The Handbook of Global Health Policy

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Global Health Partnerships: The Emerging Agenda

Jeremy Youde

Abstract

The globalization of health has led to a tremendous expansion in the number and types of actors and groups taking an active role in addressing global health concerns. The proliferation of government, international organization, private foundation, and non-governmental organization partnerships dedicated to global health issues has significantly increased the amount of resources available and raised the prominence of these issues on the international political agenda. These partnerships show much promise, but their proliferation can also lead to redundancy and create confusion of who is addressing which issues. Without assiduous monitoring and evaluation, it can be difficult to tell which partnerships are successful or whether a partnership is successfully leveraging the strengths and resources of its member organizations. More importantly, the continued global economic downturn poses serious challenges for the ability of these partnerships to maintain operations. This chapter defines global health partnerships, discusses their various forms, analyzes characteristics that promote successful collaborations, and offers suggestions for the future. To provide insight into these issues, the chapter uses the Global Fund to Fight AIDS, Tuberculosis and Malaria as a case study for analyzing the successes, shortcomings, and future challenges faced by global health partnerships in the contemporary international environment.
Key Points

- The globalization of health has led to a proliferation of partnerships among governments, non-governmental organizations, intergovernmental organizations, and the private sector.
- Partnerships can add flexibility and innovation to global responses to health issues.
- Effective global health partnerships need to both address the issue at hand and transform the partners themselves in some way.
- The increase in health partnerships has not necessarily been accompanied by rigorous monitoring and evaluation for effectiveness.
- Economic austerity measures have made global health partnerships attractive as potential cost-saving measures, but effective partnerships still require significant resources.

Key Policy implications

- Global health partnerships need to improve their coordination with governments.
- The continued global economic downturn significantly challenges the ability of these partnerships to carry out their operations.
- Successful partnerships can give meaningful voice to their members when properly constituted.
GLOBAL HEALTH PARTNERSHIPS

Introduction

The globalization of health has led to a tremendous expansion in the number and types of actors taking an active role in addressing health concerns. National governments increasingly partner with international organizations, private foundations, and non-governmental organizations (NGOs) to fund and implement strategies designed to reduce disease burdens. New types of organizations that specifically marry public and private actors have emerged and come to have significant roles. These partnerships have significantly increased the resources available for addressing some key health concerns and increased the visibility of health on political agendas domestically and internationally. They have also introduced confusion and redundancy into disease control programs and raised questions about their long-term viability.

This chapter has four primary aims. First, it seeks to define global health partnerships and why they have achieved prominence in recent years. Second, it describes the various forms that global health partnerships have taken in contemporary global health politics. Third, it details some of the beneficial aspects of global health partnerships and describes how they might be increased more broadly. Finally, it describes some of the potential difficulties global health partnerships present for effective disease management and health promotion strategies. To achieve these aims, this chapter focuses much of its attention on the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund’s experience illustrates both the potential benefits of governments and NGOs working together to address cross-border health concerns, as well as the difficulties they face in achieving and maintaining positive outcomes.

Global Health Partnerships

At their most general level, global health partnerships entail multiple organizations combining human and/or financial resources to work together on a health issue of cross-border concern. This description is technically correct, but greater specificity will provide a more useful definition. Buse and Harmer provide a more detailed definition with a narrower scope, drawing on the global governance idea of public–private partnerships. Their definition of a global health partnership focuses on three primary elements. First, global health partnerships are established specifically to address one or more global health problem. The focus on health is not a spillover from other programs, nor is it incidental to the collaboration. Rather, addressing a global health problem is the partnership’s very reason for being. Second, global health partnerships are relatively institutionalized. The exact level of institutionalization will vary from partnership to partnership, but there must exist some sort of formalized agreement to work together and share resources. Third, global health partnerships generally combine public and private organizations and provide both with a voice in decision-making policies and procedures. The collaborative decision-making procedures will, ideally, ensure a greater level of ownership among the various parties. It is this last element, with its emphasis on consensual and collaborative decision-making, that Buse and Harmer identify as being particularly innovative and novel for global health governance (Buse and Harmer 2007).

Thanks to the growing role of global health partnerships, international resources available for health concerns have increased significantly. Between 2002 and 2006, official development assistance for health increased 25% annually, and global health partnerships receive a large portion of these funds (Dodd and Lane 2010). Part of the reason that global health partnerships have had this vital role, Dodd and Lane argue, is that
they can provide more sustained and predictable funding for projects over longer periods of time. They also help overcome policy failures by both governments and markets that have prevented a public good, such as health, getting to the poorest and most vulnerable people (Ngoasong 2009).

The connections among organizations in global health partnerships operate at two different levels. Vertical linkages are perhaps the most common. In these, international organizations and large private foundations partner with NGOs, the private sector, and national or subnational governments (Magnuson 2010). An example of a vertical global health partnership is the Global Alliance for Vaccines and Immunization (GAVI). GAVI combines the World Health Organization, UNICEF, the Bill & Melinda Gates Foundation, the Norwegian government, the Nicaraguan government, GlaxoSmithKline, and BRAC (formerly the Bangladesh Rehabilitation Assistance Commission), among others, to increase access to vaccinations in developing countries and spur research on new and more effective vaccines. It specifically draws representatives from international, national, and subnational levels to advance its larger goals. Horizontal linkages bring together similar types of groups or governments to coordinate activities, pool resources, establish international standards and norms, and report on progress to each other. In these ways, horizontal linkages seek to avoid duplicating services and encourage accountability (Magnusson 2010). An example of a horizontal global health partnership is the Meeting of the Ministers of Health of Pacific Island Countries. First held in Fiji in 1995, the Meeting convenes every two years to develop a shared vision of health in the region based on its unique geographic, economic, political, and health features. This forum allows for the development of shared ideals for regional health and establishes accountability mechanisms for ensuring that governments are living up to their promises.

While populated by different types of organizations, vertical and horizontal linkages have an important symbiotic relationship. Magnusson (2010) argues that horizontal linkages can bring some measure of rationality and order to the proliferating mass of vertical global health partnerships. By bringing together actors at a similar level, horizontal linkages try to avoid the duplication of resources and prevent overwhelming any single country or part of the global health agenda. In other words, horizontal linkages can provide the information and oversight that will allow vertical linkages to operate more efficiently. This function is particularly important, as Ciconne (2010) argues that the efficacy of global health partnerships has been undermined by their lack of public accountability and oversight.

What Makes Global Health Partnerships Work?

Simply bringing organizations together is not enough to create a useful global health partnership. Crafting a successful partnership requires taming a large-scale collective action problem, bringing together a wide variety of actors with their own agendas and interests to achieve a common end. Drawing on a decade’s worth of research and interviews with key stakeholders in a wide variety of public-private global health partnerships, Buse and Tanaka (2011) identify seven key elements that contribute to successful arrangements.

First, a partnership must identify a concrete goal that its combination of partner organizations is uniquely qualified to address and exploit that comparative advantage. This requires taking careful stock of the strengths and weaknesses of the member organizations and considering the particular talents or skills this partnership can contribute. Second, partnerships must establish, staff, and adequately fund their
GLOBAL HEALTH PARTNERSHIPS

The Global Fund to Fight AIDS, Tuberculosis and Malaria

When the Global Fund came into being, it marked something new and novel in the global health governance architecture. It was a wholly new international organization, deliberately created to stand apart from the United Nations or any other international bureaucracy. It had a relatively small staff. Its budget depended wholly on voluntary contributions from both state governments and private sources. Uniquely, the Global Fund explicitly does not conduct programming on its own and instead operates solely as a funding agency. The Global Fund also set itself apart by explicitly recognizing the unique role of civil society organizations and mandating their inclusion in the applications made by national governments. Such innovations offer new opportunities for creating responsive global health structures, but the Global Fund’s inability to live up to its promises and aspirations call its ambition into question.

The movement toward creating the Global Fund started at the G8 meeting in 2000 in Okinawa. For the first time, the G8’s agenda included health issues. The assembled states acknowledged that poor health threatened international prosperity and development. In their post-conference communiqué, the leaders expressed a commitment to reducing HIV/AIDS, tuberculosis, and malaria rates and involving civil society organizations, industry, and academia in reaching their goals. Furthermore, the G8 countries pledged to hold another conference to agree “on a new strategy to harness our commitments” (Ministry of Foreign Affairs of Japan 2000).
In calling for a new funding mechanism for global health, the G8 countries implicitly acknowledged that existing institutional arrangements fell short in tackling the challenges posed by HIV/AIDS, tuberculosis, and malaria. Though a relatively new disease, HIV/AIDS threatened to overwhelm states with high infection rates and imposed severe strains on national health budgets. Tuberculosis, long thought to be under control, made a dramatic resurgence as it co-infected HIV-positive persons and drug-resistant strains emerged. Malaria rates surged as drug-resistant strains expanded geographically. These new crises overwhelmed the World Health Organization – an institution whose regular budget had remained stagnant since the early 1980s and was generally accorded little respect because health was considered “low politics” (Fidler 2005: 180). With the 2000 G8 summit in Okinawa, the leaders of the world’s largest economies acknowledged that health was more significant to international politics than previously assumed. They also acknowledged that additional actors and resources were vital for effectively addressing these crises. Instead of relying on outsiders telling countries how to implement programs, the attendees recognized that states needed to rely on local expertise and take ownership of their health interventions if they were to succeed (Brown 2010). Crafting better interventions would require states to create and implement their own programs, but they would need resources to carry them out. That is where the G8 saw the potential for a new international health organization.

Building on the momentum of the summit in Okinawa, the Organization of African Unity held a special session in Abuja, Nigeria, in April 2001 where member governments pledged to increase their own health spending and requested donor states to “complement our resource mobilization efforts to fight the scourge of HIV/AIDS, tuberculosis, and other related infectious diseases” (Organization of African Unity 2001: 5) by creating a global fund of $5–10 billion for creating and implementing programs targeted toward these diseases.

With this momentum, the creation of the new organization came at a rapid pace. At the United Nations General Assembly’s Special Session on HIV/AIDS in June 2001, Member States pledged to create and support a new international funding mechanism for addressing HIV/AIDS. They affirmed their desire to create a fund with $7–10 billion available annually to low- and middle-income states and those with high HIV infection rates, and called on donor states to pledge 0.7% of their gross national product for overseas development assistance and offer debt relief to the most heavily indebted states (United Nations General Assembly 2001: 38–40). This declaration encouraged the international community to create the Global Fund and allowed the United Nations to give its official support for the Fund’s creation.

Informal organizational meetings for the new Global Fund began in July 2001 in Geneva. Nearly 40 delegates attended these early planning meetings from a wide range of concerned actors – donor states, recipient states, civil society organizations, the United Nations, and private industry. Drawing on this wide range of interested parties, the Global Fund presented itself as a public–private partnership that could combine the group’s collective strengths into a force for good. These meetings set the general framework for the new organization, established its parameters, and put forward the Global Fund’s mandate. In January 2002, the Global Fund’s Executive Board met for the first time, and the Fund issued its first grants to 36 countries 3 months later (Bartsch 2007). Since that time, the Global Fund has provided more than $19.4 billion for 780 grants in 144 countries. Those funds have allowed 2.82 million people to access antiretroviral treatment to fight HIV, treated 7.11 million people for tuberculosis, and distributed 124 million insecticide-treated nets to stop the spread of malaria (Global Fund 2010b).
Unlike most international organizations, the Global Fund extends beyond states to include non-state actors as active participants with a voice in the policy-making process. It provides explicit roles for donor countries, recipient states, and civil society organizations in an effort to achieve a high degree of deliberative governance and allow as many voices as possible to be heard. It functions as a hybrid, operating between public and private sources of authority and legitimacy. Bartsch describes it as “a new way of doing business in the field of development cooperation and health that goes beyond the state-centered intergovernmental approach of other actors in global health governance” (Bartsch 2007: 147). With its unique structure, the Global Fund has the potential to transcend traditional boundaries, but frequently finds itself unable to fully live up to its stated goals.

The Global Fund’s operations are divided into seven key groupings: the Executive Board; the Secretariat; the Technical Review Panel; the Partnership Forum; the Country Coordinating Mechanisms; the Principal Recipients; and the Local Fund Agents. Some work at the organization’s headquarters in Geneva, while others work in the member countries (Bartsch 2007: 151). Overseeing the whole organization is the Executive Board, which ultimately makes all the strategy, policy, operational guidelines, and funding decisions. Reflecting the diverse constituencies involved with the Global Fund, the Executive Board’s membership includes donor countries, recipient states, and representatives from civil society organizations around the world. The Secretariat handles the Global Fund’s daily operations, ensuring compliance with Fund directives, raising additional funds, and reporting the Fund’s activities to the Executive Board and the public. The Technical Review Panel (TRP) assesses the feasibility and technical merit of projects and provides recommendations to the Executive Board, which ultimately decides which proposals to fund. Within its membership, the TRP seeks to balance gender, region, and specializations. The panel includes up to 40 members in any given round of proposal evaluations. The Partnership Forum provides an opportunity every two years for all Global Fund stakeholders to come together to discuss strategies and policies. The Partnership Forum’s recommendations help to inform the Executive Board in its oversight responsibilities. At the country level, the Country Coordinating Mechanism (CCM) has a vital role in crafting and putting forward proposals. CCMs bring together local stakeholders to develop proposals for funding from the Global Fund, drawing on governmental and non-governmental expertise. CCMs also serve as the vital link between the Global Fund and the recipient country, operating as an informational conduit. Once a country receives a grant, the CCM also oversees the grant’s implementation. The Principal Recipient receives the actual grant from the Global Fund and implements programs. Initially, the Principal Recipients tended to be government agencies (particularly Ministries of Health), but NGOs, academic institutions, and faith-based organizations increasingly act as Principal Recipients. Countries may designate multiple organizations to serve jointly as Principal Recipients. Finally, the Local Fund Agent acts as an independent auditor and oversees, verifies, and reports on grant performance to the Global Fund.

Among these seven groups, though, the Executive Board receives the bulk of attention. The Executive Board’s composition makes it the key site for bringing together a wide variety of stakeholders and concerns about the relative weight of their influence. The board consists of 25 members (not including the executive director) coming from three different blocs: donors, recipients, and international organizations and the Swiss government (a non-voting bloc). Within these blocs, there exist careful formulas to maintain balance and provide for a higher degree of representation of different constituencies.
Among the donors bloc, eight of the representatives come from donor states (generally selected from the most generous donors). The other two bloc members represent private interests in donor states: one from private industry and one from private foundations. Within the recipient bloc, seven members come from developing countries, one comes from a northern-based civil society organization, one comes from a southern-based civil society organization, and one comes from a civil society organization representing the interests of those affected by HIV/AIDS, tuberculosis, and/or malaria. The non-voting bloc represents the World Health Organization, UNAIDS, World Bank, global partner organizations that work with Global Fund recipients, and the Swiss government.

Despite attempts at balance and providing opportunities for genuine deliberative decision-making, the Executive Board has come under fire for not living up to its promises. The civil society organizations on the Executive Board generally focus on HIV/AIDS, leaving organizations with more direct experience with tuberculosis and malaria without direct representation. Representatives from some developing states have also expressed dismay that they are losing influence relative to donor states. When the board decided to add a seat for an affected community civil society organization, it also added another seat for the donor states to keep the two blocs balanced in size. This raised alarm that the donor states would have an oversized influence on the board and dilute the ability of the recipient states to make their voices heard. Some recipient states also saw this move as an attempt to weaken the influence of national governments in developing countries vis-à-vis civil society organizations, many of which relied on funds from donor states for their operations. They instead envisioned an organizational structure more akin to the World Health Assembly, where each Member State gets a vote and an opportunity to participate in debates regardless of funding (Bartsch 2007).

At a more fundamental level, questions have emerged about whether it is even possible for recipient state interests to get a fair hearing within the structures of the Executive Board. The Global Fund's mandate explicitly recognizes the importance and value of providing a wide range of constituencies with the opportunity to have a genuine influence on policy. The board's structures and mechanisms greatly emphasize the need for deliberative participatory decision-making (Brown 2010). Despite such pledges, interviews with Executive Board members suggest that these deliberative efforts are undermined by the ability of donor states to effectively set the agenda and the terms of debate. Because they have the power of the purse, the donor states can remove or promote certain alternatives, be more or less generous with their pledges, and steer policies in certain directions that will benefit their interests (Brown 2010). One study of the Executive Board's deliberative practices found that some recipient states felt that the interests of the donors, rather than the recipients, were paramount within the organization and that the health experts consulted by the donor states often lacked local legitimacy or accountability (Brown 2009).

In other words, some recipients felt that the Global Fund talked a good game about being a deliberative and inclusive partnership, but that the donor states still ran the show.

The Global Fund's Successes and Failures

The Global Fund's creation presented the international community with a new type of international organization – one that focused solely on funding rather than program implementation, sought to empower recipient states, and to incorporate state and non-state actors into all levels of the decision-making process. Buse and Tanaka give the Global Fund high marks for clearly identifying its mission and unique strengths and introducing good governance measures, but they chastise the organization for its relative lack of
sustainability, poor country capacity-building measures, and weak organizational effectiveness measures (Buse and Tanaka 2011). Their findings suggest that the Global Fund, while successful in some areas, must address some significant lapses in order to become more useful to the international community and continue its very existence.

First, by creating a primary multilateral source for channeling resources to states in need, the Global Fund has added greater efficiency to the foreign aid process. Bilateral funding, which still makes up the majority of development assistance for health, tends to favor recipients with longstanding or strategic ties to the donor rather than the recipient state's relative need. Bilateral aid flows also do little to promote widespread information sharing and can add administrative costs for recipient countries, meaning that a lower proportion of the aid actually goes to help people (Doyle 2006). Furthermore, existing bilateral and multilateral funding sources proved themselves unable to mobilize enough resources to effectively combat HIV, tuberculosis, and malaria (Bartsch 2007). Since its creation in 2002, the Global Fund has become an increasingly important source of development assistance for health. In its first year of operation, donations to the Global Fund made up less than 1% of all global funds for development assistance for health. By 2007, the Global Fund received 8.3% of the global total of development assistance for health (Ravishankar et al. 2009). By 2009, nearly one quarter of all international assistance for HIV/AIDS went through the Global Fund (Kates et al. 2010). With these funds, the Global Fund is responsible for providing approximately 25% of all HIV/AIDS funding internationally, 67% of the international funding for tuberculosis, and 73% of international funding for malaria (Global Fund 2010a). It distributes approximately 60% of its annual grants to HIV/AIDS programs, 24% for malaria, 14% for tuberculosis, and 2% for health systems development. Roughly half of the grant money goes toward paying for pharmaceuticals and treatment supplies (Lisk 2010).

The funds available through the Global Fund have added to the overall international resource pool for these three diseases. The Fund's allocation decisions are guided by the "additionality principle"—grants provided by the Global Fund should not subtract from other donors' or funding commitments. Instead, Global Fund grants increase the amount of money going to a particular country for work on reducing the effects of these three diseases. They do not replace other funding sources; rather, they fill gaps (Lisk 2010).

Second, the Global Fund's structure and grant application process require a high degree of country ownership that should increase the likelihood of an intervention's success. The Global Fund does not actively seek out grant recipients; it instead employs a "country-defined" or "demand-driven" model. Because the Global Fund cannot implement its own programs, it places the burden on applicants to identify their problems, suggest a solution, and demonstrate the feasibility of their proposal (Kaiser Family Foundation 2009). With such a format, the Global Fund has sought to encourage higher levels of country ownership, bottom-up participation, and opportunities for southern countries to take an active role in global health governance processes. It also empowers the recipient countries to make decisions about potentially sensitive issues, such as the role of generic pharmaceuticals in national treatment strategies and creating prevention strategies that will resonate with local populations (Bartsch 2007). CCMS coordinate a state's application and offer opportunities for a wide variety of actors to take an active role in identifying proper prevention, treatment, and care strategies.

The major problems with the Global Fund tend to focus on the disjunctures between the organization's stated goals and its actual operation. It is one thing to proclaim a new approach to addressing global health needs; it is entirely another thing to put that proclamation into practice. The difficulties faced by the Global Fund implicitly raise questions
about the ability to craft and effectively implement a new approach to international organizations given the existing state of the global health governance architecture.

Realizing the new structures and strategies envisioned by its founders continues to bedevil the Global Fund, and the promises of broad participation from a wide variety of stakeholders have largely failed to materialize. Deliberations within the Executive Board are largely seen as favoring the donor states and giving recipient states and civil society organizations a marginalized voice. The promises of accountability and broad participation run into problems when faced with the realities of the distribution of political and economic power in the international arena (Brown 2009, 2010). The problems with a lack of voice go beyond the Executive Board. CCMs, designed to coordinate a country’s Global Fund application and draw on a wide range of local expertise, frequently fail to involve non-governmental sources. Government ministries tend to dominate CCMs, and NGOs have little or no input in many cases. Where NGOs have formal representation within CCMs, they often face significant obstacles to meaningful participation, such as a lack of funds to travel to meetings or information deficits that limit their ability to contribute to policy-making (Bartsch 2007).

Complaints about the lack of representation for NGOs have not gone unheeded. Current CCM guidelines from the Global Fund recommend that NGOs make up at least 40% of the membership of a given CCM (Global Fund 2008). Prior to the release of these guidelines, there had been a push to mandate 40% as the minimum level of NGO representation on CCMs. CCMs failing to meet this requirement, according to the proposal, would be ineligible to receive Global Fund grants. Ultimately, the Executive Board decided against requiring a minimum level of representation on the grounds that such a requirement would violate the spirit of country ownership (Bartsch 2007). It is an odd position. The Executive Board wants to encourage widespread participation in CCMs so as to encourage a greater sense of country ownership in their projects, but rejects an attempt to require it because that would violate country ownership. In the place of a formal policy, the Executive Board strongly encourages countries to have their CCMs meet the 40% goal, and a Global Fund study suggests that countries are increasing the participation rates for NGOs on CCMs (Global Fund 2008).

More recently, some donors have raised significant questions about the level of oversight that exist for Global Fund grants. In early 2011, Germany announced that it would suspend its €200 million annual contribution to the Global Fund in light of reports of a high degree of corruption. Germany was the Global Fund’s third largest donor, and its decision to withhold payments until it was satisfied that the Global Fund employed sufficient measures to prevent money from going missing, could strike a significant blow to the Global Fund’s financial viability (BBC 2011). Two months earlier, the Swedish government, which had contributed €85 million per year for the previous three years, announced that it would not be making pledges to the Global Fund over its concerns about corrupt activities in four African grant recipient states. Sweden’s AIDS ambassador, when making the announcement, stated that Global Fund officials had failed to adequately investigate the allegations and punish the misdeeds (Usher 2010). Responding to the German and Swedish governments’ charges, a spokesperson for the Global Fund states that its investigations found that $34 million — or 0.3% of all of its allocations to that point — had been misallocated. While decrying those instances, the Global Fund representatives argued that the low amount proved that corruption was not endemic among its grant recipients and that it was the Global Fund’s own accounting requirements that brought the corruption to international attention (BBC 2011). While some have taken the evidence of misallocated AIDS funds as proof that the Global Fund’s systems are inadequate, others have
praised the Global Fund for its vigilance. Roger Bate, a fellow at the American Enterprise Institute, praised the Global Fund’s transparency. He wrote, “If the Global Fund operated like every other multilateral aid agency, we wouldn’t have the information about fraud and other bad behavior that is leading to these funding suspensions. The Fund is admirably open about its failings” (Bate 2011). In November 2011, both countries signaled that they would honor their 2011 financial pledges and would continue to provide funding to the organization during 2012 (IRIN 2011).

Finally, and perhaps most importantly, the global economic downturn has undermined the Global Fund’s ability to fund programs. In November 2011, the Global Fund announced that it would stop making new grants until at least 2014 due to a shortfall in fundraising activities. The previous pledge round, completed in October 2010, raised $11.7 billion – $1.3 billion short of the Fund’s worst-case-scenario “austerity budget” and far less than the $20 billion the organization hoped to raise. Compounding the problem, a number of countries have failed to fulfill their current pledges, some states have stopped making pledges to the Fund, and pressure within the US Congress has raised doubts about the United States’ ability to satisfy its obligations (McNeil 2011). The Fund is establishing a Transitional Funding Mechanism to provide emergency funding to countries to maintain essential services and avoid disruptions in antiretroviral drug access, but it will not permit any expansion of activities (IRIN 2011). The Global Fund is to distribute $10 billion between 2011 and 2013, funding 400 programs in more than 100 countries, but it cannot pay for these programs to add patients or expand services (Brown 2011). As a result, numerous nongovernmental organizations, like South Africa’s Treatment Action Campaign, may not have the financing necessary to continue operations (York 2011).

These shortfalls result from the economic pressures being placed on governments. With most developed countries facing austerity budgets, enthusiasm for overseas development assistance has fallen. As a result, the Global Fund faces “the most dire financial situation it has ever seen since its creation,” according to a statement from Médecins Sans Frontières (York 2011). The continued viability of global health partnerships like the Global Fund to contribute positively to global health depends crucially on their ability to distribute resources. The global economic downturn has not undermined the underlying logic and intellectual support for global health partnerships, but it has severely compromised the international community’s ability to realize their potential. Williams and Rushton (2011) suggest that global health partnerships may weather the economic storm better than governments, but private organizations lack the resources to plug the shortfalls being realized by the Global Fund.

Conclusions

Global health partnerships introduce significant opportunities for public and private entities to collaborate in a mutually beneficial manner to promote good health internationally. When successful, they can leverage the competitive advantages of the partner organizations to produce health outcomes that exceed what each partner could do on its own. Despite such promise, global health partnerships prove incredibly difficult to structure and organize in a manner that will positively contribute to providing necessary services, ensuring some level of sustainability, and incorporating national buy-in from state governments. The successes and failures thus far of the Global Fund demonstrate both how these collaborative arrangements can have a positive effect and how difficult they can be to maintain – even with the best of intentions.
What are the lessons organizers of global health partnerships can draw in order to increase the likelihood of success in the future? The Global Fund's experience emphasizes three important lessons that global health partnerships can draw from in the future. First, global health partnerships must genuinely appreciate and operationalize the notion of "partnership" itself. This has been a particular problem for the Global Fund. It may sound tautological to argue that partnerships require partnership among member organizations, but too many global health partnerships only pay lip service to the roles of stakeholder involvement and genuine dialogue. It is too often the case that certain members of a partnership, particularly NGOs, cannot adequately participate in crafting and implementing the collaboration's mission. Often, these problems arise out of structural imbalances in the partnership's organizational arrangements or informal procedures that remove much of the decision-making from collaborative forums (Buse and Harmer 2007). When this happens, it both undermines the efficacy of the partnership and discourages organizations from entering into other partnerships in which they could have a useful role. Organizations entering into global health partnerships need to ensure that they are willing and actively interested in working with others—even when that means that an organization may not always get its way when designing and implementing programs.

Second, global health partnerships must not forget to work with the governments in whose countries they will be implementing their programs. The Global Fund encourages recipient governments to assume a great deal of ownership, but actual practice sometimes belies these promises. National governments may not formally be part of many partnerships, but ignoring their needs, wishes, and capabilities can seriously imperil the success of a partnership's programs. The multiplicity of global health partnerships can be difficult for national governments to navigate, and onerous reporting requirements can distract from a country's ability to implement health programs (Gconne 2010). A lack of buy-in and commitment from the recipient country is a problem, as are programs that fail to align with the recipient state's own priorities. This is not to say that national governments should always hold veto power over global health partnerships, but such partnerships must recognize that states are not empty vessels into which they can pour their programs. States—even poorly managed ones—retain their autonomy and sovereignty. Working with recipient states in a collaborative manner can thus increase the likelihood that a partnership's programs will achieve a positive outcome.

Finally, global health partnerships, like any other international undertaking, require adequate resources in order to carry out their missions. Increased efficiencies and eliminating corruption can certainly help ensure that more funds go toward programs that help people, but none of these programs can advance if governments surive the partnerships of resources. This is especially important when dealing with an issue like HIV/AIDS, where the interruption of medical services can make a person's health status significantly worse and more difficult to treat. Creating partnerships and then failing to endow them with the resources necessary to carry out their missions both endangers the health of millions around the world and undermines the place of global health on the international agenda.

The future of global health funding looks fairly bleak and the failure of the international community to achieve the health-related Millennium Development Goals may augur the increased importance of global health partnerships (see Chapter 28). By leveraging their combined resources and incorporating both state and non-state actors to work toward common goals, these partnerships may help the international community make meaningful progress toward addressing pressing global health needs. To do this, though, global health partnerships must take proactive efforts to demonstrate their effectiveness, efficiency, and transparency.
Key Reading


References


