat at the policy table to previously marginalised groups, such as people who use drugs and men who have sex with men.<sup>7,8,21</sup> Although this sense was shared by networks of people living with HIV/AIDS interviewed in Zambia, CCMs have also been criticised as masking more complex political processes and drawing on simplistic perception of NGOs as uniform actors and representatives of civil society.<sup>25</sup> The varied evidence of participation suggests a hierarchy of power among civil society groups that is reflected in participation in the CCMs.<sup>26</sup> It provides a lesson for those wishing to engage civil society that meaningful participation of even the most marginalised will require active support and must take into account differences in power, even among those facing marginalisation.

### A changed fund?

Following the crisis in 2011, the Global Fund has undergone a restructuring process: many senior managers have left, a new strategy was adopted for 2012–16 and a new executive director was appointed in 2013.<sup>27</sup> The organisation also announced a new funding model, which provides the most marked changes to date and indicates an institutional response to the challenges discussed. Key features include greater limitations on which countries are eligible to apply for funding in an effort to ensure greater targeting of resources towards the greatest need. Changes have also been made to the proposal process to ensure greater flexibility of funding. Countries will receive greater guidance on the level of funding available (in line with need) and will develop applications through a more iterative process, receiving feedback throughout. This is intended to ensure greater predictability of funding, addressing the concerns described above. Funding will be available on a continuous basis – a change from the previous ‘rounds’ – and the organisation intends to work with countries towards longer-term financing options, which may include countries increasingly co-funding programmes with the aim of ensuring greater sustainability.<sup>28</sup>

To address issues around strengthening of health systems and to ensure both integration of Global Fund programmes with recipient countries’ services and plans, and greater coordination and harmonisation with other funders, proposals have to demonstrate how these fit with national health plans or strategies and complement other activities.<sup>28</sup>

Together with the iterative process for proposal development, it is envisaged that more proactive and responsive management of grants and relations with countries will lead to more accurate risk assessment. The level of oversight of grants in the new funding model will depend on implementers’ risks. All of these measures are intended to ensure greater efficiency and oversight of grants.

The new funding model emphasises country dialogue, underlining the importance of engaging with all stakeholders. However, current documents are silent on the kinds of support that may be provided to enable a genuinely inclusive process, and it will be interesting to see how this plays out in practice.

### Conclusion – the road ahead

As the Global Fund enters its second decade of operations, a critical question for the organisation will remain whether donors (governments, foundations and the private sector) regain and

retain trust in its ability to ensure accountable implementation of programmes and avoid future financial irregularities. The recent announcement that the Obama administration was seeking \$1.65 billion for the fund in its budget appropriations is a welcome indicator in this respect (maintaining the current levels of funding),<sup>29</sup> as was the German government’s announcement of a \$1 billion donation to the fund.<sup>30</sup> Equally important to the fund’s future will be demonstrating the greater impact and increased efficiencies of its new funding model, especially if funding for health continues to level off.

Debates about the system-level impact of the Global Fund (and other initiatives like it) are likely to continue.<sup>31</sup> It will be difficult to assess whether the revised funding model succeeds in its intention to ensure greater harmonisation with other funders at the country level and to support national systems. To ascertain whether it succeeds will require ongoing qualitative monitoring and research at the national and sub-national levels.

Although questions of sustainability and impact continue to loom large, many people will welcome the news that the Global Fund is accepting new proposals – not least the more than 4 million people who depend on its resources for their anti-retroviral medication.

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