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The Global Fund to Fight AIDS, TB and Malaria & Health Systems Strengthening: An Organizational and Policy Analysis

By

Stephanie Elise Weber

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Public Health

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Richard Scheffler, Chair
Professor Thomas Rundall, Emeritus
Professor David Levine

May 2011

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By Stephanie Elise Weber

Abstract

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Professor Richard Scheffler, Chair

Background: Over the last twenty years, despite unprecedented new resources to global health, there has been insufficient progress to achieve the health-related 2015 Millennium Development Goals. Health systems have been perceived as the binding constraint. Major global health agencies have expanded their funding priorities from disease specific programs to include support for health systems strengthening. Strengthening health systems broadly is beyond the mandate of agencies such as the Global Fund. Nonetheless, since its inception, the Global Fund has supported health systems; however, it has had a long-running organizational struggle with how to do it. Mechanisms for health systems support have varied, and proposals for health systems support consistently have been of a lower quality than disease proposals. The Technical Review Panel of the Fund has criticized it for lack of clarity about what it means by health systems strengthening and called into question the Fund's ability to support effective responses to health systems constraints. **Purpose**: The purpose of this dissertation is to present a case study of the Global Fund's policies and strategy on health systems strengthening using the lens of neo-institutional theory. This dissertation explores the role legitimacy and the cognitive beliefs about health systems strengthening held by stakeholders in the Global Fund's environment have played in shaping the Fund's policies on health systems strengthening. **Methods**: Qualitative research methods are used to examine the beliefs about health systems strengthening held by members of Board delegations and the role these beliefs played in shaping the Global Fund's strategy on health systems strengthening. Official Global Fund documents were reviewed and primary data was gathered through 31 semi-structured in-depth interviews with members of the Board delegations, Secretariat, Technical Partner organizations and other relevant stakeholders in the Global Fund's environment to complement the document review. **Findings**: (1) Health system strengthening is a vague concept. (2) Depending on the context, there are two meanings – a technical one and a political one. (3) There is dispute over what constitutes acceptable health systems strengthening work. (4) Health system strengthening is essential for the success of the Global Fund, but there is disagreement over whether the Global Fund should engage in health system strengthening; if it does, how, and to what extent. (5) Linking funding to measurable health outcomes is essential for legitimacy. Health systems strengthening is beyond the scope of the Fund's mandate, current technical capacity and organizational design. The Fund ought to focus on what it does well, which is financing scale up of essential inputs. The Health Systems Funding Platform provides an opportunity for the Fund to support public health system strengthening in a way that will appease key stakeholders but still allow it to stay within the bounds of its disease-specific mission.

For my grandmother, Pura Cordova Herrera (1930-2007)
and
my stepfather, James John Pancotti (1956-2008)

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List of Acronyms

AmFm	Affordable Medicines Facility Malaria
CCM	Country Coordinating Mechanism
CIDA	Canadian International Development Agency
CMH	Commission on Macroeconomics and Health
DAH	Development Assistance for Health
DFID	Department for International Development
FLW	First Learning Wave
GAVI	Global Alliance for Vaccines and Immunisations
GFATM	Global Fund to Fight AIDS, TB and Malaria
GHAI	Global Health Agencies and Initiatives
HSS	Health systems strengthening
IMCI	Integrated Management of Childhood Illnesses
LFA	Local Fund Agents
MAP	World Bank's Multi-Country AIDS Program
MDG	Millennium Development Goals
NGO	Non-Governmental Organization
NSA	National Strategy Application
OAU	Organization of African Unity
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OIG	Office of the Inspector General
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PR	Principal Recipient
SDA	Service Delivery Area
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
UN	United Nations
UNAIDS	UN Joint Programme on HIV/AIDS
UNGASS	UN General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

Over the last twenty years, there has been an unprecedented flow of money, resources and attention to global health. Particularly in the last decade, a plethora of new global health agencies and initiatives have emerged to improve health outcomes in developing countries. Development assistance for health has grown from $5.6 billion in 1990 to $21.8 billion in 2007 (Ravishankar et al., 2009). The proportion of development assistance for health channeled through United Nations agencies and development banks has decreased from 1990 to 2007, whereas the Global Fund to Fight AIDS, TB and Malaria ("Global Fund"), the Global Alliance for Vaccines and Immunisations (GAVI), and non-governmental organizations (NGOs) have become the conduit for an increasing share of development assistance for health (Ravishankar et al., 2009). Much of this scale-up in resources has been focused on commodities and technologies (Ravishankar et al., 2009).

However, even with this huge influx of resources, there has been insufficient progress to achieve the health-related Millennium Development Goals (MDGs) by the target year of 2015.[1] Maternal mortality and under-five mortality rates remain unacceptably high in all regions, but especially in sub-Saharan Africa and South Asia.[2] HIV/AIDS still infects people faster than the pace of antiretroviral treatment roll-out, and inequalities within and across countries are widening (Cometto et al., 2009). Health systems have been perceived as the binding constraint. Since at least 2004, there has been a growing consensus that stronger health systems, including an adequate health workforce, are a necessary step to achieving better health outcomes and meeting the MDGs (Travis et al., 2004).

Over the last five years, major global health agencies and initiatives have expanded their funding priorities from "vertical" programs that are disease or intervention specific to programs that support health systems strengthening. In December 2005, after considering a 2004 study commissioned to review the key barriers to increasing immunization coverage, the GAVI Secretariat concluded the barriers were broader than the immunization system alone and included "health workforce allocation and motivation, transport, fund flow to peripheral levels and planning and management at peripheral levels" (WHO, 2007a). The GAVI Secretariat approved an initial, separate health systems strengthening investment of $500 million for 2006-2010 (WHO, 2007a). The Global Fund, as well, supports health systems strengthening. In 2008, the Global Fund introduced the possibility for countries to apply for a separate funding stream to support "proven and effective interventions . . . that address the three diseases in ways that will contribute to strengthening health systems" (WHO, 2007a).

However, strengthening health systems broadly is beyond the mandate of disease- and problem-specific agencies such as GAVI and the Global Fund. While these organizations recognize the necessity of some system strengthening work to support the achievement of their goals, they are concerned they not be drawn into major investments not specifically in support of their primary mission (Berman et al., 2009). Additionally, organizations like GAVI and the Global Fund are not particularly well-suited to address all system strengthening issues (Berman et al., 2009).

[1] The MDGs target the major poverty-linked diseases devastating poor populations. They focus on maternal and child health and the control of HIV/AIDS, tuberculosis and malaria (WHO 2006).

[2] http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:21725423~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html (Accessed March 14, 2010)

They lack the technical capacity to address cross-cutting issues such as sector financing and sustainability or governance reforms, and their disease- and intervention-specific missions restrict them.

Since its inception, the Global Fund has said that it will support health systems strengthening activities. However, the Global Fund has had a long-running struggle with *how* to support health systems strengthening activities. Mechanisms for requesting health systems strengthening support have varied over funding rounds, and proposals for health systems strengthening support consistently have been of a lower quality than disease proposals (GFATM, 2008e). The Technical Review Panel of the Global Fund has criticized the Fund for its lack of clarity about what it means by health systems strengthening and in 2008 called into question the ability of the Fund to support effective responses to health systems constraints in the Fund's current framework (GFATM, 2008e).

The purpose of this dissertation is to present a case study of the Global Fund's policies and strategy on health systems strengthening using the lens of neo-institutional theory. Specifically, this dissertation explores the role legitimacy and the cognitive beliefs about health systems strengthening held by stakeholders in the Global Fund's environment have played in shaping the Fund's policies and strategy on health systems strengthening. It is hypothesized that certain cognitive beliefs held by stakeholders have pressured the Fund to support a scope of health systems strengthening activities that is beyond its mandate. The Fund, meanwhile, has had to signal compliance to these beliefs to maintain its legitimacy, but has struggled with how to do this signaling and also stay within the bounds of its mandate. Using the data uncovered, this dissertation will (1) identify the underlying reasons why the Global Fund has had a long-running struggle with how to support health systems in its recipient countries; (2) explain why its policies on health systems strengthening have shifted with each round of funding; (3) explain why the guidelines have been unclear about what the Global Fund means by health systems strengthening; (4) explain why proposals for health systems strengthening support have been of a lower quality than disease proposals and more frequently rejected; (5) explain the spectrum of beliefs about health systems strengthening held by various constituencies of the Board; (6) present a picture of the debates among the Board over health systems strengthening; (7) discuss what adopting a broader approach to health systems strengthening means for legitimacy, as well as what rejecting the broader approach means. This dissertation closes with thoughts about what the Fund can do in the future to improve its health systems strengthening policies and strategy while also maintaining its legitimacy as an organization.

Chapter One

Success Has Many Fathers: Origins of the Global Fund to Fight AIDS, TB and Malaria

This chapter is divided into two sections. Section one describes the geo-political context within which the Global Fund was created and the social and organizational motivations to establish the Global Fund. Section two describes the structural and contextual dimensions of the Global Fund according to organizational theory. These two descriptions lay the foundation for the case study of the Global Fund's experience with health systems strengthening presented in Chapter 3.

Part One: Origins of the Fund

"Success has many fathers." These were the words used by one key informant to describe the origins of the Global Fund. This informant was trying to explain that there were many people involved in the creation of the Global Fund, and its origins cannot be traced to any one person. Additionally, there is no consensus on the precise origins of the Fund. Instead, there were a number of critical events around the turn of the century that laid the groundwork for the creation of the Fund, and there were a number of actors, each with slightly different agendas, whose agendas converged around the creation the Fund. Understanding what these events were, who these actors were, and what their beliefs were (and in some cases still are) is critical to this investigation, as the actors' varying agendas and disparity in beliefs contribute to the explanation of why the Global Fund has struggled with health systems strengthening.

In 1996, the world saw its first real victory in the fight against AIDS. Researchers had discovered that protease inhibitors, when used in combination with other antiretroviral drugs, proved highly effective in slowing the pace of damage to the immune system caused by HIV. This combination therapy came to be known as highly active antiretroviral therapy. While highly active antiretroviral therapy was not a cure for AIDS, the discovery of combination therapy transformed HIV infection from a deadly disease to a serious, but manageable, chronic illness. There was just one problem – it was exorbitantly expensive – costing anywhere from $10,000 – $30,000 per year.

AIDS drug assistance programs were developed in the United States to help HIV-positive people without insurance access the lifesaving medicines. However, these programs could not help the 32.5 million HIV-positive people in the developing world, most of whom lived in Sub-Saharan Africa on less than $1 a day. By 2000, 25.3 million people in Sub-Saharan Africa had HIV. 5.8 million people in South and Southeast Asia, 1.4 million people in Latin America, and 349,000 people in the Caribbean were HIV positive. While HIV had penetrated every continent and virtually every country across the globe, it was taking a particularly devastating toll on Africa, where 70% of adults and 80% of children with HIV lived. According to UNAIDS, "the virus in Sub-Saharan Africa threatens to devastate whole communities, rolling back decades of progress toward a healthier and more prosperous future" (UNAIDS, 2000).

In the late '90s, and leading up to the turn of the century, there was a widespread feeling that the

main actors in global health had fallen down on the job of dealing with the HIV/AIDS epidemic and resurging epidemics of both malaria and TB (Board-Multilateral-2; Secretariat-4; Board-Private Foundations-1). "There was considerable unease that the sort of euphemistic 'health community' was not attacking these jobs" (Board-Multilateral-2). There had not been any real success in showing reductions in incidence of HIV or increases in the number of people in treatment (Board-Private Foundations-1). Donors had lost confidence that horizontal investments were effectively addressing real, urgent health needs of countries (Board-Private Foundations-1). They felt money going in was not addressing urgent health problems (Board-Private Foundations-1).

> [I]t's hard for [donors] to feel good when they're putting all this money into health systems – and it frankly wasn't that much money – but putting money into these health systems and yet seeing, you know, all these horror stories of AIDS, TB, and malaria virtually going unchecked (Board-Private Foundations-1).

At the same time, a growing body of concerned and outraged public health practitioners, activists, consumer advocates, academics, and even some lawmakers, were coalescing into a global movement to mount an urgent response to the AIDS pandemic. The aspect of the movement led by civil society[3] was anchored in a human rights framework that valued health as a fundamental human right and emphasized universal access to AIDS treatment. As has been well documented and described by other sources, AIDS activists in the late '90s initiated an impassioned assault on the pharmaceutical industry, the United States government and intergovernmental agencies, such as the World Trade Organization. Activists sought to shame pharmaceutical companies for creating a man-made obstacle to treatment access in the developing world through the exorbitant price of drugs as well as the industry's vigorous opposition to countries importing drugs or manufacturing generic versions.

Activists were spectacularly successful in mobilizing public opinion to support global access to AIDS treatment. Highly publicized protests and "zaps" on Vice President and then Democratic Presidential Candidate Al Gore and US Trade Representative Charlene Barshefsky created enormous pressure on the U.S. government to reverse its policy of threatening trade sanctions against countries (notably South Africa) that pursued compulsory licensing or parallel importing. Activists were also successful in getting the pharmaceutical industry to offer deep price cuts to developing countries on its AIDS drugs. In the words of one AIDS activist, "this was the kind of environment we were acting in, where the Clinton administration had never spent a penny on cheap, quality antiretrovirals and . . . brand name pharmaceutical companies were aggressively, aggressively opposing the idea that generic copies of medicines should be made widely available in developing countries. In fact, they were investing tons – millions of dollars – to oppose that line of thought. I emphasize this because, as you know, things have changed completely over the

[3]Civil society refers to the arena outside of the family, the state, and the market where people associate to advance common interests. According to the London School of Economics Centre for Civil Society, "Civil societies are often populated by organizations such as registered charities, development non-governmental organizations, community groups, women's organizations, faith-based organizations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups." For more information about civil society, see Wikipedia: http://en.wikipedia.org/wiki/Civil_society

last decade" (Board-Civil Society-1).[4]

While AIDS activists were advocating for access to medicines, the WHO, the UN and developing country governments were advocating for more money. Early on, these advocacy efforts were not aligned. The WHO was interested in a scale up in resources for global health more generally, something they called "Massive Effort" (Technical Partner-3). In late 1998, and throughout 1999, cabinet members of the newly elected Director-General of the WHO, Dr. Gro Harlem Brundtland, thought about increased funding for global health and conceived of different ideas for how to achieve support (Technical Partner-3). From the beginning of her tenure in 1998, Dr. Brundtland wanted to be more aggressive about raising the amount of money needed to tackle communicable diseases in developing countries (Technical Partner-3). Around the same time, in parallel with "Massive Effort," colleagues in UNAIDS were thinking about an AIDS fund. "AIDS was very much the issue of the moment. . . . And the vision that they had . . . was very much around AIDS and drugs or commodities, diagnostics and so forth " (Technical Partner-3).

Over the next year and a half, the AIDS stream and the more general health stream planned in parallel (Technical Partner-3). Throughout 1999, there was active thinking within parts of the UN and in the bilateral programs of some G8 countries about what needed to be done in order to get more resources for health generally (Technical Partner-3). Prior to the G8 Summit in Okinawa in July 2000, WHO hosted a planning meeting for "Massive Effort" in Winterthur, Switzerland (Technical Partner-3). After this meeting, Dr. Brundtland's cabinet members wanted to mention the possibility of a new fund in her speech for Okinawa, but were instructed not to mention it (Technical Partner-3).

In December 2000, there was a follow-up meeting in Okinawa on the health agenda. While there was "rumbling in the margins about the creation of a fund," Japan, as the host country, did not make explicit public mention of the fund (Technical Partner-3). By the end of the meeting, "there was a certain amount of frustration that there was a lot of . . . 'backroom talk' about new money and yet real reluctance from the Japanese to be upfront about it" (Technical Partner-3). In January 2001, a small group of G8 members met in Ottawa to talk about a new fund for global health. Members of the group were the "healthist folk" from DFID, the EC, the US, and Canada (Technical Partner-3), and they were interested in a fund to finance commodities and cost-effective interventions (Board-Government-4). The idea did not progress far, as momentum had shifted towards an AIDS fund.

Between January 2001 and April 2001, a number of key events occurred that strengthened the access to AIDS drugs movement as well as the idea of an AIDS fund. First, in January 6, 2001, well-known economist Jeffrey Sachs, along with fellow Harvard economist Amir Attaran, published an article in *The Lancet* calling for an order of magnitude increase in official development assistance for HIV/AIDS. While AIDS had grown into the largest pandemic in history, they argued, funding for AIDS was very low and had not kept pace with the growth of the epidemic (Attaran & Sachs, 2001). Attaran and Sachs proposed a new funding stream of $7.5 billion annually for HIV/AIDS directed toward funding projects "proposed and desired" by

[4] For a more detailed account of the history of the global access to AIDS treatment movement, see *Drugs into Bodies* by Smith and Siplon (2006).

affected countries. They also recommended the new funding stream be based on grants, not loans.

At this time, Sachs was also leading the WHO Commission on Macroeconomics and Health and serving as Special Advisor to Secretary General Kofi Annan. His involvement with the Commission and role as Special Advisor underpinned and legitimized his calls for greatly enhanced resources for AIDS. In the Commission's seminal report published in late 2001, Sachs, along with the other authors, called for a massive scale up of investment in health as a means to economic development. Their rationale was that disease was a major determinant of poverty, and to deal with poverty, one had to deal with disease. This assertion was contrary to previous interpretations of poverty as a cause of disease and viewed health through the lens of its influence on economic productivity, not as a fundamental human right. The Commission recommended a dramatic increase in donor spending – $27 billion by 2007 and $38 billion by 2015 – in the form of grants, not loans. The Commission also revived the vertical approach to eradication of specific diseases, rather than development of integrated national health programs and health systems (Waitzkin, 2003).

Outside of the Commission's work, key events occurred in early 2001 in relation to the price of drugs. In February 2001, the Indian pharmaceutical manufacturer, CIPLA, announced it had achieved production of combination therapy at prices much lower than those purported by drug companies (Smith & Siplon, 2006). CIPLA CEO Yusuf Hamied offered a generic version of combination therapy for $350 – a 96.6% discount of the same combination available in the US for $10,400 (Smith & Siplon, 2006). In the wake of CIPLA's announcement and bad public relations over their lawsuit against the government of South Africa, between March 6, 2001 – April 19, 2001, the pharmaceutical industry began offering price cuts of up to 90% to a number of African countries (Smith & Siplon, 2006). On April 19, 2001, the Pharmaceutical Manufacturers of America dropped their case against South Africa and paid the legal costs for the South African government (Smith & Siplon, 2006). The CEO of Glaxo-SmithKline was quoted saying, "We don't exist in a vacuum," and "public opinion" was "a factor in our decision-making" (Smith & Siplon, 2006). These key events, in combination with the recommendation of the Macroeconomics Commission to support a more vertical approach to health, fueled the idea of an AIDS fund. By April 2001, it was clear to the general health stream that there was "advanced thinking" backed by "higher political forces" (i.e., Secretary General Kofi Annan) for an AIDS fund (Technical Partner-3).

In April 2001, the general health stream decided to join forces with the AIDS stream (Technical Partner-3). There was a critical meeting that month in London, which brought together key U.N. organizations and a few G8 and non-G8 bilaterals. At that meeting, there was agreement that the two streams would join forces and would characterize the effort "as an AIDS and health fund" (Technical Partner-3). After the meeting, some attendees wrote a paragraph for a speech, which was then faxed to Kofi Annan. The next day he delivered the speech in Abuja, Nigeria to African leaders at the summit of the Organization of African Unity (Technical Partner-3; Feachem & Sabot, 2006). In the speech, Mr. Annan called for the creation of a "war chest" of $7-10 billion annually for AIDS alone (Feachem & Sabot, 2006). African leaders endorsed the need for greater efforts to fight HIV/AIDS on the continent and committed their leadership to the cause (Feachem & Sabot, 2006). In May 2001, Mr. Annan went to Geneva to deliver a speech to the World

Health Assembly. In the speech, he talked about "a health and AIDS fund" and made reference to health system strengthening (Technical Partner-3).

After the World Health Assembly in Geneva, the Secretary General called for a consultation to be held within two weeks to get developing countries' reaction to the fund and ensure the UN had a good profile in the initiative. At the consultation, it was agreed that a health and AIDS fund was a good idea that had political legs and that AIDS should feature prominently in the mandate, but the actual format and name were unclear. Health systems were also mentioned. "There was talk about health systems in . . . not a terribly concrete way, but it was there" (Technical Partner-3). Additionally, suspicions of turf and institutional battles began to emerge between countries and between different members of the G8 and UN. "There were a lot of raw nerves, and those raw nerves carried on over the next month into the [UN General Assembly Special Session on HIV/AIDS] 2001" (Technical Partner-3). However, UNGASS was reasonably successful. The Secretary General's call was endorsed at the groundbreaking meeting, and then "[e]veryone started talking about a health and AIDS fund" (Technical Partner-3). The political tension then shifted to whether its birth would be by virtue of the UN or the G8.

The decision to create the new funding stream was taken by Heads of State at the G8 Summit in Genoa in July 2001 (Feachem & Sabot, 2006; Technical Partner-3; Board-Government-4; Government-1; Transitional Working Group-1). The fund was announced and pledges were made (Technical Partner-3; Government-1). The US contributed $1 million in start-up funding to get the organization off the ground. Following the summit in Genoa, a consultative process to determine the structure of the organization brought together governments, private companies, NGOs, and others (Feachem & Sabot, 2006; Technical Partner-3; Government-1; Transitional Working Group-1). This "consultative process" was named the Transitional Working Group and consisted of 45 representatives of various delegations (Transitional Working Group-1). The former Minister of Health of Uganda, Dr. Chrispus Kiyonga, was elected to lead the Transitional Working Group. At the time, he was an eminent Minister without Portfolio in the Office of the President in Uganda.

The Transitional Working Group was in charge of hammering out the details of the new fund. They had to determine what the new fund was going to be about, how it should work, how it should be organized, what it should focus on, and what it would be called, among other issues (Transitional Working Group-1). Agreeing about these things was a significant challenge, as there were a variety of viewpoints around the table. "[W]e spent almost an entire day-and-a-half of the first two-day meeting . . . talking about . . . the Purpose Statement of the Global Fund, which is a statement of about five lines" (Transitional Working Group-1). There were a number of European donors – such as Italy, France, Norway, Sweden and Denmark – who were interested, and adamant, in having a global health fund. They felt strongly that the fund should focus on health in general and not be disease-specific (Transitional Working Group-1). But there were others – the Secretary General among them– who thought the fund should focus on HIV. Activists, as well, wanted the fund to focus solely on HIV. The United States, along with a few other governments and special interest groups who were engaged in malaria and TB, thought the fund should expand beyond HIV to include TB and malaria (Transitional Working Group-1). On one hand, these groups wanted a mechanism that would also get funds to them; however, in the case of TB, there was also a medical rationale, as TB was a frequent comorbidity of HIV/AIDS.

"[T]here was a lot of discussion around . . . what would actually make sense and why should it be health systems or a more general health fund, or why should it be a more, as it is termed these days, 'vertical oriented'— with more vertical orientation on HIV, TB and malaria" (Transitional Working Group-1).

The reasons for the three-diseases approach varied. AIDS activists and special interest groups wanted money for their interest areas and did not want to see the money diluted into something more general. Donors, meanwhile, were pragmatic. They knew that to generate the money required to support the Global Fund as a new organization, the Fund would have to be concrete and understandable and show measurable results. "[P]olitically . . . you had to have something very concrete . . . that you could advocate for [and] put in front of these political people who are signing the checks and passing the appropriations bills" (Transitional Working Group-1). Donors who traditionally supported health systems strengthening were concerned that if they put their funding into something much broader than those three diseases, it would be diluted; then it would be harder to get a strong focus on results and to be able to measure those results (Secretariat-4).

> I don't think it meant that those donors didn't think that health systems were important; I think it was just at that stage they were concerned that a Global Fund for health systems would be a black hole in which it would be near impossible to measure results. And if you can't measure results, you wouldn't be able to get additional resources in the future. Everybody recognized that proving the results was critical to mobilizing future resources (Secretariat-4).

In the end it was decided that the focus would be on AIDS, TB and malaria. The Transitional Working Group met three times in Brussels in late 2001 – once in October, November and December (Transitional Working Group-1). In January 2002, the Global Fund held its first Board Meeting. In July 2002, Sir Richard Feachem was appointed the first Executive Director of the Secretariat, and in December 2002, the Fund made its first disbursement to grantees.

Part Two: Organizational Structure and Design

The Global Fund is a non-profit organization that was incorporated in Geneva, Switzerland on January 22, 2002. It is a public-private partnership between governments, civil society, the private sector and affected communities.[5] The purpose of the Global Fund is to attract, manage and disburse additional resources to prevent and treat HIV/AIDS, tuberculosis (TB) and malaria.[6] Its goal is to reduce the burden of AIDS, TB and malaria,[7] and its vision is a world free from the burden of these three diseases.

The Global Fund was founded on a set of principles that guide all of its activities. These principles include:

- Operate as a financial instrument, not an implementing entity
- Make available and leverage additional financial resources
- Support programs that evolve from national plans and priorities
- Operate in a balanced manner in terms of different regions, diseases and interventions
- Pursue an integrated and balanced approach to prevention and treatment
- Evaluate proposals through independent review processes
- Operate with transparency and accountability[8]

These principles are fully described in the Global Fund's *Framework Document* (GFATM, 2002a).

The Global Fund has seven core structures: the Board of Directors; the Secretariat; the Technical Review Panel; Country Coordinating Mechanisms; Principal Recipients; Local Fund Agents; and the Trustee. At the highest level is the **Board of Directors**. The Board is responsible for the governance of the organization. It is composed of representatives from donor and recipient governments, civil society, the private sector, private foundations, partners (such as UNAIDS, Roll Back Malaria and Stop TB) and communities living with and affected by the three diseases. In total, there are 26 constituencies on the Board. 20 constituencies are voting members and six are *ex officio* members without voting rights. Each constituency is allowed to bring up to 10 delegates per Board Meeting. There are also a number of observers who are allowed to attend Board Meetings. For a list of Board constituencies see Appendix 1.

The Board is responsible for establishing strategies and policies, making funding decisions and setting budgets. Unofficially, Board Members also bear responsibility for raising awareness about the work of the Global Fund and rallying their constituencies to contribute resources to the Fund. The Board carries out its official responsibilities through six committees: Ethics; Finance and Audit; Policy and Strategy; Portfolio; Affordable Medicines Facility Malaria (AmFm); and

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[5] Public-private partnerships are government service or private business ventures that are funded and operated through a partnership of government and one or more private sector companies. Definition accessed online February 13, 2010: http://en.wikipedia.org/wiki/Public%E2%80%93private_partnership

[6] http://www.theglobalfund.org/en/about/?lang=en

[7] http://www.theglobalfund.org/en/performance/impact/?lang=en

[8] http://www.theglobalfund.org/en/how/?lang=en

Market Dynamics and Commodities. The Board meets at least twice annually. The current Chair of the Board is Dr. Tedros Adhanom Ghebreyesus, Minister of Health of Ethiopia. He was elected in July 2009 to succeed the Global Fund's fourth Chair, Mr. Rajat Gupta of the Private Sector.

In many aid organizations, donors' votes are given greater weight, often based on the size of their contribution. The Global Fund's Board is unique in that its membership is divided between representatives from recipient and donor nations and each member's vote is given equal weight (McCarthy, 2007). Additionally, the Board integrates the private sector, private foundations, civil society and communities affected by the three diseases into its governance, thereby creating an innovative governance model. This innovative governance model allows a more complex, "multi-relational" balance of power, one where citizens, companies and governments are working side-by-side to shape policy (Buse et al., 2009). The Board has met 22 times. The Twenty-Third Board meeting will be May 11-13, 2011 in Geneva.

Below the Board is the **Secretariat**, which is responsible for the management of the organization. The Secretariat oversees the day-to-day operations, including mobilizing resources from the public and private sectors, managing grants, providing financial, legal and administrative support, and reporting information on the Global Fund's activities to the Board and the public. The Secretariat also has responsibility for executing Board policies and overseeing monitoring and evaluation. It is based in Geneva, Switzerland and has no staff located outside its headquarters. About 568 employees representing more than 97 nationalities work at the Secretariat's headquarters.[9]

The Executive Director of the Secretariat is Dr. Michel Kazatchkine. Dr. Kazatchkine is the second Executive Director of the Fund. The Board elected him to the position in 2006. Previously, Dr. Kazatchkine had served as Chair of the Technical Review Panel and Vice-Chair of the Board. On the Board, he represented France.

At the Twenty-Second Board Meeting, the Board approved the 2011 Operating Expenses Budget of $324.7 million (GFATM, 2010b). The operating budget has grown considerably since the launch of the organization in 2002, as has the number of employees at the Secretariat. In 2004, the operating budget was $52.7million (up 66% from 2003). However, no donor contributions go toward operating expenses (GFATM, 2010b).

The third core structure of the Global Fund is the **Technical Review Panel**. The Technical Review Panel provides the scientific expertise for the organization. The Technical Review Panel is an independent group of international experts in the three diseases and cross-cutting issues. The Technical Review Panel meets to review eligible grant proposals for technical merit (soundness of approach, feasibility and potential for sustainability) and recommend proposals for funding to the Board. The Technical Review Panel consists of a maximum of 40 experts. The Board appoints each expert for a period of up to four Rounds.[10]

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[9] http://www.theglobalfund.org/en/secretariat/?lang=en
[10] http://www.theglobalfund.org/en/trp/?lang=en

The fourth core structure of the Global Fund is the **Country Coordinating Mechanism**. Country Coordinating Mechanisms provide local control and influence over the content of programs. The Country Coordinating Mechanism is a partnership composed of key stakeholders in a country's response to the three diseases. Each country must establish a Country Coordinating Mechanism in order to apply for Global Fund support. Country Coordinating Mechanisms must include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people living with the diseases. The Country Coordinating Mechanism is intended to link public and private organizations in recipient countries into a network (Buse et al., 2009). Members of the Country Coordinating Mechanism are not paid for their participation. Additionally, the Country Coordinating Mechanism does not handle Global Fund financing itself. It is responsible for designing, writing and submitting proposals to the Global Fund and nominating the entities accountable for administering the funding and overseeing grant implementation. For each grant, the Country Coordinating Mechanism nominates one, or a few, public or private organizations to serve as the Principal Recipient.[11]

The **Principal Recipient** is the fifth core structure of the Fund. The Principal Recipient is the organization responsible for implementation of the grant, including sub-contracting to other organizations. The Global Fund signs a legal grant agreement with a Principal Recipient to receive Global Fund financing directly. The Principal Recipient then uses the financing to implement prevention, care and treatment programs or passes it on to other organizations (sub-recipients) who provide those services. Many Principal Recipients both implement and make sub-grants. There can be multiple Principal Recipients in one country. The Principal Recipient also makes regular requests for additional disbursements from the Global Fund based on demonstrated progress towards the intended results.[12]

The sixth core structure of the Fund is the **Local Fund Agent**. Monitoring, evaluation and verification are the responsibility of Local Fund Agents. Since the Global Fund does not have staff at the country level, it contracts with firms to act as Local Fund Agents. Local Fund Agents are the "eyes and ears" of the organization. They monitor implementation and oversee, verify, and report on grant performance. They are responsible for providing recommendations to the Secretariat on the capacity of the entities chosen to manage Global Fund financing and on the soundness of regular requests for the disbursement of funds. They submit result reports to the Secretariat. Local Fund Agents are selected through a competitive bidding process. The Local Fund Agent is an important part of the Global Fund's fiduciary arrangements. However, it is not an "agent" in the true sense of the word and is not empowered to represent the Global Fund's views or make decisions regarding grants. The Local Fund Agent is also not permitted to undertake a number of activities with respect to any grants that it oversees. The Local Fund Agent:

- May not participate in the design of the grant-funded program;
- May not participate in the implementation of the program;
- May not provide technical assistance to the Principal Recipient or sub-recipients;
- May not provide capacity building to the Principal Recipient or sub-recipients;

[11] http://www.theglobalfund.org/en/ccm/?lang=en
[12] http://www.theglobalfund.org/en/recipients/?lang=en

- May not make decisions on the grant (all decisions are made by the Global Fund);
- May not audit a Principal Recipient for which it is the Local Fund Agent.

The Global Fund normally has one Local Fund Agent in each country where it has approved a grant. This gives the Global Fund access to local knowledge that may be relevant to grant performance. There are some cases, however, where it is not possible to have a Local Fund Agent in the country. In these cases, the Local Fund Agent is based in a nearby country and flies in from time to time to verify grant implementation. [13]

The seventh core structure of the Global Fund is the **Trustee**. The World Bank serves as the Global Fund's Trustee. It is responsible for managing contributions and investing resources according to its own investment strategy. The Trustee makes disbursements from the Trust Fund upon written instruction from the Secretariat.[14]

In addition to these seven core structures, there is an Office of the Inspector General. The mission of the Office of the Inspector General is to provide the Global Fund with independent and objective assurance over the design and effectiveness of controls in place to manage the key risks impacting the Global Fund's programs and operations (risk management). The Office of the Inspector General was established by the Board of the Global Fund in July 2005 and operates as an independent unit of the Global Fund, reporting directly to the Board.[15]

The Technical Evaluation Reference Group serves as an important advisory body providing independent assessment and advice to the Board on issues it determines to require Board attention. Membership of the Technical Evaluation Reference Group is drawn from a range of stakeholders, including practitioners, research institutions, academics, donor and recipient countries, and non-governmental organizations. Members of the Technical Evaluation Reference Group are nominated and confirmed by the Board. The Board also directs the Technical Evaluation Reference Group to examine specific programmatic aspects of the Fund. The Technical Evaluation Reference Group advises the Global Fund Secretariat on evaluation approaches and practices, independence, reporting procedures and other technical and managerial aspects of monitoring and evaluation at all levels. The Technical Evaluation Reference Group carried out the multi-million dollar Five-Year Evaluation of the Global Fund.

The Partnership Forum is a part of the Global Fund's governance structure. The Partnership Forum is a process, not an event. It consists of online discussions in the e-Forum, consultations on Partnership Forum themes at a variety of internal and external events throughout the year, and a stakeholder meeting for invited participants every two years. The Partnership Forum provides a platform for open discussions on Global Fund strategies and policies. It is open to a broad group of stakeholders (including civil society, the private sector and academia) and provides a communication channel for feedback from stakeholders who are not formally represented elsewhere in the governance structure of the Global Fund. In theory, Partnership Forum

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[13] http://www.theglobalfund.org/en/lfa/?lang=en
[14] http://www.theglobalfund.org/en/structures/?lang=en
[15] http://www.theglobalfund.org/en/oig/?lang=en

recommendations guide the decisions taken by the Global Fund Board.[16]

The objectives of the Partnership Forum are to:

- Review and provide feedback on the progress of the Global Fund;
- Develop recommendations on Global Fund strategy, policy and practice;
- Mobilize and sustain political commitment to take actions to fight the three diseases and to ensure sustainable long-term financing.

Previous Partnership Forum meetings were held in 2004 in Bangkok, Thailand, in 2006 in Durban, South Africa, and in 2008 in Dakar, Senegal. There was supposed to be a Partnership Forum meeting in 2010, but the Global Fund's website does not indicate this happened.[17]

Structural and Contextual Dimensions

In this section, the organizational design of Global Fund according to structural and contextual dimensions is presented. Structural dimensions describe the internal characteristics of the organization and contextual dimensions describe the organizational setting influencing and shaping the structural dimensions (Daft, 2007). The Global Fund is an open system organization. As such, the Global Fund interacts with and must continually adapt to changes in its external environment. The environment intervenes on the Global Fund to cause problems, and efforts to make the Global Fund more effective cannot be done through internal design alone (Daft, 2007).

Structural Dimensions

The Global Fund is a highly formalized organization. Its procedures, job descriptions, regulations, policy manuals, and other important documentation such as Board Meeting Notes, grant proposals (both successful and unsuccessful), Technical Review Panel recommendations, grant agreements, progress reports, evaluations, studies, and performance indicators are all written down and publicly available on their website. Access to this degree of information makes the Global Fund a relatively transparent organization. Additionally, the Global Fund is highly specialized. Employees perform tasks that are assigned to them in their job roles. The Global Fund is a tall hierarchy with narrow spans of control. Decisions about funding are centralized; the Technical Review Panel makes recommendations to the Board about what proposals to Fund. However, decisions about the content of proposals are decentralized to Country Coordinating Mechanisms. In their proposals, countries have to be transparent about who is invited to join the Country Coordinating Mechanism, how it is managed, and how the content of the proposal is generated. The professionalism of the Global Fund varies by the five parts of the organization. The top management, middle management and technical core are all highly professional, with many of the employees having ten to twenty years of formal education and training. However, the level of formal education and training for administrative support staff and technical support staff is lower, generally less than ten years. The personnel ratios of the Fund are low.

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[16] http://www.theglobalfund.org/en/partnershipforum/?lang=en

[17] Disclosure: As of February 16, 2010, I am a member of the Partnership Forum.

Contextual Dimensions

The official goal of the Global Fund is to attract, manage and disburse additional resources to prevent and treat HIV/AIDS, TB and malaria. The operative goal of the Global Fund is to disburse around $2.2 billion per year and "significantly [build] demand" from countries (GFATM, 2008a). The Global Fund has an annual resource goal of $8 billion (GFATM, 2008a). In its 2008 Annual Report, the Global Fund stated an objective of making a "sustainable and significant" contribution to the achievement of the Millennium Development Goals. This objective is new and intriguing, as two of the three health-related MDGs are beyond the current mandate of the Fund (they include targets for maternal and child health).

The strategy of the Global Fund is to execute similar activities (i.e., targeted aid) more efficiently than its "competitors" do. In order to do this, the Fund relies on a three-pronged approach. First, it has a narrow mandate. The Fund focuses on three diseases only. Second, the Global Fund is not an implementing agency. It does not operate programs nor does it provide technical assistance to countries. Instead, the Fund relies on a network of partnerships with other development organizations on the ground to supply local knowledge and technical assistance.[18] By operating as a funding agency only, the Fund can remain small and avoid becoming a top-heavy bureaucracy. Third, the Global Fund is results-based and performance-oriented. All Global Fund grants are managed for results through transparent performance frameworks. Fund programs are provided with initial support based on the quality of their applications. In order to receive subsequent financing, programs must demonstrate results against defined, time-bound performance targets. Countries propose targets for approval by the Global Fund.[19]

If donations to the Fund are sufficient, the achievement of its official goal depends on the effectiveness of individual country systems and the structures recipient countries have in place to manage funded activities (Brugha et al., 2004). In practice, this strategy has led to problems. It has become a source of tension as some agencies have felt the Fund, by creating programs without providing technical assistance to countries, imposes "unfunded mandates" to provide assistance (McCarthy, 2007). Additionally, the "hands off" approach has been criticized as the cause of many programs to underperform or even fail (McCarthy, 2007). The Fund, however, stands by its decision not to provide technical assistance. In part, this stance is to enforce the "country-driven" approach where programs are designed and implemented by organizations in the recipient countries, not in Geneva. According to Michel Kazatchkine, the Executive Director of the Fund, "the country-driven approach is essential for the Fund's success" (McCarthy, 2007).

In terms of size, the Global Fund is a small organization relative to the size of the funds it disburses. In 2002 the Secretariat had 25 employees, now it has approximately 568. Its operating budget has grown from $17.9 million in 2003 to $324.7 million for 2011. It disburses approximately $2.2 billion per year. As of May 2011, it has 893 grants for a total approved grant amount of $22.2 billion.[20] In terms of technology, the Global Fund is a low-tech organization. It uses computers for basic word processing, communication, administration and coordination. There are two primary activities of the Global Fund. The first activity is to raise money and the

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[18] http://www.theglobalfund.org/en/how/?lang=en

[19] http://www.theglobalfund.org/en/performancebasedfunding/?lang=en

[20] http://portfolio.theglobalfund.org/

second is to distribute the money in a timely manner to countries through a grant process. The Global Fund communicates with applicants through its website, where it posts "Calls for Proposals," proposal guidelines, proposal forms and funding decisions. The Global Fund also uses its website to solicit donations from private donors. Support from country governments is solicited during meetings known as "Donor Replenishment Meetings." October 4-5, 2010, donors met in New York for the Third Voluntary Replenishment meeting. Donors pledged $11.7 billion to the Global Fund for 2011-2013. These pledges were the largest financial pledge to date for the Global Fund. In 2007, donors pledged $9.7 billion for the period 2008-2010.[21]

The Global Fund's environment can be understood by analyzing its domain, or "chosen environmental field of action," and its sectors (Daft, 2007). The Global Fund operates in the domain of official development assistance (more narrowly, development assistance for health). This domain has ten sectors: industry; raw materials; human resources; financial resources; market; technology; economic conditions; government; socio-cultural; and international. For this chapter, I will discuss only two sectors – *industry* and *market* – as these two sectors define the Global Fund's stakeholders. Industry describes the Global Fund's competitors, industry size and competitiveness and related industries. Market describes the Global Fund's customers, clients, and potential users of products and services.

I divide the Global Fund's industry sector into four groups. The first group is made up of the 30 wealthy nations in the Organization for Economic Cooperation and Development (OECD).[22] The OECD is the global "club" for donors of official development assistance. The development agencies of OECD countries are known as bilaterals, which means state-to-state cooperation. The second group consists of multilaterals. These are the international organizations that represent the interests of all states and promote cooperation between them. Multilaterals include the United Nations; the sub-organizations of the United Nations (e.g., UNAIDS, UNICEF, UNFPA); the WHO; and the World Bank, among others. The Global Fund, as well, is considered a multilateral. The third group of actors consists of the categorical agencies, alliances, and initiatives. The ones of particular relevance to the Global Fund are GAVI, PEPFAR (President's Emergency Plan for AIDS Relief), the President's Malaria Initiative, Roll Back Malaria, and the Stop TB Initiative. The fourth group of actors consists of the private sector, which includes traditional private sector organizations as well as private foundations and non-governmental organizations.

The Global Fund's market sector (its "customers") is a heterogeneous group that includes developing country governments, multilaterals, NGOs, private sector organizations, consultants, and academic institutions. Only governments can apply for funding, but once funding is awarded, the money can be distributed to other actors through sub-contracts. This group also includes the people living with or affected by the three diseases, who are, ultimately, the intended beneficiaries of the Fund's support.

The actors in the Global Fund's industry and market are also its stakeholders. I categorize stakeholders differently than I do actors in the industry and market. Stakeholders belong in four

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[21] http://www.theglobalfund.org/en/replenishment/newyork/

[22] http://www.oecd.org/document/58/0,3343,en_2649_201185_1889402_1_1_1_1,00.html

groups. The first group is the donors. This is a heterogeneous group that includes governments as well as the private sector. Interestingly, there are governments who donate to the Global Fund who are also recipients of Global Fund money (e.g., China, Cameroon, Nigeria, Romania). These countries are not in the OECD. There is also at least one government who donates to the Fund who is neither a recipient nor in the OECD – Saudi Arabia. Both Saudi Arabia and China are considered non-traditional donors. The top two donors to the Fund are the United States and France. As of April 2010, the United States has contributed $4.3 billion and France has contributed $1.9 billion. The next four top donors include the European Commission, Japan, Germany and the Gates Foundation. The European Commission has contributed $1.1 billion; Japan has contributed $1 billion; Germany has contributed $986 million; and the Gates Foundation has contributed $650 million.[23]

The second group of stakeholders is made up of funding recipients. I described this group above in the Global Fund's market sector. The third group of stakeholders consists of the agencies and individuals that supply technical assistance to the Global Fund's programs. This group is also heterogeneous and includes bilaterals, multilaterals, and other categorical agencies. The fourth group of stakeholders includes the organizations whose work is affected by the Global Fund. These are mainly other disease-specific initiatives, such as the World Bank's Multi-country AIDS Program, PEPFAR, Stop TB, Roll Back Malaria, and PMI, among others. Interestingly, many of these organizations also fall into the category of stakeholders who provide technical assistance to the Global Fund's programs. The Global Fund tries to work closely with these organizations so as not to duplicate efforts, impede efforts, or create unnecessary reporting burdens on countries where multiple programs operate simultaneously.

Given the sheer number and diversity of actors in the Global Fund's environment, it operates in a highly complex environment. However, the environment tends to be stable. The domain remains the same over a period of months and years. As such, the Global Fund deals with low-moderate uncertainty. The area of uncertainty that is most important to the Global Fund, and also the one addressed in this dissertation, is resource-dependence. The Global Fund depends on stakeholders in its environment to provide money and technical expertise – resources essential to its operation and survival. It also depends on recipient countries to have strong systems and structures to absorb the additional funds and manage funded activities. This dependence makes the Global Fund vulnerable, and represents an important contingency for the structure and internal behaviors of the Fund. According to organizational theory, organizations facing high uncertainty generally have a more horizontal structure that encourage cross-functional communication and collaboration to help the organization adapt to changes (Daft, 2007). Interestingly, the Global Fund has not responded to environmental uncertainty by increasing the complexity of its internal organizational structure. It is a vertical organization and has remained that way since its inception. Instead, the Global Fund attempts to manage uncertainty by employing buffering and bridging tactics. Of these two, the Global Fund relies heavily on bridging to secure its power vis-à-vis its stakeholders.

Specifically, the Global Fund uses co-optation and strategic alliances to manage its stakeholders. Co-optation is "the incorporation of representatives of external groups into the decision making

[23] http://www.theglobalfund.org/en/pledges/?lang=en

or advisory structure of an organization" (Scott, 2003). The most common form of co-optation is appointing representatives to the Board of Directors; however, co-optation can also occur by appointing representatives to task forces, committees and special interest groups. The Global Fund uses all four. The Board of Directors has members from donors, recipients, the private sector, the World Health Organization, the World Bank, UNAIDS, and communities affected by the three diseases.

Conclusion

Incorporated in 2002, the Global Fund is a public-private partnership between governments, civil society, the private sector and affected communities. Its vision is a world free from the burden of AIDS, TB and malaria. The operative goal of the Global Fund is to disburse around $2.2 billion per year and significantly build demand from countries. The Global Fund operates in a highly complex environment. Its strategy is to execute targeted aid more efficiently than its "competitors" do. If donations to the fund are sufficient, achieving its official goal depends on the effectiveness of individual country systems in the structures recipient countries have in place to manage funded activities. The next chapter describes the literature on health systems strengthening in the context of the Global Fund and presents a conceptual framework for health systems strengthening.

Chapter Two

Setting the Stage for the Organizational and Policy Analysis

This chapter reviews the literature on health systems strengthening in the context of the Global Fund. The review presents a conceptual framework for health systems strengthening. This conceptual model allows categorization of the range of activities falling under the term "health systems strengthening" and the roles of various organizations in supporting health systems. Next, the chapter gives an overview of the Global Fund's experience with health systems strengthening over time and describes the problem statement for this dissertation. Following the problem statement, specific aims and research questions are presented and the theoretical framework guiding the research is discussed.

Literature Review

Over the last seven years, health systems strengthening has emerged as a priority on the global health policy agenda. Leading global health financing institutions and donors have rewritten their strategies to stress the importance of health systems strengthening, and substantial financial support has been committed by donors to strengthening health systems in developing countries (Berman et al., 2009). Health systems strengthening also enjoys strong political support in high-level fora such as the G8 and H8. Shakarishvili et al. (2009) argue that the reason for this high-level support and rise on the policy agenda is that there has been a critical shift in thinking about how to achieve better health outcomes to meet the MDGs by 2015. According to Shakarishvili et al. (2009), around the time the Global Fund was created, the prevailing belief was that stronger health systems (including adequate capacity) would emerge as an outcome of increased investment in disease control. Now, they argue, strong and effectively functioning health systems are considered a prerequisite for disease-specific projects to meet their goals; and there is an increasing recognition that broader health systems strengthening needs to accompany the scale-up of stand-alone programs (Shakarishvili et al., 2009). This recognition has direct implications for the Global Fund and other high profile disease or intervention-specific initiatives, such as the GAVI Alliance.

Accompanying the momentum of health systems strengthening has been a movement for global health partners to collaborate and better coordinate their health systems strengthening activities. However, coordination is difficult because there is no consensus on what health systems strengthening means, how to do it, or how to analyze health systems strengthening investments (Berman et al., 2009; Shakarishvili et al., 2009). Part of the problem with defining health systems strengthening is that there is not a common conceptual framework around health systems. Different agencies and scholars have different ways of describing and analyzing health systems. This conceptual diversity around health systems leads to confusion about what constitutes health systems strengthening and the various roles global partners should play in supporting health systems strengthening (Shakarishvili et al., 2009; Berman et al., 2009). In this chapter, I describe the health system framework put forth by the WHO in 2007 and adopted by the Global Fund. I also describe a conceptual framework for health systems strengthening forward by Berman and colleagues.

In its *2000 World Health Report*, WHO defines *health systems* as "comprising all the

organizations, institutions, and resources that are devoted to producing *health actions*" (WHO, 2000). Health actions are "any effort whether in personal health care, public health services, or through intersectoral initiatives, whose purpose is to improve health" (WHO, 2000). The report outlines three fundamental goals of the health system:

1. Improve the health of the population
2. Respond to people's expectations
3. Provide financial protection against the costs of ill health (also described as fairness in financial contribution) (WHO, 2000)

The report operationalizes the goals through four functions:

1. Service provision
2. Resource generation
3. Financing
4. Stewardship (WHO, 2000)

The objective of the *2000 World Health Report* was to measure how well health systems around the world attained these goals and to rank health systems.

In 2007, WHO furthered its work in health systems through its report *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes* (WHO, 2007b). This document outlines the "building blocks" of health systems, *vis a vis* the aforementioned goals. They added the additional goal of improved efficiency to the original three. The 2007 report defined system building blocks (Table 1); however, it did not develop specific process indicators for the building blocks.

Table 1: Definition of WHO Health System Building Blocks

Service Delivery Delivery of effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.
Health Workforce Working in a responsive, fair, and efficient way to achieve the best health outcomes possible, given available resources and circumstances; i.e. there are sufficient numbers and mix of staff, fairly distributed, and they are competent, responsive and productive.
Information System Ensuring that ensure the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance, and health status.
Medical Products, Vaccines, and Technologies Ensuring equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy, and cost effectiveness, and their scientifically sound and cost-effective use.
Health Financing Raising adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them

Leadership / Governance Ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.

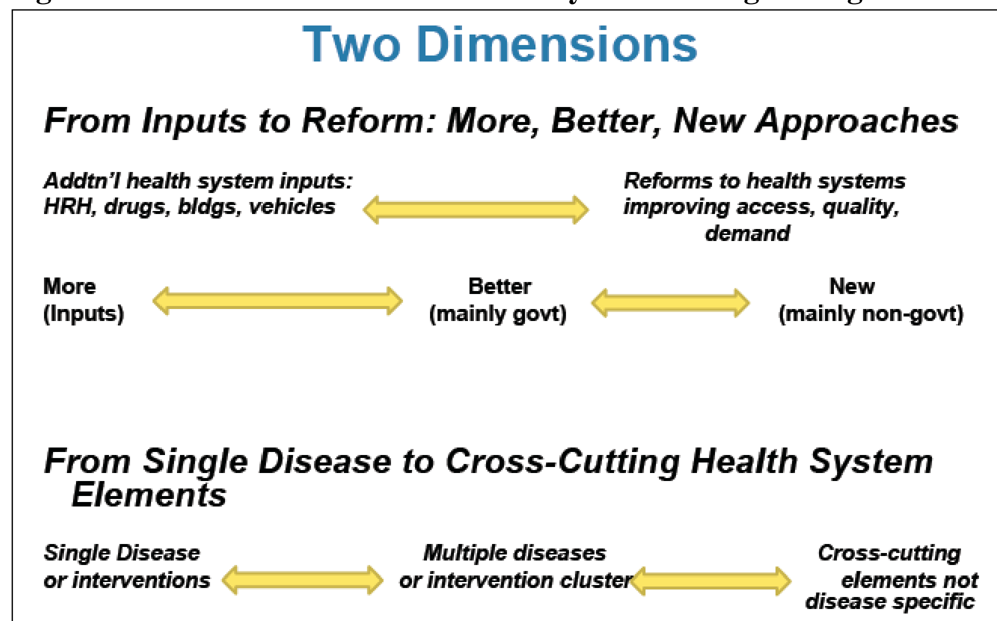
Source: WHO, 2007b

The Global Fund adopted the building blocks framework in its guidelines to applicants to attempt to clarify what it means by health systems strengthening.

In their 2009 paper, "Unpacking health systems strengthening," Berman and colleagues offer an approach to the discussion about what constitutes health systems strengthening and the various roles global partners could play in supporting health systems strengthening. Rather than defining health systems strengthening, they argue it is better to understand there are many different types of health systems strengthening efforts.

Berman and colleagues use a framework of "Two Dimensions" to explain the scope of health systems strengthening activities. One dimension involves types of actions to strengthen health systems. This dimension is a continuum of "more" resources (mainly inputs) to "better" uses of resources through existing channels (mainly government) to use of resources through "new" channels/actors (mainly non-governmental). Activities range from additional health system inputs – such as more health workers, drugs, vehicles, equipment, buildings – to health system reforms that improve access, quality and demand. Reforms change the processes by which the health system accepts inputs and translates them into results. In this dimension, reforms can target the government ("better") or the private sector ("new").

Figure 1: "Two Dimensions" of Health Systems Strengthening Activities

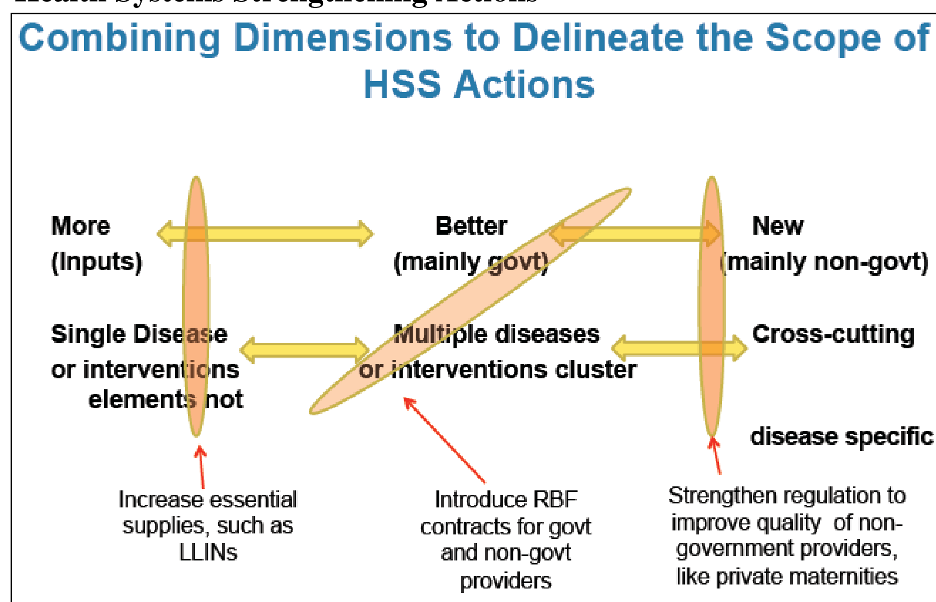


Source: Berman et al., 2009

The second dimension focuses on the types of services addressed by health systems strengthening. It runs from "single disease" (or intervention) to "multiple diseases" (or

intervention clusters) to "cross-cutting" health system elements (not disease-specific). "Multiple diseases" (or intervention clusters) are activities that address many health problems at once, such as reproductive health or integrated management of childhood illnesses. Activities that are "cross-cutting" are not disease-specific and instead attempt to address issues across the health system, such as regulatory frameworks. Combining these two dimensions helps to delineate the scope of health systems strengthening activities.

Figure 2: Combining Dimensions to Delineate the Scope of Health Systems Strengthening Actions



Source: Berman et al., 2009

For organizations like the Global Fund, the second dimension is particularly important. The Global Fund recognizes that addressing cross-cutting elements are sometimes essential to improving health system performance for the three diseases that are its mandate, however, it is also concerned that it not be drawn into major investments not specifically in support of its primary mission (Berman et al., 2009). Additionally, the Global Fund is not particularly well-suited to focus on cross-cutting health systems strengthening issues such as sector financing and sustainability or governance reforms (Berman et al., 2009). The Global Fund is better suited to finance scale-up of essential inputs – such as anti-retrovirals, bed-nets and human resources – that links them more closely with "more" strategies (Berman et al., 2009).

The Global Fund and Health Systems Strengthening

The Global Fund has a long history with health systems strengthening. Since its inception, the Global Fund has said that it will support health systems strengthening activities; however, the way it has allowed countries to apply for health systems strengthening support has evolved considerably over time. Mechanisms have varied over funding rounds, and, consistently, HSS proposals have been of lower quality than disease-specific proposals. Chapter 3 presents a history of the Fund's experience with health systems strengthening. This chapter gives an overview of the policy changes to allow the reader to better understand the problem statement this dissertation will address.

The *Framework Document* of the Global Fund states that the Fund will support programs that "address the three diseases in ways that will contribute to strengthening health systems" (GFATM, 2002a). To date, there have been ten rounds of funding. In Rounds 1-3, applicants had the option of applying for health systems strengthening expenditures through a 'cross-cutting' (or "Integrated") component that was in addition to the three stand-alone disease components (plus an HIV/TB component). Applicants could request funds through this "integrated" component for programs addressing system-wide or 'cross-cutting' issues relevant to the fight against the three diseases.

Round 4 continued the separate "Integrated" component but with increased information on what could be requested. Guidelines defined this system-wide approach with cross-cutting aspects to strengthening health systems as "a comprehensive response to the three diseases." In Round 5, the application format changed. In an effort to improve upon and clarify the "Integrated" component in Round 4, the Global Fund introduced a separate "Health Systems Strengthening" component. In practice, the guideline definitions for both were very similar (WHO, 2007a).

In Round 6, the application format changed again. There was no longer a separate component for health systems strengthening. Instead, applications for activities to strengthen health systems had to be included within the disease component for which such activities were deemed necessary. Round 7 used the same approach as Round 6, but introduced the notion of a health system "strategic action" within the disease component. "Round 7 guidance more explicitly allows applicants to request funding for cross-cutting health systems strengthening actions that will benefit other components, whether or not these are included in the application, provided that there is no duplication of funding" (WHO, 2007a).

In Round 8, the Global Fund reverted back to the strategy of a separate "Health Systems Strengthening" component for cross-cutting issues. Countries could apply for support for health systems strengthening activities if they had identified "gaps and constraints" in the health system that had an impact on HIV, TB and malaria outcomes (GFATM, 2008f). The interventions had to be 'cross-cutting' and benefit at least two of the three diseases. Applicants were guided to include requests for health systems strengthening within specific disease proposals 'whenever possible', but could use the separate health systems strengthening component if necessary (GFATM, 2008f). The health systems strengthening component could be included in only one disease proposal. (Countries are allowed to submit one proposal per disease for each Round.) The process for Round 9 and Round 10 was similar to that of Round 8 (GFATM, 2009d). In 2009, the Global Fund launched the First Learning Wave of National Strategy Applications in an effort to contribute to broader health systems strengthening.

Despite this long history, internal and external reports have indicated a persistent lack of quality in health systems strengthening proposals (WHO, 2007a; GFATM, 2008e; GFATM, 2009d). Over succeeding rounds, a greater proportion of HSS proposals have been judged below standard compared to disease-specific proposals (GFATM, 2008e). Additionally, the overall quality of health systems strengthening proposals has not improved much over subsequent rounds (WHO, 2007a). Round 8 saw the highest success rate of health systems strengthening proposals to date – 53%. The success rate for health systems strengthening proposals in Round 9 declined a bit to

50% (GFATM, 2009d). For Round 10, the Technical Review Panel did not report the success rate for health systems strengthening proposals, rather it reported the success rate of disease-specific applications and integrates the 4B health systems strengthening component with these figures (GFATM, 2010e).

The problems with proposals have varied from Round to Round. In Rounds 5 and 6, proposals were "too broad, ambitious and vague in their objectives and/or proposed activities, work plans and budgets" (WHO, 2007a). In Round 6, some proposals suggested health systems strengthening activities that were very likely to undermine other elements of the health care system (WHO ,2007a). Also in Round 6, the Technical Review Panel noted "there remained a lack of justification for proposed HSS activities on the basis of specific constraints faced by countries" (WHO, 2007a). In Round 8, few countries identified their health systems strengthening needs by reference to a recent in-country review of constraints and gaps in the health system (that would act as bottlenecks in the achievement of disease outcomes) (GFATM, 2008e). In both Rounds 6 and 9, the Technical Review Panel noted the failure of many proposals to locate their health systems strengthening activities within the broader national context, specifically, within a national health strategy (WHO, 2007a; GFATM, 2009d). Also in Round 8, the Technical Review Panel criticized the Global Fund's insistence on links to heath outcomes for health systems strengthening activities:

> The Global Fund's strong emphasis on HIV, TB and malaria outcomes will prove problematic for countries in their elaboration of effective responses to HSS constraints that are fundable through the Global Fund's framework. (GFATM, 2008e)

This criticism by the Technical Review Panel seems to call into question the ability of the Global Fund to support health systems strengthening more broadly within its current mandate.

To improve the quality of health systems strengthening proposals, in Rounds 8 and 9, the Global Fund suggested countries use the WHO "Health System Framework for Action" to develop interventions. Upon reviewing the proposals, the Technical Review Panel noted that "countries seemed to use the ideas and examples from the building blocks quite literally" and described "mechanical and formulaic presentations of needs" (GFATM, 2008e). The Technical Review Panel noted in Round 9 that applicants often requested a "shopping list" of all theoretical health systems strengthening needs without giving thought to longer term health systems strengthening programmatic planning and expected impact (GFATM, 2009d). Additionally, in Round 9, the Technical Review Panel found there was a general lack of understanding among applicants regarding the difference between health systems strengthening interventions that should be included in the disease-specific section versus in a health systems strengthening cross-cutting component (GFATM, 2009d).

In Round 10, the Technical Review Panel indicated that its experience and current thinking in WHO suggest that the WHO "building blocks" do not make suitable service delivery areas for articulating funding support for HSS interventions (GFATM, 2010e). Additionally, discussions with Technical Partners leading up to the Round 10 Technical Review Panel review highlighted the fact that proposals to strengthen health systems, regardless of whether these interventions

were ultimately incorporated into the disease proposal or submitted under the HSS section of the proposal form (section 4B/5B), did not receive the same level of support from Technical Partners as did efforts to develop the disease-specific proposals (GFATM, 2010e).

In parallel with Round 9, in early 2009, the Executive Director of the Global Fund and the Chief Executive of GAVI informed the High-Level Taskforce on Innovative International Financing for Health Systems of their intention "to begin jointly programming GAVI Alliance and the Global Fund resources towards health systems strengthening" (Berman et al., 2009). In March 2009, the Global Fund, GAVI and the World Bank, with technical support from the WHO, launched inter-agency consultations on aligning health systems strengthening funding frameworks with the goal of "a common HSS investment strategy" (World Bank, 2009). The Global Fund is currently pursuing a Pilot of the joint programming, which will be described in more detail in Chapter 3.

In light of the opportunity afforded by this joint programming, the Technical Review Panel urged the Secretariat and partners (WHO, GAVI and World Bank) "to ensure that lessons learned from the various stakeholder experiences to date with health systems strengthening be fully leveraged to improve guidelines to countries, to simplify the application materials, and that adequate provision for technical support is made available to health systems strengthening applicants prior to the launch of Round 11" (GFATM, 2010e).

Problem Statement

The Global Fund is dependent on stakeholders in its environment for essential resources. All of these stakeholders have representation on the Global Fund's Board, and each has an essential role to play in the Fund's progress toward its goals. Donor governments, private foundations and the private sector provide money; technical partners provide technical assistance to the Secretariat and country applicants; civil society delivers services and advocates for more resources; and recipient country governments set country priorities and implement and monitor programs. To maintain its legitimacy as an organization, and thereby ensure continued access to essential resources, the Global Fund must appease its stakeholders by conforming to their cultural-cognitive beliefs. Sometimes, however, these beliefs conflict with each other – as well as with the mandate of the Fund. When this conflict happens, the organization experiences technical failures, as illustrated by the Fund's experience with health systems strengthening. Conflicting beliefs lead to poor policies around how countries apply for health systems strengthening support. These poor policies result in confusion and frustration on the part of country applicants and missed opportunities in poorly designed health systems strengthening applications to the Fund.

Specific Aims

The goal of this dissertation is to understand the role legitimacy has played in shaping the Global Fund's strategy and policies on health system strengthening. Using the lens of neo-institutional theory, this dissertation examines the way the Global Fund's strategy on health systems strengthening was established and maintained. Beliefs about health systems strengthening held by various constituencies on the Board are investigated to understand legitimacy. This dissertation uses qualitative research methods and the case study approach to examine beliefs

and the role of these beliefs in establishing the Global Fund's strategy on health systems strengthening. In particular, the beliefs of past and present members of Board delegations about health system strengthening are examined.

Research Questions

1. What does the Global Fund mean by health system strengthening?

2. What have been the organizational policies and activities of the Global Fund (not the recipient countries) towards health system strengthening?

3. What has been the role of various Board delegations in shaping the Global Fund's policies and activities around health system strengthening?

4. What does the Global Fund need to do in the future to improve its health system strengthening policies while maintaining its legitimacy as an organization?

At the end, this dissertation addresses what the Fund can do in the future to improve its health system strengthening strategy while maintaining its legitimacy as an organization.

Theoretical Perspective

The theoretical perspective used in this research is a dominant trend in institutional theory called new institutionalism. Before defining new institutionalism and applying to this research, let me first define institutional theory.

Institutional theory is a position within organizational theory that focuses on the interaction between the institution (i.e., the organization) and the institutional environment. Specifically, institutional theory considers the processes by which social structures in the institutional environment – such as schemas, rules, and norms – become established guidelines for institutional behavior.[24] Different aspects of institutional theory explain how these social structures are created, diffused, adopted and adapted over time.[25] Institutional theorists assert that the norms and values in the institutional environment strongly influence the development of formal structures and behaviors in the organization, often more profoundly than market pressures.[26]

New institutionalism favors the view that organizational success is not solely dependent on "efficient coordination and control of productive activities" (Rundall et al., 2004). Rather, success depends on the organization "conforming to and becoming legitimated by" stakeholders in its environment (Rundall et al., 2004). From this perspective, organizations survive and succeed by adopting structures and processes to conform to the norms and values espoused in the institutional environment. Adoption of these norms and values pleases stakeholders and helps the organization achieve and maintain legitimacy (Daft, 2007).

Legitimacy is "a condition that reflects the alignment of an organization with the normative, regulatory and cultural-cognitive rules and beliefs prevailing in the organization's wider field and social environment" (Scott et al., 2000 referencing Scott, 1995). Normative, regulative and cultural-cognitive elements each provide a somewhat different basis for legitimacy. Normative legitimacy stresses "internalization of and compliance with collective values and norms: legitimacy as morally governed behavior" (Scott et al., 2000). Regulative legitimacy stresses "conformity to rules and, if necessary, the exercise of rewards and penalties: legitimacy as legally sanctioned behavior" (Scott et al., 2000). Cultural-cognitive legitimacy stresses "consistency with cultural-cognitive schemas and models: legitimacy as recognizable, taken-for-granted structures and behavior" (Scott et al., 2000). This dissertation focuses on the cultural-cognitive legitimacy forces at work on the Global Fund and does not deal deeply with the forces of regulative and normative legitimacy.

New institutionalism emphasizes cultural-cognitive forces in institutional environments (Scott et al., 2000). A set of constitutive rules resides in the institutional environment – templates and archetypes provide "models" for structural design, while schemas (thought patterns) and scripts provide "menus" for routines and actions (Scott et al., 2000). Organizations absorb and incorporate these rules and use great effort to ensure the visibility of these rules to outsiders (Scott, 2003). This dissertation analyzes how the Global Fund has absorbed and incorporated

[24] Accessed March 9, 2010: http://en.wikipedia.org/wiki/Institutional_theory

[25] Ibid.

[26] Accessed March 9, 2010: http://faculty.babson.edu/krollag/org_site/org_theory/Scott_articles/rs_insti_theory.html

the templates, archetypes, schemas and scripts for health systems strengthening over time.

The extent to which an organization is judged to conform to appropriate procedures (normative legitimacy), legal rules and codes of ethics (regulatory legitimacy), and taken-for-granted beliefs (cultural-cognitive legitimacy) has critical implications for the survival of the organization (Scott et al., 2000). As such, organizations will conform to these three forces even in situations where no specific technical advantages are obtained (Scott, 2003). In other words, formal structures may not be rational – they will reflect the expectations and values of the environment rather than the demand of work activities (Daft, 2007).

Figure 3: Conceptual Model of Three Forces in Environment that Influence Legitimacy

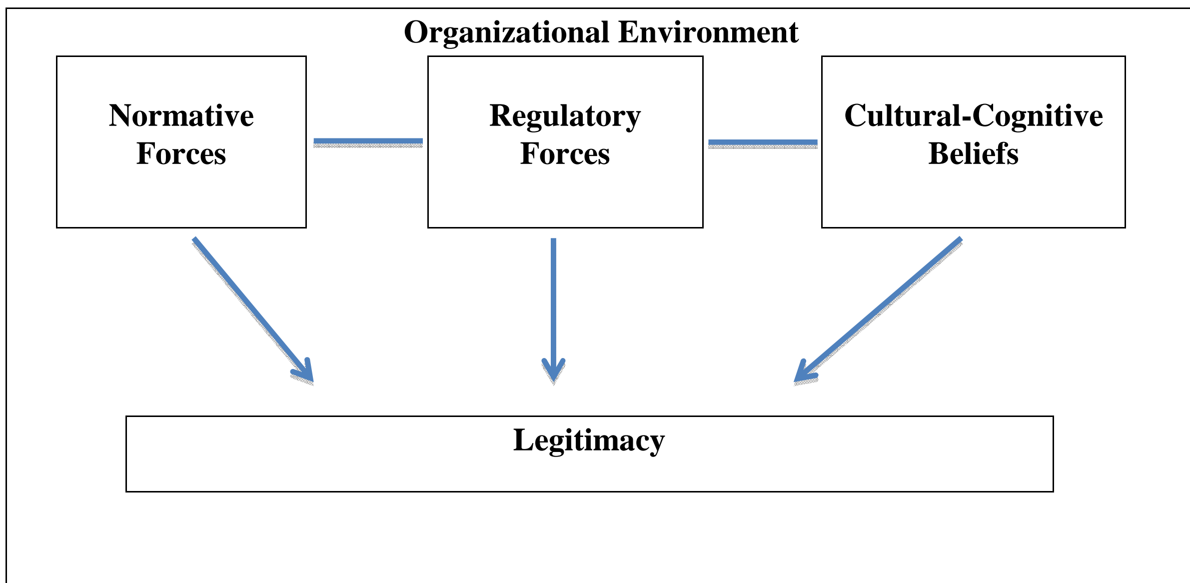


Figure 3 presents a conceptual model showing the three forces in the organizational environment – normative, regulatory, and cultural-cognitive – that influence an organization's legitimacy. These three forces are equally important for legitimacy. As described previously, each element provides a somewhat different basis for legitimacy. An organization's survival depends on signaling compliance with these forces to key stakeholders in its environment.

Methods
In this dissertation employs qualitative research methods and the case study approach to examine beliefs about health systems strengthening held by members of Board delegations. The role these beliefs played in shaping the Global Fund's strategy on health systems strengthening is also examined. The aim is to understand the way the Global Fund's strategy on health systems strengthening was established and maintained.

The first step in this research was to review official Global Fund documents. The Global Fund's *Framework Document*; the Guidelines and Proposal Forms used in funding Rounds 1-10 (n=20); the reports of the Technical Review Panel for Rounds 2-10 (n=9) [27]; the reports of Board Meetings (n=22); and the reports of the 12th, 13th and 14th meetings of the Policy and Strategy Committee (n=3) were reviewed. Any reference to health systems strengthening was excerpted and used to construct a case record. Using this case record, a timeline of Board Decisions, subsequent policy changes, and outcomes was created. Global Fund-related documents, such as the "Shakow Report" (Shakow, 2006); the *Global Fund 5-Year Evaluation* (TERG, 2009); three advocacy documents created by civil society Board Members; the WHO *Report to the Secretariat on the Global Fund's Strategic Approach to HSS* (WHO, 2007a); the WHO 2007 report, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes* (WHO, 2007b); the guide to applying for health systems strengthening support from the Global Fund created by Physicians for Human Rights and HS20/20; and the Report of the High-Level Taskforce on Innovative International Financing (TIIFHS, 2009) were also reviewed.

The document review was complemented with primary data collection gathered through 31 semi-structured in-depth interviews with current and former members of Board delegations; current and former employees of the Secretariat; a former member of the Technical Evaluation Reference Group; current and former employees at Technical Partner organizations; current and former employees at multilateral institutions; former employees of a bilateral ("Government"); and a former member of the Transitional Working Group. Interview requests were emailed to 75 people. 31 subjects were interviewed. 15 declined. 29 did not respond. Utilizing existing knowledge and contacts, informants were purposefully sampled. The "snowball" sampling methodology was also utilized. Subjects were recruited via email using a subject recruitment email. To this email a description of the research, the interview guide (see Appendix 2), and my CV were attached. 23 informants were recruited using the snowball technique.

Table 2: Summary of Recruitment of Interview Subjects

Relationship to Global Fund	Contacted	Interviewed	Declined	No Response	Referred to Others
Board	44	15	7	22	13
Secretariat	11	8	1	2	8
Technical Review Panel	1	0	1	0	0
Technical Eval. Ref. Group	1	1	0	0	0
Technical Partners	1	1	0	0	0
Multilaterals (not on Board)	6	4	1	1	4
Government (not on Board)	2	1	0	1	1

[27] There is not a TRP Report for Round 1.

Transitional Working Group	1	1	0	0	1
GAVI Alliance	3	0	1	2	0
"Other"	5	0	4	1	4
Total	**75**	**31**	**15**	**29**	**32**

Table 3: Breakdown of "Board" Category from Table 2

Board Constituency	Contacted	Interviewed	Declined	No Response	Referred to Others
Canada, Germany, Switzerland	1	1	0	0	1
Communities	1	0	0	1	0
Developed Country NGO	5	3	0	2	2
Developing Country NGO	6	2	2	2	1
Eastern Europe & Central Asia	0				
Eastern Mediterranean Region	0				
Eastern & Southern Africa	6	0	0	6	0
European Commission	0				
France & Spain	1	0	0	1	0
Italy	0				
Japan	0				
Latin America & Caribbean	0				
Point Seven	1	1	0	0	1
Private Foundations	3	1	2	0	2
Private Sector	4	2	2	0	2
Southeast Asia	1	0	0	1	0
UK & Australia	1	1	0	0	1
USA	3	1	0	2	0
Western and Central Africa	0				
Western and Pacific Region	1	0	0	1	0
UNAIDS (non-voting)	3	0	1	2	1
WHO (non-voting)	2	0	0	2	0
World Bank (non-voting)	2	2	0	0	2
Swiss Member (non-voting)	0				
Partners (non-voting)	1	0	0	1	0
Observer (non-voting)	2	1	0	1	0
Total	**44**	**15**	**7**	**22**	**13**

Interviews were conducted between October 2010 and March 2011. All interviews, except for two, were conducted over Skype. The software "Call Recorder" was used to record the interviews of subjects who consented to be recorded. For subjects who did not consent to recording, notes were taken by hand and later transcribed. Only 6 subjects did not consent to recording. 25 interviews were recorded. Recorded interviews were then transcribed and edited for accuracy. All subjects agreed to be interviewed on the condition of anonymity. As a result, extra measures were taken to ensure the protection of subject privacy and confidentiality of subject data. In the write up of the case study and results, no subject is personally identified. Instead, a key is used to identify subjects. The key is presented in Appendix 3. In the write up, there is not a distinction between current and former Board delegates, as this distinction is too personally identifying. However, Board delegates are identified according to their delegation, as that identification is important for the case study and analysis. Follow-up interviews were conducted in April 2011. 11 subjects required follow-up for clarification of their data. The recruitment strategy was to represent the viewpoints of as many delegations as possible. This breadth of sampling provided a wide range of perspectives and addressed issues of external validity.

To conduct the analysis, results of the document review were combined with results of the interviews. This combination explains the historical pattern of the Global Fund's approach to health system strengthening. Chapter 3 presents a detailed, comprehensive case study of the Global Fund's experience with health system strengthening. This case study shows the Global Fund's struggle with legitimacy and describes how certain constituencies on the Board tried to expand the mandate of the Fund to include a fourth leg for health systems strengthening activities, while other constituencies resisted this expansion.

The research began with ten cultural-cognitive beliefs about health systems strengthening (confirmatory codes), but these codes were modified to reflect emerging codes/themes that were not apparent at the start (inductive coding). Only inductive codes were used to analyze the data. See Appendix 4 for a list of the inductive codes and their meanings. These codes are anchored in the theoretical framework of neo-institutionalism as well as Berman's framework of Two Dimensions. The codes reflect the conceptual diversity around what people believe health systems strengthening means in the context of the Global Fund and what it ought to mean. Codes to explain what delegations on the Board believe ought to be the role of the Global Fund in health systems strengthening going forward were also used.

To code the data and analyze the codes, the analytical software "Dedoose" was used. To code the data, transcripts were uploaded to Dedoose and then reviewed. Excerpts of text were highlighted and the relevant codes applied. After coding the data, the "immersion and crystallization" technique was used to determine patterns in the data. Excerpts for each code were downloaded, printed and reviewed to determine patterns (i.e., "themes"). Of particular interest were patterns by code, as well as patterns of code co-occurrence, especially occurrences of three or more codes. Four separate notes documents were created for the patterns. The first document listed overall patterns. These were themes that occurred across many interviews. The second document listed the reasons subjects gave for supporting the health system strengthening "not tied to the three diseases" and "tied to the three diseases." These reasons were not parsed out by subject, but rather were overall trends. The third document lists subject by subject how the subject defined

health system strengthening and what the subject believed ought to be the role of the Global Fund in health systems strengthening. Any comments, critiques or suggestions subjects gave for the Global Fund, many of which were not specific to health systems strengthening, were also included. The fourth document analyzed trends by code and subject. To do this, code excerpts were reviewed and a list of subjects and corresponding belief as indicated by code was created. This process was laborious and time-consuming and ultimately yielded many overlapping findings. However, it allowed patterns of code co-occurrences by subject to emerge. Chapter 4 presents the results of the analysis. This chapter focuses on dominant trends as well as beliefs by Board delegation.

Human Subjects

The study received IRB approval by the UC-Berkeley Committee for the Protection of Human Subjects on October 22, 2010. Participation in the study was voluntary and each participant was given a written description of the project in advance of the interview. Oral consent was obtained to audio-record the interviews. Participants were allowed to decline to answer any question at anytime and to stop the research at anytime. Research did not pose risk "above that of daily life," however the identity of all interview subjects will be kept confidential in the presentation of the findings.

Implications

The Global Fund is one of the largest financiers in global health. The Global Fund has a total portfolio of 893 grants valued at $22.2 billion in grants in 150 countries.[28] It is the main source of financing for programs to fight AIDS, TB and malaria providing a quarter of all financing for AIDS, two-thirds for TB, and three-quarters for malaria.[29] An estimated 35% (or about $7 billion) of total approved financing supports health system components. Its status as a major donor in global health means that the Global Fund influences health systems directly through the resources it provides and indirectly through its guidelines and investment decisions, as countries adjust their policies and practices in response.

This research will contribute to the field in three important ways:

- It documents the Global Fund's experience with health systems strengthening and shows how prevailing beliefs in the institutional landscape of global health have influenced the Fund's strategy and policies around health systems strengthening.
- It contributes to answering the difficult question of how the Global Fund can participate in health systems strengthening in a meaningful way without widening the scope of its mandate beyond its technical capacity.
- It provides a discussion of health systems strengthening policy recommendations that may be applicable to other categorical initiatives.

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[28] http://portfolio.theglobalfund.org/?lang=en
[29] http://www.theglobalfund.org/en/about/?lang=en

Chapter Three

History of Health Systems Strengthening at the Global Fund

> *"Whether politically it's been difficult or not for the Global Fund to call it health systems strengthening, it's been doing it from the start, and it's contributed a lot to it. Maybe it could've contributed more . . . if it'd been possible to have a very clear strategy and definition agreed for the Global Fund in terms of what it's trying to do or achieve." (Secretariat-Past-4)*

The Global Fund's history with health systems strengthening has its roots in the philosophical debates about horizontal versus vertical approaches to global health. However, the full story is beyond those debates. This chapter weaves together the story of the political debates that led to the Fund's current definition of health systems strengthening and describes its organizational policies around health systems strengthening. These policies are described in detail to show how they have evolved over time. In this way, Research Questions One and Two are explicitly addressed in this chapter. The role various Board members have played in shaping the Fund's policies on health systems strengthening are also explained. This chapter shows how certain constituencies on the Board have tried to expand the mandate of the Fund to include a fourth leg for health systems strengthening activities, while other constituencies, often for different reasons, have resisted this expansion. In this way, Research Question Three is addressed. The chapter closes with where the Board stood on this issue as of the Twenty-Second Board Meeting in December 2010.

Polyvalent Investments

From the beginning, Board Members and the leadership of the Secretariat were aware that the Global Fund would have to engage in some sort of support for the "systems" that deliver care for the Fund to achieve its goals around the three diseases (GFATM, 2002b; Board-Government-1; Secretariat-Past-1; Secretariat-Past-3).[30] At the first Board Meeting, the Health Minister of France, speaking on behalf of his own and three other European countries, said, "health systems in developing countries had to be improved so that the courses of treatment could be administered" (GFATM, 2002b). Although this awareness existed, the Global Fund's strategy around health systems strengthening support at the time was neither explicit nor very well thought-out (Board-Government-4; Board-Government-3). The guiding principle about health systems support was that stronger health systems (including adequate capacity) would emerge as a "spillover" of increased investment in disease-specific programs (Shakarishvili et al., 2009). This principle is embodied in the language about health systems in the Global Fund's *Framework Document*, which states that the Fund "will support programs that address the three diseases in ways that will contribute to strengthening health systems" (GFATM, 2002a). However, what this means and how to do this is something countries have struggled to

[30] By "systems," I mean the overhead that is required to succeed in implementing vertical programs. For example, supply chain management; healthcare training; data systems for epidemiology and surveillance; some of the cost of the physical facilities or transport mechanisms needed to get care to people; laboratory capacity – things that bear the burden of increased efforts in AIDS, TB and malaria but are not specifically designed just for those diseases.

understand throughout the ten rounds.

One of the key reasons the strategy on health systems strengthening engagement was not more explicit early on was because there was a strong recognition that the three diseases – particularly HIV – were the advocacy tool used to generate the resources to create the Fund (Secretariat-Past-1; Technical Partner-Multilateral-3; Government-1; Secretariat-Past-4). Consequently, the discourse about health that was common at the time – "building national capacity, strengthening health systems" – was deliberately shifted to "deal with the killer diseases" (Technical Partner-Multilateral-3). The discourse was shifted to attract new sources of money, sources that would not have been responsive to the standard development orthodoxy. According to one official at a multilateral institution who was closely involved with the creation of the Fund, "Suddenly, everyone was getting more serious about money. We . . . realized the serious sources of money were from largely G8 countries that were way below [.7% of GDP] – Germany, Japan, the US . . . and also from the private sector. So, the political thinking behind it was to say . . . we've got to get the others into the scheme, and we've got to do it in a way that they will be able to sell to their publics" (Technical Partner-Multilateral-3).

At the time the Fund was created, donor governments such as the US and Japan were skeptical of undefined investments in health systems. They saw investing in health systems as a black hole where money went in and little health came out (Board-Government-4; Secretariat-Past-4). There were examples of large-scale investments in health systems that did not have any significant impact on health (Board-Government-4), and some examples that just focusing on health systems led to a reduction in health outcomes (Board-Government-2). The US government was particularly skeptical of health system investments that were not tied to health outcomes (Board-Government-2). However, even some of the donors who traditionally supported health systems strengthening, such as the UK, were concerned that if they put all their funding into something much broader than those three diseases, it would be diluted and it would be hard to get a strong focus on measurable results (Secretariat-Past-4). Measurable results were critical for the Fund, as they were how it would mobilize future resources (Secretariat-Past-4).

In addition, among those mobilizing political will for the Fund, few wanted to talk about what would happen to the existing health infrastructure in countries, including human capacity, when large amounts of money hit (Government-1). Those pressing for increased resources did not want to dwell on the issue, as it sent mixed messages to donors (Government-1). According to one USAID official, "one of the reasons it really wasn't discussed is that you can't ask donors for millions and billions of dollars and, at the same time, say, 'Well, we also need to set aside a lot of money to build up the in-country capacity so that people can actually spend this money wisely' " (Government-1). Some people did raise the issue, such as the Chairman, President and CEO of Pfizer, Henry McKinnell. On June 25, 2001, McKinnell said the $7 to $10 billion target set by U.N. Secretary-General Kofi Annan was overly ambitious because the infrastructure did not exist to put the money to work. "Trying to put that much money into the system would be like pushing on a string," said McKinnell, who was also the chairman of the Pharmaceutical Research and Manufacturers of America. "We couldn't spend that money if we had it."[31] Advocates, however, saw McKinnell's comments as a smokescreen, as just another excuse for

[31] Agovino (2001). "Delegate: AIDS Goal Too Ambitious," Associated Press, June 25. http://www.aegis.org/news/ap/2001/AP010664.html

not scaling up universal AIDS treatment (Board-Civil Society-1; Smith and Siplon, 2006). Consequently, in the fever to get more money, health system capacity was swept under the rug.

Rounds 1-4

For the first three rounds of funding, applicants had two choices for how to get support to improve their health systems. They could apply for system strengthening funds through stand-alone disease components, or they could use an "Integrated" component for programs that addressed system-wide or 'cross-cutting' issues. In the stand-alone disease component, system-strengthening activities had to be tied to improved health outcomes for the specific disease. For example, countries could apply for funds to improve laboratory capacity for TB and training for laboratory technicians. 'Cross-cutting' activities had to impact one or more of the three diseases, but could also affect health problems beyond the three diseases. For example, in the 'cross-cutting' component, countries could request support to strengthen monitoring and evaluation systems or supply chains, which would impact at least the three diseases but likely other diseases and health problems as well. Round 4 continued the "Integrated" component but with increased information to applicants on what could be requested. Guidelines defined the "Integrated" approach as "a comprehensive response to the three diseases that focuses on system-wide approaches and cross-cutting aspects to strengthen health systems" (GFATM, 2004e).

Some countries were adept at securing 'cross-cutting' investments. However, many countries did not take advantage of the opportunity. According to one Board Member, "[T]he early experience was quite mixed. Some countries did include broader health systems strengthening elements, but I also heard from people who were involved at country level in developing proposals that there was a tendency to interpret what the Global Fund would mean and interpretations were usually quite narrow" (Board-Government-1). By "narrow," this Board Member means that proposals did not address the wider health system elements, such as barriers or bottlenecks that were needed to implement the proposal (Board-Government-1).

Narrow interpretations were partly a result of policies in Geneva not translating very well to what happened in capitals (Board-Civil Society-1). "[Y]ou have UN representatives, donors, others saying, 'Oh, no. You know, you shouldn't focus on scaling up ART; you should focus on this instead' " (Board-Civil Society-1). Additionally, the people developing the proposals and providing technical assistance were usually people from disease specific programs – people without expertise in how to address wider system issues (Board-Government-1; GFATM, 2005d). "Sometimes technical advisors said, 'Well, you better not include staff costs because then the TRP will reject it' " (Board-Government-1).

The interpretations stemmed, in part, from the fact the Board did not provide clear policies on the scope of activities to be funded in "Integrated" proposals (GFATM, 2004d). The clearest guidance they provided was that system-strengthening activities, whether disease-specific or system-wide, had to be linked to improved health outcomes for one or more of the three diseases. They did not provide examples of what these linkages should or could look like (GFATM, 2005d).

Linking system-strengthening activities to process and output indicators is not a particularly hard task to do. The challenge is measuring the health impact of the investment and connecting the

impact to health outcomes, such as reduced morbidity and mortality for the three diseases or health more generally. Judging from the statistics on approved proposals provided in Technical Review Panel reports, establishing the connection between system strengthening activities and health outcomes was easier for countries to do when these activities were requested as part of a disease-specific component, rather than the "Integrated" component. In Round 3, for example, no "Integrated" components were recommended for funding, whereas 58% of all approved components were for HIV/AIDS (GFATM, 2003e). In Round 4, six "Integrated" components were approved compared to 72 HIV/AIDS components, 46 for malaria and 48 for TB (GFATM, 2004d). Initially, the answer was to change the language in the guidelines to make it clear that countries could include funding in proposals for the wider system issues (Board-Government-1). As stated earlier, Round 4 provided increased information to applicants on what could be requested in the "Integrated" component. For example, applicants were encouraged to address staffing levels and staff distribution, so that programs had sufficient human resources to handle the expansion of services described in proposals. Applicants were allowed to request funding for training of health workers in the three diseases, both technical and managerial training, as well as compensation for these health workers. Additionally, applicants were encouraged to address the "broader systems" needed to respond to AIDS, tuberculosis and/or malaria, including monitoring and evaluation (including the development of a single national monitoring and evaluation framework, and disease surveillance systems), procurement and supply management, and coordination (GFATM, 2004e).

However, that guidance did not result in improved proposals that took onboard health systems elements (Board-Government-1). In Round 4, only 4% of proposed components were "Integrated," whereas 65% were for HIV/AIDS and 21% were for malaria (GFATM, 2004d). Four percent was a small improvement over Round 3, where less than 3% of proposals had an "Integrated" component (GFATM, 2003e) and Round 2, where less than 1% did (GFATM, 2002d). Certain Board delegations, particularly those from civil society and developing countries, grew increasingly frustrated. They felt there was not adequate opportunity – explicit opportunity – to access health systems strengthening funds. According to a former member of the Secretariat, "Some [Board Members] felt we should . . . make a more open avenue for applicants to request those types of funds" (Secretariat-Past-2). As a result, in Round Five (2005), the Board approved a separate "HSS window" for countries to develop stand-alone health systems proposals that would be connected to what they wanted to achieve in AIDS, TB and malaria. The stand-alone proposal was intended to provide more incentive to countries to focus on system-wide issues (Board-Government-1). The guidelines for this window were similar to the guidelines for the "Integrated" component of Round Four. Approving the window was not a battle among the Board; however, the Board did struggle with providing clear guidance, as they did not want to limit the flexibility of applicants (Board-Government-1). "[C]ountries might have very different barriers in their health systems, so the Board didn't feel like prescribing, 'Well, you can ask for staff and information systems but not for infrastructure' " (Board-Government-1). Early on, being over-prescriptive was anathema (Secretariat-Past-1).

Lack of clear guidance, however, proved to be a misstep. The results of Round Five were extremely disappointing. While the demand increased, the success rate plummeted. Out of 30 stand-alone health systems strengthening proposals submitted, only three were approved. The success rate of the health systems strengthening proposals (10%) was the lowest of any

component in any round in the Fund's history. "[I]t was really, I think, the sort of lowest down that the Global Fund had in terms of proposals that were approved" (Board-Government-1). The three successful proposals – Rwanda, Cambodia, and Malawi – shared characteristics of other successful proposals; they were focused on a small range of activities, were realistic and implementable, and had clearly set out objectives, strategies and activities, which were linked to detailed and coherent budgets and work plans (GFATM, 2005d). Rwanda's proposal focused almost entirely on an innovative financing strategy, while Malawi's focused on the human resources aspects of health systems strengthening (GFATM, 2005d). According to the Technical Review Panel, "these proposals made a compelling case for a general, but focused health systems strengthening strategy, and argued that it would contribute to the fight against one or more of the diseases in both general and specific ways" (GFATM, 2005d).

The other 27 proposals had characteristics typical of other unsuccessful proposals; they were too broad and ambitious, too vague in their objectives and/or proposed activities, and had poor work plans and/or budgets (GFATM, 2005d). In addition to these problems, however, the Technical Review Panel believed that there were technical problems specific to the health systems strengthening proposals and the execution of the health systems strengthening window that contributed to the low success rate. First, the Technical Review Panel believed the definition of health systems strengthening in the Proposal Form and Guidelines was "too vague and too broad" with little guidance on a specific focus for the proposals (GFATM, 2005d). According to one Board Member, many countries did not understand what was and was not allowed, nor did they understand how to link the activities to results in the three diseases. "Most countries hadn't been able to clarify linkages between . . . what they were proposing in their health systems strengthening activities and results that could be achieved in AIDS, TB and malaria. There were totally unfocused proposals – proposals that didn't have any links between . . . results and activities" (Board-Government-1). The Technical Review Panel believed requiring linking health systems strengthening activities to one or more of the three diseases was not a good approach. "[B]y definition, HSS proposals are broad and general in nature and may not lend themselves to direct and specific linkages with one or more of the three diseases" (GFATM, 2005d). In many of the proposals, the Technical Review Panel reported, "the linkage between the HSS activities and the diseases was contrived or superficial, and usually not convincing" (GFATM, 2005d). Related to this point, the Technical Review Panel believed there was "insufficient consideration given to the impact of inviting separate HSS proposals, while still insisting there be a specific linkage to one or more of the three diseases" (GFATM, 2005d).

Applicants were unsure as to whether to include health systems strengthening elements only in their health systems strengthening proposal or to hedge their bets by including health systems strengthening elements in both health systems strengthening and disease-specific proposals in case only one was successful (GFATM, 2005d). "It appears that the WHO and perhaps some other agencies specifically advised some countries to include health systems strengthening elements in both health systems strengthening and disease proposals, as a risk mitigation strategy" (GFATM, 2005d). The Technical Review Panel encountered a significant problem in a few cases where the disease component was recommended for funding but was contingent on successful implementation on resources applied for in an unsuccessful health systems strengthening component (GFATM, 2005d).

The Technical Review Panel highlighted other technical problems with the execution of the window. For example, the Technical Review Panel felt the Proposal Form, which was designed for disease-specific components, was unsuitable for the submission of health systems strengthening proposals, as the Proposal Form forced many responses which were not relevant to health systems strengthening proposals, and required measurement of impacts that were "not appropriate" for health systems strengthening proposals (GFATM, 2005d). Further, the Form did not create space for information on the country's health system that was critical, such as the existence of Sector-wide Approaches or other financing and donor arrangements and a detailed description of the human resources situation (GFATM, 2005d). Further, the Technical Review Panel believed the Global Fund system was neither set up to generate strong health systems strengthening proposals nor to evaluate them effectively (GFATM, 2005d). The Technical Review Panel was concerned that Country Coordination Mechanisms lacked the expertise to develop (or oversee the development of) strong health systems strengthening proposals; technical partners were still at an early stage in their ability to assist countries to develop effective health systems strengthening proposals; and the Technical Review Panel itself was not ideally equipped to evaluate health systems strengthening proposals, as that required different skills from evaluating disease-specific proposals (GFATM, 2005d).

However, most critically, the Technical Review Panel identified a philosophical problem – confusion over the Fund's mandate:

> "[W]hile . . . many of the problems identified in the health systems strengthening proposals . . . may be attributable to lack of experience with this type of proposal, the TRP also believes that the poor quality of these proposals reflects confusion in the GFATM as to the precise mandate of the Fund in relation to HSS proposals; and that this confusion was reflected in the various problems identified here" (GFATM, 2005d).

Indeed, many proposals failed not only because they could not meet the technical threshold, but also because it was not clear what would be the added value of the Global Fund in supporting the activities. There was significant overlap in many proposals between activities proposed and the mandates of other organizations, such as the World Bank and the Regional Development Banks. "I recall a proposal from Ethiopia – their $600 million proposal to build hospitals and clinics all over the country – which Ethiopia obviously needs . . . but it is not the sort of thing that the Global Fund should engage in" (Board-Government-1). After seeing the results of Round 5, Board Members began to question more openly the comparative advantage of the Global Fund with regard to health systems strengthening. "[We] then realized . . . that the Global Fund was entering into an area where others with country presence would have much better mandate and would be much better positioned to fund [these activities]" (Board-Government-1). The Technical Review Panel called on the Board to debate and refine the Fund's mandate in relation to health systems strengthening proposals (GFATM, 2005d).

At the 11th Board Meeting, where the results of Round 5 were discussed, more than half of the delegates made comments and suggestions regarding the health systems strengthening component, and opinions varied widely. Some Board Members thought the Global Fund was entering into an area where other agencies with a country presence, such as the World Bank,

WHO or bilateral donors, would be better positioned to fund these activities (GFATM, 2005b). Some thought the Global Fund was not equipped to consider health systems strengthening proposals, while others thought the health systems strengthening component should be integrated back into the other three components. Still others thought the health systems strengthening component was crucial, as weak health system infrastructure over time would increasingly become the bottleneck for successful implementation of funded programs. Some worried that embarking on strengthening health systems could end up using a substantial portion of the funds, while others thought the Global Fund had a role to play in health systems strengthening but that it had not yet found its comparative advantage. Some, including the TRP, thought the Portfolio Committee needed to better define the scope of what the Global Fund wished to fund in health systems strengthening (GFATM, 2005b). A number of delegates also made comments about technical assistance to countries and the need to strengthen the corps of cross-cutting experts on the Technical Review Panel. The Chair of the Technical Review Panel said that if health systems strengthening proposals were going to become an important component for the Global Fund, the Technical Review Panel would have to strengthen its cross-cutting expertise (GFATM, 2005b). In a Decision Point on health systems strengthening, the Board requested the Portfolio Committee "to take note of the lessons learned and issues arising out of the technical review of Round 5 proposals, as well as the recommendations of the Technical Review Panel," and resolve them, including revising the Proposal Form and Guidelines for Proposals for consideration at the 13th Board Meeting (GFATM, 2005b). Countries, meanwhile, were frustrated at having put so much effort into proposals that were not funded. "It is very unsatisfactory for countries" (Board-Government-1).

Round 5 closed on June 10, 2005 and Round 6 was not opened until May 5, 2006. In the interim, a number of significant activities unfolded between the 11th and 13th Board Meetings, leading up to the launch of Round 6, which influenced the Board's debate about how to structure the proposal form and guidelines for health systems strengthening. First, in late 2005, between the 11th and 12th Board meetings, the WHO chaired a working group on health systems strengthening as a component and provided the Portfolio Committee with a first-draft report for discussion (GFATM, 2005c). In January 2006, the developed country NGO delegation – led by HealthGAP, Physicians for Human Rights, and Global AIDS Alliance – sent a document to the Portfolio Committee outlining their rationale for the Global Fund to retain health systems strengthening as a distinct category in Round 6 and loosen the restrictions around linking these activities to health outcomes for the three diseases (Board-Civil Society-1; Technical Partner-Multilateral-2; Sign-on Letter, 2006). Many health system weaknesses "are too large to address through a disease specific lens," they reasoned, and not addressing those weaknesses would hinder the Global Fund's ability to reach its objectives, waste valuable resources, continue to cause duplication, and in some cases, actually harm non-AIDS, TB and malaria health services by creating perverse incentives and labor market distortions.

In the document, the delegation specifically addressed concerns expressed by Board Members who wanted to close the window for health systems strengthening support. First, the delegation argued, broad health systems strengthening support would not be an expansion of the Fund's mission; rather, it was an essential activity for the Fund to achieve its mission. Second, health systems strengthening would not be too expensive, nor would it be a drain on limited resources, as the demand for health systems strengthening expressed in Round 5 was only 16% of the total.

Third, restricting the types of activities for which applicants could request health systems strengthening support would not be a good idea, as system barriers varied by country setting, and countries ought to have broad leeway in determining what activities to propose. Fourth, measuring results in health systems strengthening would not be a problem, as the Global Fund already had a strong monitoring and evaluation component and required recipients to show positive results to continue receiving funding. Fifth, the Global Fund would not be engaging in broad health systems strengthening support alone, as evidenced by two of the three approved Round 5 proposals, which show that Global Fund support was complementary. They gave the example of Malawi's health workforce program that received support from the UK and other bilateral donors and Rwanda's community-based insurance program that had World Bank as well as bilateral support. Lastly, they argued, sustainability should not be a barrier, as the Global Fund already supported health activities that required long-term external support (Sign-on Letter, 2006).

Primarily, the delegation argued that supporting health systems strengthening was the best way for the Fund to achieve its mission; however, as an undercurrent, they also believed that existing funding mechanisms were not meeting the demand for health system strengthening (Sign-on Letter, 2006). In this belief, civil society was not alone. The Executive Director of the Global Fund at the time, Sir Richard Feachem, also felt other organizations, notably the World Bank, were not stepping up in the area of health systems strengthening. At the 13th Board Meeting in April 2006, the Board decided to remove the health systems strengthening category as a separate component in favor of including health systems strengthening activities as part of a disease component (GFATM, 2006a). Activities to strengthen health systems had to be included within the disease component for which such activities were deemed necessary (GFATM, 2006d). Additionally, the guidelines were revised to emphasize linkages to existing programs previously funded by the Global Fund and to other donor funded programs (GFATM, 2006a).

Although the sign-on letter did not stop the window from closing in Round 6, it did contribute to an important policy debate among the Board as to what would be the Global Fund's strategy around health systems strengthening going forward. The timing of the debate was critical, as the Global Fund was in the process of developing its four-year strategy. The developed country NGO delegation saw this process as an opportunity to open the window again (Board-Civil Society-1).

The strategy was to be hammered out in the Policy and Strategy Committee of the Board, which was chaired by a member of the US delegation. The Policy and Strategy Committee had a long list of issues to address in its strategy development process. Health systems strengthening was one of the issues, but, according to one Board Member, it was one of the last issues to be settled by the Board because it was controversial and there was no consensus (Board-Civil Society-1). Civil society worked very hard to push the perspective of using a window to accelerate expression of quality demand for health systems strengthening as related to the three diseases (Board-Civil Society-1). "We did media work. We lobbied . . . allies on the committee and on the Board to try to create a shared position, which we did" (Board-Civil Society-1). But, according to this Board Member, the US, in particular, pushed back very hard and objected (Board-Civil Society-1). The concern of the US, as explained by another member of the US delegation, was that there was nothing concrete about the health systems strengthening window.

"It's an abstraction because no one has said what it means, what its goals are, what its objectives are. . . . [W]hy would you separate a health system from health outcomes? If it is part of health outcomes, the Fund has always done that" (Board-Government-2). Civil society, however, along with representatives from various Ministries of Health, strongly believed that the Fund needed to support "activities that are tied to the needs of the entire health system and the full range of national health goals, not only needs and goals specific to one disease" (Sign-on letter, 2006). Consistently, their rationale was that providing support for disease-specific programs without also supporting the underlying systems "risks reducing the capacity of those systems to deliver other vital health services" (Sign-on letter, 2006). They saw the window as critical for countries to ask for health systems strengthening support that was beyond the three diseases.

Donors, meanwhile, along with the Private Sector and Private Foundations delegations, balked at the idea, but each for different reasons. For the US, the objection was philosophical. People in the US delegation did not think that health systems strengthening meant anything:

> It's a meaningless term that should never be used. It's pointless. . . . The purpose of health is to improve the health of an individual and community; to save and lift up lives. The purpose of health. . .is not to build infrastructure and hire people. . . . [I]f all you're doing is counting new healthcare workers and new buildings built – that is not what the Fund is about – that is not what global health is about. . . . And, in fact [health systems strengthening] has never worked. . . . [H]ealth systems was the "in" thing 30 years ago. There are plenty of data that just focusing on health systems [doesn't] lead to any health outcomes. We have no data that simply investing in health systems leads to improved health. So, start with health. And that's what the Fund does. It starts with health. (Board-Government-2)

Other donors' objections were less philosophical and more pragmatic. Point Seven, for example, believed in doing broad-based systems support but did not think the Global Fund was the right organization to do it. They thought other donors, such as the World Bank, had more value added in that area (Board-Government-1). The UK, as well, did not see vertical funds as the best place to take on health system strengthening. They thought that required much more country-level engagement. Additionally, they, along with other donors, saw health systems strengthening as expensive and expansive. "[H]ealth systems strengthening is as long as a piece of string, if you use the WHO framework. You could be doing everything from health sector reform, to training health workers, to whatever, building facilities" (Board-Government-3).

The Western European donors' pragmatic objections to the Global Fund's involvement in health systems strengthening evolved into a debate over the "division of labor" in global health. At the heart of the debate were questions around which global health agency should have the lead in doing health system strengthening work and what role the Global Fund should have, if any. In particular, Western European donors wanted the World Bank to prioritize Health, Nutrition and Population within the institution and assert political prominence in this area (Board-Civil Society-1). The Bank already focused on infrastructure projects and broader, long-term system reform (Secretariat-Past-3). Richard Feachem, meanwhile, continued to push the World Bank. At the 14th Board Meeting (October 2006), he said he wanted "clear, comprehensive

commitment from the World Bank to health systems strengthening as the primary focus of World Bank action in the health sector" (GFATM, 2006b). In 2007, the Bank published its strategy on Health, Nutrition and Population, which emphasized health systems strengthening. The strategy was seen from many quarters as an opportunity for the Bank to claw its way back toward prioritization of health investments (Board-Government-3).

From civil society's perspective, this discussion was divorced from any interrogation of the Bank's impact on health through its structural adjustment policies and discussion about when it does invest in health, what kind of outcomes it has and what kind of track record it has (Board-Civil Society-1). "Theoretically, the World Bank [has the skill set], but the fact is it's also performed really poorly on its health systems strengthening activities, really, if you look at the evaluations" (Secretariat-Past-3). On the Board, the dynamic that emerged around the issue was that the US and civil society were at loggerheads, while the rest of the donors and civil society were at loggerheads, but for completely different reasons. According to a Board Member from the developed country NGO delegation, the Western European donors saw the window as drawing oxygen away from a last ditch opportunity to create political currency for the Bank in health system strengthening (Board-Civil Society-1). In no uncertain terms, the UK and other donors, were keenly interested in scaling up their investments in the Bank around health systems and "buying influence" in this area (Board-Civil Society-1). Civil society, meanwhile, saw that if the Bank took the lead in health systems strengthening, it would also get the money, not the Global Fund. Their objections were partly grounded in past criticisms of the Bank – its track record, its commitment to moving quickly, its record of health results – but were, fundamentally, deeply rooted in the Bank's long history of exclusion of civil society. Civil society sees the Bank as a regressive organization – one out of touch with 21st century governance and implementation. "The Bank is, really, very much behind the Fund when it comes to all these issues" (Board-Civil Society-1). The US government, meanwhile, had long been skeptical of multilateral institutions (Buse et al., 2009), including the World Bank. Civil society was able to leverage this skepticism to oppose rising prominence for the Bank (Board-Civil Society-1). While the Western European donors wanted to see the World Bank step up to the plate on health systems financing, the US and civil society founds themselves as unlikely allies in opposition to this idea.

At the 15th Board Meeting in April 2007, the issue was still not resolved. On health systems strengthening, the Policy and Strategy Committee view was that the Global Fund should invest in activities through grants to help health systems overcome constraints to achieving improved outcomes, but there was no consensus on whether to establish a separate health systems strengthening component as in Round 5 or to keep the component attached to disease proposals; the appropriate parameters for allowable health systems strengthening activities (e.g., there was no consensus around supplementing salaries in the public sector as part of this approach); the nature of continuity of health systems strengthening funding; and the possible use of ceilings for health systems strengthening funding (GFATM, 2007a). At this meeting, a number of delegates highlighted the importance of involving WHO in a dialogue on the issue and drawing on that organization's expertise to address the concrete points raised by the Policy and Strategy Committee (GFATM, 2007a). At the same time, there was broad support for the Policy and Strategy Committee and Portfolio Committee to work hand-in-hand on this issue, "as there were both strategic and practical considerations that would need to be addressed" (GFATM, 2007a).

On July 30-31, 2007, the WHO hosted a technical consultation on the Global Fund's strategic approach to health systems strengthening. Their findings were presented in a report to the Secretariat in September 2007 (WHO, 2007a).

At the 16th Board Meeting, in November 2007, the Board put the issue to bed with a compromise. In Decision Point 10, the Board agreed that "the Global Fund shall provide funding for 'HSS' actions within the overall framework of funding technically sound proposals focused on the three diseases (GFATM, 2007b). The health systems stregthening proposals had to be integrated within the relevant disease component "whenever possible," but for actions that benefitted more than one disease ('cross-cutting HSS actions'), applicants could complete a distinct but complementary section within a disease component (GFATM, 2007b). Activities still had to be linked to improved health outcomes for the three diseases, but the Board agreed to recommend categories for health systems strengthening actions and principles to guide applicants in deciding which categories of health systems strengthening actions to apply for, as well as to specify which actions may not be financed by the Global Fund. The compromise kept the scope of health systems strengthening work restricted to the three diseases, which is consistent with the *Framework Document*, but it allowed a separate (but linked) proposal for health systems strengthening to help encourage demand. Additionally, since health systems strengthening proposals were separate from disease proposals, the Technical Review Panel had the option to approve both proposals, approve only the health systems strengthening proposal, approve only the disease proposal, or neither. For the full text of the Decision Point, see Appendix 5.

To reach this compromise, the US and others acquiesced. However, not everyone was happy with the compromise. Certain donors, such as Japan, felt they had been misled. These donors joined the Global Fund because they wanted to crank up their support to HIV and malaria, not running health systems. "The clear line in Japan and many others was, 'If we want to do health systems funding, we would not necessarily choose the Global Fund' " (Board-Government-3). The Technical Review Panel, as well, expressed frustration about the tie to disease outcomes and the limits it placed on what countries could propose (GFATM, 2008e). Relatively speaking, the approach seemed to work, as Round 8 had one of the highest success rates of health systems strengthening proposals to date – 53% (GFATM, 2008e). But in its Report on Round 8, the Technical Review Panel criticized the compromise, calling into question the ability of the Global Fund to support health systems strengthening more broadly:

> The Global Fund's strong emphasis on HIV, TB and malaria outcomes will prove problematic for countries in their elaboration of effective responses to HSS constraints that are fundable through the Global Fund's framework. (GFATM 2008e)

Civil society, as well, continued to harbor frustration. "From my perspective . . . there are huge missed opportunities. And if you diagnose why that is, part of it is because many countries still don't know the extent of the flexibility and don't know how to ask for the resources in a technically sound way" (Board-Civil Society-1).

2008 - Present

Outside the Global Fund, health systems strengthening rose on the global policy agenda, and reached its peak in September 2008, when Prime Minister Gordon Brown of the UK and Bob Zoellick, President of the World Bank, convened a High-Level Taskforce on Innovative International Financing for Health Systems ("The Taskforce"). Its aim was to identify innovative and additional sources of funding for health systems strengthening in the 49 lowest-income countries of the world and to improve the efficiency and effectiveness of aid to health (McCoy, 2009). The Taskforce was made up of 14 members, all of whom were high level political figures from developed and developing countries and the United Nations. There was one member from civil society. Not surprisingly, the United States was not represented. The Taskforce also consisted of two Working Groups, one focused on "costs and constraints" and the other focused on "raising and channeling funds." The Global Fund and GAVI each had one representative among these two groups. The Gates Foundation had a representative, as did McKinsey (i.e., the private sector). Interestingly, the representative from McKinsey, Rajat Gupta, was Chair of the Global Fund's Board just prior to the current Chair, Minister Tedros. Japan had a focal point to the Taskforce; however, members of the Taskforce and Working Groups mainly were from Western European countries, multilaterals – such as the World Bank and the WHO – and some of the more politically aggressive developing countries, such as Ethiopia, Rwanda, Uganda and Liberia. The government of India was not represented, nor was China, or any other country in South or East Asia or Latin America.

According to one member of civil society I interviewed, initial discussions of the Taskforce did not include GAVI and the Global Fund (Board-Civil Society-1). Early discussions were between the World Bank and Ethiopia (Board-Civil Society-1). Recognizing that they were being excluded, the Executive Director of the Global Fund, Michel Kazatchkine, and the Chief Executive of GAVI, Julian Lob-Levyt, wrote a letter to the High-Level Taskforce in early 2009 to inform them of their intention to begin jointly programming GAVI and Global Fund resources for health systems strengthening (Berman et al., 2009). Others then suggested involving the World Bank in the joint programming, and then the WHO joined as well (Board-Civil Society-1). In March 2009, the Global Fund, GAVI and the World Bank, with technical support from the WHO, launched inter-agency consultations on aligning health systems strengthening funding frameworks with the goal of "a common HSS investment strategy" (World Bank, 2009). Consequently, instead of having two actors who were similar to each other in terms of mission and governance, the joint programming became three actors hosted by the WHO (Board-Civil Society-1). The final recommendations of the Taskforce, delivered in September 2009, called on the Global Fund, GAVI and the World Bank to establish a common funding platform for health systems strengthening across the three agencies.

The Taskforce also called for 'up to ten billion dollars a year' of additional resources to strengthen health systems and scale up essential care in 49 low-income countries. The Taskforce drew on two separate and different costing models, as well as various assumptions about economic growth and health spending patterns of governments, donors and private individuals, to develop this headline figure. As a result, there was at least significant hope that a common platform for health systems strengthening would be accompanied by a very substantial and rapid increase in funding (Technical Partner-Multilateral-1).

According to someone closely involved with the Platform's inception, energy early on was

focused on how to get the agencies to agree on what they would do together (Technical Partner-Multilateral-1). The task was challenging, as the three agencies are very different in the way they are organized and operate. The Global Fund and GAVI have Board-driven decision making processes, so staff energy is focused on preparing statements for the Board and getting the Board to agree on things, whereas the Bank does not work that way. The Bank can do things internally and through its normal engagement with countries. Additionally, each organization has had different historical experiences with health systems strengthening. For the Global Fund, and to some extent GAVI, health systems strengthening has been a political beast, hotly debated by the Boards, whereas the World Bank engages with governments to promote sector-wide support and capacity building as part of how it does business. This lack of commonality proved problematic early on (Technical Partner-Multilateral-1). Additionally, the organizations were operating in a time of global financial crisis and deep economic recession. As a result, the expectation that the Platform would be a vehicle for substantial new money gradually confronted the reality that there probably would not be, at least not anytime soon (Technical Partner-Multilateral-1). Consequently, expectations were scaled back. Instead of creating a new infrastructure, the agencies began exploring how the Platform could integrate closer with International Health Partnership Plus (IHP+), which is more about aid effectiveness and reducing transaction costs, than massive new amounts of money.

At the 12th Policy and Strategy Committee Meeting, prior to the 20th Board Meeting in November 2009, the Secretariat presented two options (referred to as "Tracks") for a common platform for joint funding and programming of health systems strengthening. Track 1 relates to:

> [E]xisting HSS grants which have been approved by the GAVI and Global Fund Boards in countries where the World Bank also has HSS investments. The work would explore opportunities for improved harmonization of these existing investments and better alignments with country mechanisms, using flexibilities afforded to the three agencies under current policies. (GFATM, 2009c)

Track 2 relates to new financing. Option 1 "envisages countries submitting a single health systems strengthening proposal to the Global Fund and GAVI for the two agencies to jointly assess these proposals and for their respective Boards to make coordinated funding decisions" (GFATM, 2009c). Option 2 "envisages funding HSS actions included in national health plans that have been jointly assessed by the three agencies (and other funding partners)" (GFATM, 2009c).

At the 20th Board Meeting, the Board acknowledged the collaborative efforts undertaken by the three agencies with technical support from the WHO to develop a proposal for the common platform (GFATM, 2009b). In Decision Point 4, the Board

> [Requested] the Secretariat, in close consultation with the Policy and Strategy Committee, . . . to elaborate . . . the operational, financial and policy implications for joint HSS funding and programming based on but not limited to the proposed Option 1 (Single HSS Funding Application) and Option 2 (Funding on the Basis of Jointly Assessed National Health Strategies) described in the Policy and Strategy Committee's Report to the Board (GFATM, 2010d). (GFATM, 2009b)

The Board asked the Secretariat to propose to the Policy and Strategy Committee, prior to the 21st Board Meeting, how a joint health systems strengthening platform could be operationalized and funded (GFATM, 2009b). The proposal ought to be based on consultations at country level with key stakeholders (GFATM, 2009b).

In discussion, some Board Members praised Decision Point 4, stating that it is very important to seek out opportunities to collaborate in order to make progress (GFATM, 2009b). Other delegates, however, were unclear about the World Bank's role in the initiative and raised concerns about whether the decision point would be interpreted as a full-scale launch into health systems strengthening (GFATM, 2009b). "Although HSS is important, questions remained about whether it goes beyond the Global Fund mandate to specifically address these issues, and whether the capacity exists within the Secretariat to handle the workload created by these agreements" (GFATM, 2009b). The decision point passed.

At the 13th Policy and Strategy Committee Meeting, in preparation for the 21st Board Meeting in April 2010, the Policy and Strategy Committee emphasized "the need to improve measurement of the impact between health systems and disease-specific interventions" and reiterated its support of "the need for the three agencies with WHO to better harmonize and align their support for HSS" (GFATM, 2010c). The PSC recognized the need for a sequential approach "which moves quickly on Track 1, proceeds with designing a joint proposal form with GAVI for Track 2, Option 1, and prepares for piloting Track 2, Option 2 in 4-5 countries" (GFATM, 2010c). The Policy and Strategy Committee also emphasized the need for an independent evaluation of the Platform with Technical Evaluation Reference Group oversight, and reiterated the need for continued communication and consultation on this initiative (GFATM, 2010c).

At the 21st Board Meeting, in Decision Point 5, the Board affirmed "the critical importance of strong health systems to achieve the Global Fund's mandate to fight AIDS, tuberculosis and malaria" and endorsed an incremental approach to coordinated health systems strengthening investments under Track 1 and Track 2 in collaboration with partners (GFATM, 2010a). The Board requested the Secretariat to continue rapid implementation of Track 1; and, based on consultations at the country level, implementation of Track 2, Option 1, through the development of a joint proposal form with GAVI. The joint proposal form would be approved by the Policy and Strategy Committee (as per current policy) for use as soon as possible and no later than Round 11. Any funding proposals using this new joint proposal form would be subject to TRP review and Board approval processes (GFATM, 2010a). The Board requested further work on Track 2, Option 2, such that the Board could approve funding requests emanating from a pilot in 4-5 countries at the same time as it approves Round 11. The Board requested that, in the interim, the Policy and Strategy Committee review and approve the pilot's design at its meeting in October 2010. The Board requested the Secretariat to increase dialogue with partners, and develop a communications strategy and mechanisms for building health systems capacity at the country level as part of the implementation and to regularly provide updates to the Policy and Strategy Committee (GFATM, 2010a). The Board endorsed the current scope of Global Fund health systems strengthening support as the scope for Global Fund health systems strengthening support within the Platform.

At the 14th Policy and Strategy Committee meeting[32] in October 2010, in preparation for the 22nd Board Meeting in December 2010, the Policy and Strategy Committee reviewed and approved the Secretariat's proposed design for the pilot of Track 2, Option 2 in 4-5 countries (GFATM, 2010d). In doing so, the Policy and Strategy Committee noted "the importance of multi-stakeholder inclusion in the development and assessment of the national health strategy, the development of the funding request and the implementation of grants derived from such funding requests" (GFATM, 2010d).

For health systems strengthening activities requested in Round 11 through normal Global Fund engagement (i.e., cross-cutting requests attached to disease-specific proposals), the Policy and Strategy Committee proposed a "technical correction" to the application policy. The Policy and Strategy Committee suggested that in Round 11 and going forward the Global Fund allow countries to submit stand-alone proposals for cross-cutting health systems strengthening activities, rather than attaching cross-cutting activities to disparate disease proposals and grants (GFATM, 2010d). They also proposed to allow consolidation of cross-cutting health systems strengthening activities into "HSS Single Streams of Funding" (GFATM, 2010d). In making this recommendation, the PSC is careful to stress that the recommended policy changes "should not change the current scope of Global Fund support for HSS activities and their connection to the three diseases," and should not be seen more as "opening. . .a separate HSS window" (GFATM, 2010d). Rather, the Policy and Strategy Committee proposed this technical change to address the "fragmentation" cross-cutting health systems strengthening activities that occurs when they are attached to disparate disease proposals and grants, an outcome that is contrary to the intent of the new grant architecture (GFATM, 2010d). Additionally, the Policy and Strategy Committee reasoned, the past policy did not serve "as a practical or appropriate basis" for the recently approved Health Systems Funding Platform, and "would have a number of adverse consequences if applied to the Platform" (GFATM, 2010d).

According to the Policy and Strategy Committee summary report of the 14th Policy and Strategy Committee meeting, one Policy and Strategy Committee constituency (unnamed) objected to the proposed changes and expressed a preference to allow the consolidation of cross-cutting health systems strengthening activities and still require the attachment of cross-cutting health systems strengthening requests to disease proposals, "so as to ensure preservation of the Global Fund's focus on the three diseases" (GFATM, 2010d). Another constituency (also unnamed) expressed that "CCMs should consult with health sector coordination bodies to ensure coherence with the national health plan and complementarity with other partners' investments in the health sector" (GFATM, 2010d). In its decision point proposed to the Board, the Policy and Strategy Committee opted for the technical change to allow separate health systems strengthening requests "focusing on system-wide approaches and actions that significantly benefit more than one of HIV/AIDS, tuberculosis and malaria components (i.e., "cross-cutting HSS component") (GFATM, 2010d).

In interviews with Board Members, a recurring theme was that the Global Fund has engaged the Platform cautiously (Board-Multilateral-1; Board-Multilateral-2). Some Board Members have been supportive of the Global Fund's engagement in the platform – civil society, for example,

[32] The Policy and Strategy Committee (PSC) met in Geneva on 26-26 October 2010 for its 14th meeting. The Chair was Dr. Suwit Wibulpolprasert (South East Asia); the Vice-Chair was Todd Summers (Foundations) (PSC14/04).

congratulated the Fund on "efforts to develop the Joint Platform on HSS" (Letter to Kazatchkine, Maloney-Kitts, 2010). Members of the private sector delegation, as well, saw the health systems funding platform as an important "exercise" for the Fund with many potential benefits (Board-Private Sector-1). "The Health Systems Funding Platform . . . is a good way to create more efficiency in the financing and implementation mechanisms" (Board-Private Sector-1). The Platform has the potential to harmonize procurement frameworks, harmonize donor financing and programs, to reduce transaction costs for countries by capturing information in a unified way among the different donors, and, ultimately, to translate into a more coordinated approach to strengthening health systems in countries (Board-Private Sector-1). Other Board Members, however, are more skeptical.

> "We still don't know what it means for the World Bank, the Global Fund, and GAVI to work together two and half years later. . . . [A]ll they seem to be focused on is a common evaluation mechanism without collapsing all the duplicative systems that we have across the World Bank, the Global Fund, and GAVI right now. So that's why people don't have any confidence in this health systems strengthening thing – because nothing's happened in two and half years and all they're focused on is joint evaluation, not joint systems, joint financing, joint approvals. So there's a real opportunity but . . . none of it's being fulfilled." (Board-Government-2).

Still other Board Members are holding out before passing judgment. "Well, . . . it hasn't even gotten started yet, so there isn't much to make of it. . . . [N]ot a single dollar has been spent under it yet so . . . I don't really have an opinion" (Board-Government-4).

At the 22nd Board Meeting Board Meeting in December 2010, the Board approved without amendment the Policy and Strategy Committee decision points regarding the pilot of Track 2 Option 2 (GF/B22/DP5) and the technical correction for health systems strengthening activities (GF/B22/DP4) (GFATM, 2010b). For the full text of these decision points, see Appendices 6-7. The Board is currently in the process of developing its strategy that will cover up to the end of 2016, with a mid-point review in 2014 (GFATM, 2010b).

Chapter 4

What the Global Fund Means by Health System Strengthening

This chapter presents results of 31 interviews. The coding process is described and a code application table is presented. Results to the question, "What does health systems strengthening mean in the context of the Global Fund?" are presented next. A code co-occurrence table and findings to the question, "What ought to be the role of the Global Fund with regard to health systems strengthening?" are presented, then trends in the answers, rationale, and recommendations by Board delegation are explained. Last, five overarching patterns are listed.

Part One: Codes and Code Application

19 codes are used in the analysis. A full list of these codes and their meanings is presented in Appendix 4. Coding was divided into two phases. In phase one, responses to the question, "What does health systems strengthening mean in the context of the Global Fund?" were coded. Responses to this question fell into two categories: definitions and comments. Definitions were coded first as "Definition," then with the relevant descriptive code, either "Disease Specific" or "Not Tied to the Three Diseases." Comments were coded first as "Comment," then with the relevant descriptive code, that included "Disease Specific," "Not Tied to the Three Diseases," as well as a range of other codes, such as "Accuracy," "Measures," "Resources," "Impact of Fund," etc. "Accuracy" tags comments on the accuracy of the Global Fund's definition of health systems strengthening. "Measures" tags comments on measuring the impact of Global Fund investments, both in relation to health systems strengthening and more generally. "Resources" tags comments on the Global Fund's financial resources and health systems strengthening. "Impact of Fund" tags comments on the impact of the Fund in relation to health systems and the impact more generally, such as lives saved and infections averted. For a full list of the codes see Appendix 4.

In phase two, responses to the question "What ought to be the role of the Global Fund in health system strengthening?" were coded. Subjects said whether they thought the Global Fund should expand its mandate to include health system strengthening or remain a Fund for the three diseases. They provided a rationale for their answer and recommendations on what the Fund ought to do in the future. These responses are presented in part three. Some subjects also provided critiques of the Global Fund as well as comments and/or suggestions. Suggestions are the same as "Recommendations." All excerpts for this question are coded as "Comments," "Critiques," or "Suggestions," then the relevant descriptive codes are attached. The co-occurrence of these descriptive codes forms the rationale and describes the recommendations. Code co-occurrence is presented in Table 7.

Table 4 presents the code application frequency. Codes go across the top; 31 interview subjects down the left-hand side. Numbers indicate code application frequency. The most frequently applied codes were "Comments" (227); "Not Tied to Three Diseases" (111); "Resources" (77); "Disease Specific" (74); and "Impact of Fund" (71). The interviews with the highest number of codes were *Board-Private Foundations-1* (82); *Board- Multilateral-2* (70); *Board-Civil Society-5* (68); *Technical Partner-Multilateral-5* (65); *Board- Government-1* (62). Across interviews, codes with the highest application numbers were "Comments" and "Not Tied to Three Diseases."

Table 4: Code Application by Interview Subject

	Comments	Impact of Fund	Appropriateness	Efficacy	Efficiency	Accuracy	Measures	Resources	Sustainability	Responsibility	Usefulness	Value	Critique	Definition	Disease Specific	Not tied to 3 diseases	Operation of the Fund	Structure	Suggestion	Totals
Board-Govt1	16	4	6	3	2		3	3		4	1			1	5	10				62
Board–Govt2	11		3				3	3		1	3	4	1	1	4	3	1			44
Board–Govt3	10	2	3	2	2		2	3		3			2		5	4	2	1		48
Board–Govt4	7	2	3	2	3	3	1	1		2	1	2		1	1	4	4		4	53
Board–Civil Society–1	13	1	4	1	1		3	3		7				1		3				47
Board–Civil Society–2	2	1		1						1										7
Board–Civil Society–3	9	2	1	1			1	3	1						2	5				33
Board–Civil Society–4	10	2	2			1	2	4		1				2	1	11				40
Board–Civil Society–5	13		4	3	3		2	4	2	7			1	2	7	2	2	4	1	68
Board–Multilateral–1	3	3	1		1	1		1					1	1		2			1	16
Board–Multilateral–2	14	7	4	3		2		4		2	1	1	2		7	8	2	2	1	70
Board–Private Foundations–1	18	7		4		1	8	1		5	1	1		2	6	10				82
Board–Private Sector–1	3	1	2	1	3			2		1						2	2			20
Board–Private Sector–2	10	7	4		5	1	5	6	2			1		1		7	1	2		55
Board–Observer–1							1							1						7
Secretariat-Past-1	2					1		2		2				1		1				14
Secretariat–Past-2	5	2	2	1	2		4	3						1	2	4				29
Secretariat–Past-3	1													1				1		8
Secretariat–Past-4	10	6	2			1	9	3		2	1	1	1	1	4	4	3			58
Secretariat–Past-5	4	1				2		2						2	1	2	1		1	21
Secretariat–Present-1	2	1					2	1					1	1	1		1		1	18
Secretariat–Present-2	4	1	1			1	5	1		2	1			1	3	3	2			31
Secretariat–Present-3	4	1						2						1	1					14
Technical Partner–NGO-1	9	4	5	3	2			5		2					1	6				42
Technical Partner–Multilateral-2	8	1	6	1	2			7		3				2	4	5				45
Technical Partner–Multilateral-3	3	1				2		2					2		2	1	3	1	1	19

Technical Partner–Multilateral-4	5	1	1	2		1	1	1						1	2	2				21
Technical Partner–Multilateral-5	18	7	2	4		2	1	1	1	2	1	1	1		9	7	1			65
Technical Eval Ref Group–1	3	3		1		1	1	1							1	1				12
Transitional Working Group–1	6	2	1	1			5	5	2			1			5	2				36
Government–1	4	1		1	1			3	3							2				19
Totals	227	71	57	35	27	20	59	77	11	47	10	12	12	25	74	111	25	11	10	

Part Two: What does health systems strengthening mean in the context of the Global Fund?

Subjects responded to this question in two ways: they either provided a definition and comments, or they just provided comments without a definition. Of the interviews, 11 subjects did not provide a clear definition in the interview and required follow-up by email. All subjects provided comments. This section presents the definitions. Comments will be presented in part three. These definitions help to shed light on what the Global Fund means by health systems strengthening (Research Questions One) and why the meaning is difficult to understand.

Definitions

Definitions fall into two categories: "Disease-specific" and "Not Tied to the Three Diseases." "Disease-specific" means that subjects provided definitions of health systems strengthening that tied it to health outcomes for one or more of the three diseases. "Not Tied to the Three Diseases" means that subjects provided definitions of health systems strengthening that were broad and not tied to health outcomes for one or more of the three diseases. Of the 19 subjects who provided definitions, 12 of them provided definitions that were "Disease-specific." Six of the 12 were members of a Board delegation; four were present or past members of the Secretariat; and two were from Technical Partner organizations. Of the seven subjects who provided definitions that were not tied to health outcomes, three were members of a Board delegation; two were past employees of the Secretariat; and two were from Technical Partner organizations. It is notable that the predominance of Board delegation members and current employees of the Secretariat tied their definition of health systems strengthening to health outcomes, which is consistent with current Global Fund policy. However, not all Board delegation members tied their definition to health outcomes, which is consistent with the controversial aspects of health systems strengthening policy among the Board. Below are two tables that present definitions.

Table 5: Definitions of Health Systems Strengthening Tied to Health Outcomes for the Three Diseases

Subject	Definition
Board Delegation – Canada, Germany, Switzerland	"Fund health systems to the extent or in ways that produce results in one or more of the three diseases"
Board Delegation – Developing Country NGO	"Capacity building of the health system to enable health systems to provide sustainable services to people living with the 3 diseases"; "[a] health system that can enable countries to respond to the epidemic of these three diseases."
Board Delegation – Point Seven	"The 6 building blocks of the WHO – the 6 building blocks of health systems – and then if you look at the Global Fund, more specifically, the really key ones – human resources, information systems, infrastructure – I think these are they key issues that come out of Global Fund proposals as main barriers"

	"I think what was believed that countries would include health systems strengthening components within their disease specific proposal and so that if they would formulate a malaria program then the sort of all the hardware that would be needed to deliver [the program] – the staff, infrastructure, the labs, transport – would be part of the proposal"
Board Delegation – Private Foundations	"the overhead that is required in order for you to succeed at doing the vertical work"; "Supply chain management systems, healthcare training systems, some of the cost of the physical facilities or you know, other transport mechanisms needed to get care to people. Data systems for EPI, surveillance, probably some laboratory capacity – things that really, you know, are – would be bearing some of the burden of increased efforts on AIDS, TB, and malaria but were not specifically designed just for those diseases." "I think that they need to continue to be tied to the success of the three diseases."
Board Delegation – UK and Australia	"Initially, I think it was seen mainly as a delivery of commodities issue, how do you sort of scale up to make sure that the medicines . . . actually got to where they're meant to go."
Board Delegation – USA	"What's needed for the outcome within limits." "Start with your outcome - your outcome of healthier people. So, in order to have healthier people, you need resources committed to physical infrastructure, human infrastructure, logistics, communications, supply-chain management."
Secretariat – Present	"I think it's quite broad from the Global Fund's perspective. With that being said, of course, you have to make an intellectual link to AIDS, TB or malaria outcomes to be able to get health systems strengthening support. The only thing we don't fund is the infrastructure projects, but we basically fund everything else, as long as you can make that intellectual link with AIDS, TB or malaria."
Secretariat – Present	"health system strengthening supports areas; and the idea was to basically provide also support and money to remove bottlenecks, as we have called it, in the delivery of services, for instance, in health systems in general, which are constraints to achieving these outcomes in the disease areas, right? And so that is the broadest definition that we have provided." "in the broadest sense, we're providing system

	support – system strengthening support – for everything that would actually have a link to improved outcomes in the three disease areas.
Secretariat – Present	"Flexible definition" "WHO framework" (i.e., six building blocks) "(1) Within a disease program, or (2) cross-cutting health system activities that are part of the disease proposal" "The Global Fund is a major investor in health system strengthening: bottlenecks, human resources for health, monitoring and evaluation systems. Much of this investment is targeted at scaling up service delivery areas. These investments also benefit other areas, such as MCH. There are positive spillover effects beyond AIDS, TB and malaria."
Secretariat – Past	"Polyvalent investments – investments in management, laboratories, infrastructure" "Don't only deal with treatment of the 3 diseases – apply for what you need, but if those things you need benefit health systems, we like that"
Technical Partner – Developed Country NGO	"Bottlenecks: HRH, info systems – How can we alleviate bottlenecks for these 3 conditions?"
Technical Partner – World Bank	"The Global Fund should be able to pay for things that strengthen the delivery of the services on which it's focused, and some of those things might be related to certain health system elements. So the most logical thing would be pay for health system related inputs, like, not just buy drugs, but help to finance the systems that distribute those drugs." "there are a lot of things related to the inputs for these control programs that are also related to the capacity of health systems to deliver these inputs." ". . . finance some of the supporting mechanisms that are also needed to make these things work."

Table 6: Definitions of Health Systems Strengthening Not Tied to Health Outcomes for the Three Diseases

Subject	Definition
Board Delegation – Private Sector	"In the context of the Global Fund, it doesn't mean anything different than it normally means. It means ensuring that the interventions that you are funding are ones that are more sustainable and are gonna affect the longer-term outcome or output, even, rather than one-off. A good example is strengthening the procurement supply chain or logistics system, rather than setting up a parallel one."
Board Delegation – World Bank	"To enable the core building blocks of the health system to function properly."
Board Delegation – World Bank	"I don't think [the] Global Fund has it's own definition. They use the standard WHO definition."
Secretariat – Past	"Health systems strengthening refers to activities and expenditures that are not disease specific: hiring HRH; building clinics; water; power; strengthening of a supply chain; national management of a health system; managers; use of data about the performance of the health system. All of this would be deemed health systems strengthening in the Fund's framework."
Secretariat – Past	"So health systems in the concept of the Global Fund is – it's pretty much the political beast, which relates to either funding, which is not for the three diseases, or any consequences of the funding of the Global Fund, which is beyond the three disease. For example, if the Global Fund funds a program that recruits people from other health programs, that will be considered as a health system issue."
Technical Partner – WHO	"The point about strengthening a system is to make it work as a system, (i.e., for primary levels to refer to secondary levels, and for them to be supported by supervision, and to have money and people and, you know, the whole systemic approach to it, looking at how health care works.) And that providing the resources that a system needs isn't quite the same as strengthening the capacity of the system to become effective."
Technical Partner – Developed Country NGO	"I think of interventions that will strengthen the broader health system." "It's having an impact that's beyond the specific disease and ideally system-wide." "Encouraging countries to think, 'What can we do through the Global Fund that will have an impact

	that goes beyond just one feature and beyond the few diseases?'"

Explanation of Definitions

A. Disease-Specific

Figure 4: Terms or Words Used to Describe Health System Strengthening in Definitions that Were Tied to the Three Diseases

Capacity Building x2	**Polyvalent investments**
Hardware	**Bottlenecks**
Overhead	**Flexible**
Six Building Blocks x2	**Inputs**
Infrastructure x2	**Strengthen delivery**
What's needed	**Supporting mechanisms**
Quite broad	**System support**

Of the 12 subjects who provided definitions of health systems strengthening that were tied to health outcomes for one or more of the three diseases, a total of 14 different terms or words were used to describe what health systems strengthening means in the context of the Global Fund. Only two people mentioned the six building blocks of the health system promoted by WHO. This is interesting, given that the Global Fund endorses these six building blocks and encourages their use in its guidelines to applicants. Two people used the phrase "capacity building;" two people used "bottlenecks;" and two people used "infrastructure." Otherwise, **there was little consistency in the phrases and words people used to describe what health systems strengthening means in the context of the Global Fund**. Additionally, the words or phrases people used were generally vague – such as, "what's needed;" "hardware;" "overhead;" and "infrastructure." Use of the word "infrastructure" is particularly interesting, as the Global Fund explicitly denies use of its funds for capital projects, such as building hospitals or clinics.

Many subjects included examples of the type of health systems strengthening investments they believe the Global Fund could support. Subjects described 12 examples. The most common examples were "human resources for health" (4 people) and "supply chain" (4 people). Three people listed "information systems," "infrastructure," and "management." Two people listed "laboratory." Some of the examples might be collapsible into super categories, such as "management" and "training" under "human resources for health." Nonetheless, it is important to recognize that **people do not necessarily use the same words to describe the same thing**.

Figure 5: Examples of Health Systems Strengthening Investments from Subjects with Definitions that Were Tied to the Three Diseases

Human Resources for Health x4	**Transport**
Information Systems x3	**Communications**
Supply chain x 4	**Logistics**
Infrastructure x3	**M&E**
Management x3	**Training**
Physical Facilities	**Laboratory x2**

B. Not Tied to Three Diseases

Figure 6: Terms or Words Used to Describe Health System Strengthening in Definitions that Were Not Tied to the Three Diseases

Strengthening x3	**Sustainable**
Core building blocks x2	**Strengthening the capacity**
Activities & expenditures that are not disease specific	**Impacts of funding**
"Political beast"	**Impacts beyond 3 diseases**

Seven subjects provided definitions of health systems strengthening that were not tied to health outcomes for the three diseases. These definitions are much harder to describe in terms of patterns. Subjects used nine different terms to define health systems strengthening. Three subjects used the word "strengthening." One subject used the phrase "strengthening the capacity." Two subjects described health systems strengthening in very broad terms, specifically, "activities and expenditures that are not disease specific." Under this definition, any expenditure that is not commodities becomes known as health system strengthening (e.g., providing water, power and ambulances is health system strengthening). Two people did reference the building blocks, but did not tie the definition to health outcomes. **One trend in the definitions is the notion of investments having an impact beyond the three diseases**. One subject defined health systems strengthening as the "political beast" and drew a distinction between health systems strengthening as what the Fund supports and the negative impacts of the Fund.

In terms of examples, three subjects mentioned "hiring human resources for health." Two subjects referenced "supply chains," and one subject, a former member of the Secretariat, gave examples that are not accepted by the Global Fund, nor are they traditional examples of health systems strengthening: "building clinics," "water," "power."

Figure 7: Examples of Health Systems Strengthening Investments from Subjects with Definitions that Were Not Tied to the Three Diseases

Hiring HRH x3	**Logistics system**
Procurement supply chain x2	**Building clinics**
National management	**Managers**
Use of data	**Water**
Power	

Across both disease-specific and not tied to the three diseases definitions, there was consistency in that no one referenced purchasing of commodities as an example of health systems strengthening.

Part Three: Code Co-Occurrences and Explanation of Patterns by Delegation

Table 7 presents the co-occurrence of codes. The codes are listed across the top and down the left-hand side of the table. Where two codes intersect, there is a square with a number inside. The number in the square represents the frequency with which those two codes were applied to the same excerpt. Examining the co-occurrence of codes provides insight to the ways two codes interact.

In this research, "Comments," which was the most frequently applied code (227), had the highest co-occurrence with "Not Tied to Three Diseases" (107); "Resources" (69); and "Impact of Fund" (66). Excluding "Comments," "Not Tied to Three Diseases," which was the second most frequently applied code (111), had the highest co-occurrence with "Resources" (45); "Appropriateness" (44); "Impact of Fund" (40); and "Measures" (34). Excluding "Comments," "Resources," which was the third most frequently applied code (77), had the highest co-occurrence with "Not Tied to Three Diseases" (45); "Appropriateness" (27); "Impact of Fund" (26). Excluding "Comments," "Disease Specific," which was the fourth most frequently applied code (74), had the highest co-occurrence with "Impact of Fund" (22); "Measures" (19); and "Resources" (16). Excluding "Comments," "Impact of Fund," which was the fifth most frequently applied code (71), had the highest co-occurrence with "Not Tied to Three Diseases" (40); "Resources" (26); and "Effectiveness" (24). "Responsibility," which is an interesting code that has implications about the future of the global fund and health system strengthening, had the highest co-occurrence with "Not Tied the Three Diseases" (22); "Appropriateness" (17); and "Resources" (11).

Table 8 presents answers by interview subject to the question, "What Ought to be the Role of the Global Fund in Health Systems Strengthening?" Of the 15 members of Board delegations interviewed, four of them thought the Global Fund out to support health system strengthening activities that were not tied to health outcomes for the three diseases. The remaining 11 members of Board delegations thought any support for health system strengthening to be tied to health outcomes for the three diseases. The following section presents the viewpoints of Board delegations on health system strengthening.

Table 7: Code Co-Occurrence

	Comments	Impact of Fund	Appropriateness	Effectiveness	Efficiency	Accuracy	Measures	Resources	Sustainability	Responsibility	Usefulness	Value	Critique	Definition	Disease Specific	Not tied to 3 diseases	Operation of the Fund	Structure	Suggestion	Totals
Comments		66	59	40	22	20	54	69	9	43	12	12	1	4	55	107	1			681
Impact of Fund	66		13	24	16	2	21	26	5	2	1	4	7	5	22	40	5	2	4	292
Appropriateness	59	13		11	10	2	10	27	3	17	1	3			9	44				225
Effectiveness	40	24	11		12		10	10	5	3	1	1			14	23				167
Efficiency	22	16	10	12			5	16	3	3	1	1			5	15	5		3	128
Accuracy	20	2	2				2	2		2	2	1		1	5	6				55
Measures	54	21	10	10	5	2		19	2	5	4	5		2	19	34	2			232
Resources	69	26	27	10	16	2	19		6	11		3		1	16	45				294
Sustainability	9	5	3	5	3		2	6						2	3	6				51
Responsibility	43	2	17	3	3	2	5	11			1	1	1		6	22	3			141
Usefulness	12	1	1	1	1	2	4			1		3			2	5				37
Value	12	4	3	1	1	1	5	3		1	3				2	7				45
Critique	1	7								1							11	5	2	30
Definition	4	5				1	2	1	2						13	8				49
Disease Specific	55	22	9	14	5	5	19	16	3	6	2	2		13		4	2			203
Not tied to 3 diseases	107	40	44	23	15	6	34	45	6	22	5	7		8	4		1			409
Operation of the Fund	1	5			5		2			3			11		2	1		9	10	60
Structure		2											5				9		3	25
Suggestion		4			3								2				10	3		27
Totals	681	292	225	167	128	55	232	294	51	141	37	45	30	49	203	409	60	25	27	

Table 8: Answers by Interview Subject to the Question, "What Ought to be the Role of the Global Fund in Health Systems Strengthening?"

Subject	Answer
Board Delegation – Canada, Germany, Switzerland	Tied to 3 Diseases
Board Delegation – Developed Country NGO	Not Tied to 3 Diseases
Board Delegation – Developed Country NGO	Not Tied to 3 Diseases
Board Delegation – Developed Country NGO	Not Tied to 3 Diseases
Board Delegation – Developing Country NGO	Tied to 3 Diseases
Board Delegation – Developing Country NGO	Tied to 3 Diseases
Board Delegation – Observer (Developing Country)	Not Tied to 3 Diseases
Board Delegation – Point Seven	Tied to 3 Diseases
Board Delegation – Private Foundations	Tied to 3 Diseases
Board Delegation – Private Sector	Tied to 3 Diseases
Board Delegation – Private Sector	Tied to 3 Diseases
Board Delegation – UK	Tied to 3 Diseases
Board Delegation – USA	Tied to 3 Diseases
Board Delegation – World Bank	Tied to 3 Diseases
Board Delegation – World Bank	Tied to 3 Diseases
Secretariat – Present	Neutral
Secretariat – Present	Neutral
Secretariat – Present	Neutral
Secretariat – Past	Tied to 3 Diseases
Secretariat – Past	Tied to 3 Diseases
Secretariat – Past	Neutral
Secretariat – Past	Tied to 3 Diseases
Secretariat – Past	Tied to 3 Diseases
Technical Partner –NGO	Tied to 3 Diseases
Technical Partner – WHO	Does not state an opinion
Technical Partner – WHO	Not Tied to 3 Diseases
Technical Partner – World Bank	Tied to 3 Diseases
Technical Partner – World Bank	Tied to 3 Diseases
Technical Eval. Ref. Group (Developing Country)	Not Tied to 3 Diseases

Belief Systems of Board Delegations

By examining the comments on the questions, "What does health systems strengthening mean in the context of the Global Fund" and "What ought to be the role of the Global Fund in health systems strengthening," the beliefs of the various Board delegations can be clarified and traced to legitimacy. In this way, Research Questions Three and Four are addressed. This section presents findings organized by clusters of Board delegations sharing similar beliefs. Quotations are used in this section to illustrate beliefs of subjects. Figure 8 presents a conceptual map of the findings.

United States / Japan / Private Sector / Private Foundations

The major theme to emerge from interviews with members of these delegations is that health systems strengthening, broadly defined, without any tie to the three diseases, is not an appropriate activity for the Global Fund to engage in. Members of these delegations recognize the importance of doing some systems strengthening work to ensure the effectiveness of live grants. However, most members of these delegations felt strongly that any system strengthening work needed to be viewed in the context of the mandate of the Global Fund and measured in

terms of improved health outcomes for the three diseases.

Their reasons for this belief varied by delegation, but there are some consistencies. For example, one theme across the interviews was that horizontal investments (i.e., health systems strengthening), so far, have not shown much impact in terms of improved morbidity and mortality. To the contrary, as suggested by one subject, just focusing on health systems strengthening could lead to a reduction in health outcomes.

> *"[I]f you go back to one of your earlier questions about why the Global Fund was created, I, frankly, think that a lot of these so-called 'horizontal investments' that had been made so far – a lot of the donors had just lost their confidence that those were actually addressing real, urgent health needs of countries." (Board-Private Foundations-1)*

> *"[I]t's never worked. I mean, there are plenty of data from – as you probably know, health systems was the 'in' thing 30 years ago. There are plenty of data that just focusing on health systems didn't lead to any health outcomes. In fact, we saw reduction in health outcomes in Zambia. Now, that was probably due to HIV/AIDS, but we have no data that simply investing in health systems leads to improved health." (Board-Government-2)*

Instead, these subjects believe the two greatest strengths of the Global Fund are its focus on three diseases (i.e. "vertical investments") and its performance-based approach (i.e., measuring and reporting health impacts for these diseases). The insistence on performance measures related to health impacts has to do with accountability and showing that money is being spent wisely.

> *"[W]e understand the connection between the systemic investments and the success in these vertical programs, but the track record so far, is poor and the evaluations that we've seen of Global Fund and GAVI around the health systems investments seem to indicate that our concerns are valid. So, you know, we were certainly part of the noise to say we need to do a better job of measuring. . . [so] that this money isn't just getting burned up with no real resulting health improvements." (Board-Private Foundations-1)*

Additionally, some members of these delegations believe that health systems strengthening more broadly defined is not the Global Fund's responsibility. In part, this belief relates to the long time horizon associated with health systems investments. However, subjects also believe the Global Fund is not well-suited to take on this work – it does not have the technical capacity or the resources. Rather, they believe other organizations are better suited.

> *"I mean, the Global Fund, and to the same, you know, to a similar extent, GAVI, are check-ready instruments based in Geneva. . . . So, when you talk about things that are quite complex and where the . . . framework for success is, you know, quite long, it just doesn't feel like that's really where the Global Fund has much business going." (Board-Private Foundations-1)*

> *"The Global Fund doesn't have the capacity or resources to take on a whole area of health systems strengthening. Even if it had enough resources, it need not take on health system strengthening as a fourth leg." (Board-Private Sector-1)*

> *"[T]he World Bank, hopefully with some changes that allow it to better engage civil society, might be better placed to do sort of the long-term help that requires much more hands-on, technical support than the Global Fund is able to give." (Board-Private Foundations-1)*

However, not all subjects in these delegations held these beliefs. One subject feels strongly that no one should do health system strengthening work. This subject believes health systems strengthening is a meaningless term that should never be used in global health. Instead, this subject believes any system strengthening work ought to be done in the context of vertical investments.

> *"[Health systems strengthening] is a meaningless term that should never be used. It's pointless. Health system strengthening means nothing and no one on Capital Hill or anywhere else thinks it means anything, and it will never have money behind it. The purpose of health is to improve the health of an individual and community to save and lift up lives. The purpose a health – health is not to build infrastructure and hire people. So, if your goal is health systems, you will create something that doesn't lead to your outcome. Start with your outcome - your outcome of healthier people. So, in order to have healthier people, you need resources committed to physical infrastructure, human infrastructure, logistics, communications, supply chain management. But, starting with the health system is nonsensical and no one will ever fund it." (Board-Government-2)*

Other subjects did not object to the term "health system strengthening," but did agree that any health systems strengthening work pursued by the Global Fund ought to be connected to improve health outcomes for the three diseases.

> *"I think it should continue to pay a fair amount of – a fair percentage of the overhead cost, but it ought to be dealt with just like that, which is, it's not the Global Fund of GAVI's responsibility to deal with the broader, longer-term, more complex health system needs of countries. It should pay its fair share of it's drain on those systems to you know, like, overhead, but leave for those that are more suited the job of that longer-term investment strategy." (Board-Private Foundations-1)*

Developed Country NGO

In contrast to the beliefs of the US/Japan/Private Sector/Private Foundations, the Developed Country NGO delegation believes that health system strengthening, broadly defined, is an essential activity for the Global Fund to engage in. They believe the Global Fund ought to provide funding for health systems strengthening work and the funding ought not to be restricted to health outcomes for the three diseases. Their rationale for these beliefs is four–fold. First, they

believe weak health systems are a key barrier to universal access to AIDS treatment. As such, health systems strengthening is necessary to achieve health outcomes around HIV/AIDS, TB and malaria.

> *"[S]o you have Civil Society on the one side saying, 'This is a huge barrier to universal access. It has to be prioritized. And the demand is huge. We know the price tag is big, and we know that's part of why you, the donors, are pushing back" (Board-Civil Society-1)*

> *"Health system strengthening is always a critical element of . . . dealing with primary healthcare issues, including AIDS, TB and malaria. I think everyone knew that. I think that people understood that to achieve people-level impact on prevention and treatment of TB and malaria, that you had to strengthen health systems. You know, people that were in the movement that were advocating universal access to AIDS treatment, we knew – everyone knew that you have to build a health system. You're providing a lifelong intervention . . . . And when you're training health workers, you can't create AIDS workers and TB workers and malaria workers. They're health workers." (Board-Civil Society-3)*

> *"AIDS treatment activists felt like in order to get to the universal access for HIV/AIDS, we needed to have a health system. We needed to have human resources for health. We needed to have effective drug procurement and distribution systems. We needed to have information systems, et cetera, et cetera." (Board-Civil Society-3)*

Additionally, they believe health system strengthening supports the mission of the Global Fund, contributes to the sustainability of Global Fund investments, and has positive externalities that benefit not only the three diseases, but other diseases as well. These views were expressed in the 2006 sign-on letter the Developed Country NGO delegation sent to the Board (see Appendix 8). However, the following quotes from interviews also illustrate these beliefs.

> *"'Okay, strengthening lab capacity; it's gonna be an excellent way to improve our ability to track, treat, cure, prevent TB, but also, to have all these spillover benefits for our laboratory system in the country.'" (Board-Civil Society-1)*

> *"[We were] encouraging countries to think, 'What can we do through the Global Fund that will have an impact that goes beyond just one feature and beyond the few diseases. . ." (Board-Civil Society-4)*

The Developed Country NGO delegation does not support the World Bank "taking the lead" in health systems strengthening activities.

> *"What we also saw happening was the situation where, if the Bank got the, like, 'gold ring' in the division of labor debate, then they would also get the money. It . . . would become a zero sum proposition . . . . [W]e wanted to prevent a bad outcome, where the Bank was seen as having the sphere of influence – be at the*

center of the sphere of influence around health system strengthening – because Civil Society very much has a critical analysis of . . . the Bank's track record, the Bank's commitment to moving quickly, moving on results, and the Bank's commitment on involving Civil Society at every level of demand creation, implementation, evaluation. It's just not there. The Bank is really, is very much behind the Fund when it comes to all these issues around 21st century governance and implementation . . . . [W]e see what you're trying to do and we don't – we won't support it. We see that you're trying to create prominence for the Bank and we don't support it." (Board-Civil Society-1)

Rather, they believe everyone has a role to play.

"[W]e tried to . . . really force some more mature discussion around the division of labor saying, 'The Global Fund – you know – there's sort of enough need for everyone. The Global Fund should not have – you know – there shouldn't be a 'lead agency', and that's just not an appropriate or efficient way to look at the problem." (Board-Civil Society-1)

In terms of the mechanism, the Developed Country NGO delegation strongly supports an open window (i.e., standalone component) for health systems strengthening funding (as opposed to funding system strengthening work through disease programs). This delegation believes the standalone component for health systems strengthening is critical for encouraging countries to use the Global Fund for health systems strengthening investments. In my interviews with subjects from this delegation, subjects expressed concern that not enough countries use the Global Fund to address system-wide barriers (e.g., the health workforce).

". . . demand around health systems to . . . countries saying, 'Well, we have this HIV problem, but we have all these other barriers and bottlenecks that are related to both HIV and to larger problems. We want to use the Global Fund to address these problems.' That was even more unheard of. And I think that concerned us a lot as activists and as Civil Society because we very much wanted to see and want to see countries use the Global Fund for those sorts of 'diagonal' investments. And, in fact, the Global Fund has no barriers in using resources for that. . . . [T]hat kind of freedom of opportunity and opportunity for innovation and synergy, I think, is, as of yet, – you know – has not been exploited. And it's very disappointing, even to this day." (Board-Civil Society-1)

"[In 2006] Civil Society worked very hard to push this perspective around using a window to accelerate expression of quality demand around health system strengthening as related to the three diseases." (Board-Civil Society-1)

The Developed Country NGO delegation sees the standalone component for health systems strengthening as an important mechanism for encouraging countries to use the Global Fund to innovate and address system-wide barriers. However, they also see the use of the money in this way as an opportunity to make these system investments subject to performance frameworks and keep civil society involved in how the money is spent.

"Civil Society . . . saw that this was a way to transform some element of health systems strengthening investments, to make them subject to performance frameworks, to outcomes measures, to involvement by Civil Society, not just government-to-government investments. So we saw sort of multiple opportunities that could be exploited there." (Board-Civil Society-1)

Developing Country NGO Delegation

The Developing Country NGO delegation also supports the notion of involving civil society in health systems strengthening investments. Both of the subjects from this delegation interviewed were careful to note that "community systems strengthening" is an important element of health systems strengthening that is often overlooked.

". . . one aspect of the health system strengthening is a community system strengthening, and whenever you go through the Global Fund documents you can see that we're always talking about the strengthening of the health systems, and also we're talking about the community system strengthening as an additional and complimentary part to the health system strengthening. And civil society was always advocating to improve the role of the communities in this." (Board-Civil Society-5)

"Health systems strengthening must include community systems strengthening. Often this is forgotten." (Board-Civil Society-1)

When asked to define community systems strengthening, one subject described it as,

". . . strengthening of community organizations, such as civil society organization, faith based organization, to provide additional services . . . for the people in need to support health systems in their role of providing treatment and care and support to people diseased" (Board-Civil Society-5)

According to this subject, one typical example of community system strengthening, is task shifting for monitoring of adherence to treatment. Many patients are not able to access hospitals or other medical institutions. For these patients that are hard to reach, the community can organize itself to support treatment delivery to them. Additionally, in many countries, prevention activities are implemented by community organizations (Board-Civil Society-2).

Subjects in this delegation agreed with the Developed Country NGO delegation that strong health systems are essential for the Global Fund to achieve its goals around the three diseases.

"[It's] not possible to address completely the three diseases without a good health system. . . . Health systems should be fully part of the Global Fund." (Board-Civil Society-2)

"[I]t's very difficult to fight three diseases if you do not have environment and a system that can support that. . . . I remember [at a WHO meeting in

> *2007] we had data that 40 % of medical equipment in developing countries is not used, mainly because the health workers do not know how to use it." (Board-Civil Society-5)*

However, both subjects from this delegation were clear in their views that the mandate of the Global Fund should not be expanded to include health systems strengthening. Rather, the Global Fund should continue to focus on the three diseases and support health systems through its investments in the three diseases. Subjects do not support expanding the mandate to include health systems is because (1) resources are limited, (2) there is no evidence that supporting health systems will bring more resources to the Fund, and (3) the Fund has not yet reached the goals for the three diseases that it was set up to achieve.

> *"It should remain a global fund for AIDS, TB and malaria. We have not yet reached the objective of the initial creation of the Global Fund." (Board-Civil Society-2)*

> *"My personal opinion that we should stay linked with the three diseases, what is our core mandate . . . . Sometimes it seems to me that we do not recognize that there is an economic crisis around us, and the economic crisis should inevitably influence our plans . . . . I think that the main problem – why my delegation oppose expansion of mandate – because we do not see the avalanche of new donations waiting for us just because we expand our mandate." (Board-Civil Society-5)*

Point Seven (Denmark, Luxembourg, Netherlands, Norway, Sweden and Ireland)
From the early days of the Global Fund, members of the Point Seven delegation understood the role of strong health systems in the success of the Global Fund. This delegation always supported the idea of using the Fund's resources to strengthen health systems. However, after seeing the results of Round Five, when a standalone component for health systems strengthening was used, this delegation felt a "very open window" for health systems strengthening was not the best use of Global Fund resources, nor was it an approach that worked for countries.

> *"From the early days, it was seen that functioning health systems were key to the success of the Global Fund. You cannot achieve results in the field of AIDS, TB and malaria if there is not a functioning health system to deliver these results . . . . [B]ut it has always been difficult to find the right modality of doing that." (Board-Government-1)*

> *"[Point Seven] didn't have any problem with the Global Fund per se funding health systems, but we were not sure whether having a very open window would be the best use of Global Fund's resources. . . . [T]his sort of really open-ended health systems window – it is confusing for countries and it is very unsatisfactory for countries to put all of that effort in developing proposals that cannot be funded." (Board-Government-1)*

Instead, this constituency believes the Global Fund is not the right organization to do broad-

based systems support. They believe other donors have more "added value" in this area.

> *". . . the Global Fund was entering into an area where others with country presence would have much better mandate and would be much better positioned . . . as I said, the World Bank for funding infrastructure or the Regional Development Banks. They have much clearer mandate to fund those sort of activities than the Global Fund." (Board-Government-1)*

However, they do believe the Global Fund has a role to play in health systems strengthening, but it needs to consider what other organizations – such as bilaterals and development banks – are doing and complement those activities. To this end, Point Seven supports the Health Systems Funding Platform and desires to see the Global Fund put money behind it.

Canada/Germany/Switzerland
I found the beliefs of the subject I interviewed from this delegation to be a hybrid of those of the US/Japan/Private Sector/Private Foundations and Point Seven. Specifically, the subject believes the Global Fund ought to fund health systems activities, as long as the investments produce results in one or more of the three diseases. Additionally, the subject believes health systems strengthening is a vague concept and more research needs to be done to understand whether or not health systems investments actually produce changes in health outcomes.

> *"[I]f the answer to that is no, then – or, you know, it wouldn't be yes or no. It would be, 'Not as large as other investments,' let's say. Then the Global Fund shouldn't be involved in health systems, and neither should anybody else, right? In other words, if it's not a good idea then nobody should be doing it." (Board-Government-4)*

However, this subject believes, even if health systems investments do produce results, the Global Fund is not well-suited to engage in this work. The Global Fund does not have the on-the-ground, in-country presence necessary to understand the complexity of the health system. Additionally, health system strengthening does not play to the Global Fund's advantages.

> *"The other possibility is that it is a good idea that these investments do produce results. And then the question is, 'Is the Global Fund well suited to do that?' And probably there the answer is no. It doesn't play to the Global Fund's advantages, which are, you know, more on the specialization in three important areas, three important diseases.*
>
> *You know the Global Fund doesn't really have the ability, there's no on-the-ground presence, you know, it doesn't have the ability to really do health systems work to understand the complexity of the health system. It's probably not the best organization to do health systems say compared to the World Bank. So, I think it's kind of double sort of hurdle the health systems work has to face. First, is it a good thing in general? And even if so, is it a good thing for the Global Fund to do? I doubt that both of those hurdles can be surmounted." (Board-Government-4)*

Instead, this subject believes the World Bank ought to be the organization that focuses on health systems work, as it has *"the depth to understand health systems and works with the country on health systems or other complex issues" (Board-Government-4).* The Global Fund ought to focus on doing more with the money it has.

> *"That is the biggest most important thing they can do. . . . I think the main thing isn't so much which measures they would be taking or which things they would be funding, as, within the things they fund, how they would be organizing and delivering that. . . . [It's] working with countries to chose the more efficient (i.e., lower cost) way to deliver [services] – i.e. deliver it to more people with the same amount of money – i.e. save more people's lives. That would make a huge difference." (Board-Government-4)*

United Kingdom and Australia

Initially, the UK position was that vertical funds were not the best place to take on health systems strengthening. They believed strongly that health systems strengthening work required country-level engagement, which the Global Fund does not have. However, after several unsuccessful attempts to get the World Bank to step up its commitment to health system strengthening, the UK agreed to allow Global Fund resources to be used for systems strengthening activities, though their first-line was to restrict the Fund to a narrow focus. They were afraid a focus on health systems strengthening would dilute the Fund's resources and affect treatment figures.

> *". . . because of the politics around it, and the G8 politics, and the need for politicians to report on universal access, [we said] that it should be a pretty limited role.*
>
> *You know, the UK government and other governments have other ways of funding health systems strengthening, so it wouldn't necessarily think the Global Fund was the best vehicle for that." (Board-Government-3)*

Going forward, this delegation is hopeful for the Health Systems Funding Platform to be a new way of working, one that will allow agencies to be more effective in the way they spend resources on health systems strengthening.

> *"My own view is that Global Fund's role should be relatively limited, because I still don't feel that institutions that are based in Geneva can do a terribly good job on health system support. I do feel that the platform . . . has some potential in that it's a partnership of four agencies, because those agencies have a country presence.*
>
> *There's a lot of questions about how effective the agencies currently do health systems strengthening, and I think there's quite a lot of hope for this new way of working. . ." (Board-Government-3)*

World Bank

Members of this delegation believe that well-functioning health systems are essential for the Global Fund to reach its goals around the three diseases.

> *". . . health systems, in a sense, is a euphemism – not a very good one – for saying, 'At some point, you're not going to be able to deliver malarial services. You're not going to be able to deliver HIV services unless you deal with the system that delivers it.' " (Board-Multilateral-2)*

However, members of this delegation do not believe the Global Fund should engage in health system strengthening work, as this work is not within the Fund's current mandate. Additionally, health systems strengthening was not the original intent of the Global Fund, nor is it the Fund's core competency. Instead, they believe health system strengthening requires long-term engagement with countries through technical assistance, which the Global Fund does not do, nor should it.

> *"[Health systems strengthening] was not the objective of the Global Fund. . . . The Fund was created to be a quick dispersing, non-bureaucratic mechanism to get money out quickly to address AIDS. TB and malaria were added on because they are exacerbated by AIDS, and because they are comorbidities.*
>
> *The Global Fund is a financing institution. The mandate of the Fund is to raise and disburse funds. It is not supposed to deliver technical assistance." (Board-Multilateral-1)*

Figure 8: Summary of Cultural-Cognitive Beliefs about Health Systems Strengthening in the Context of the Global Fund Presented by Board Delegation

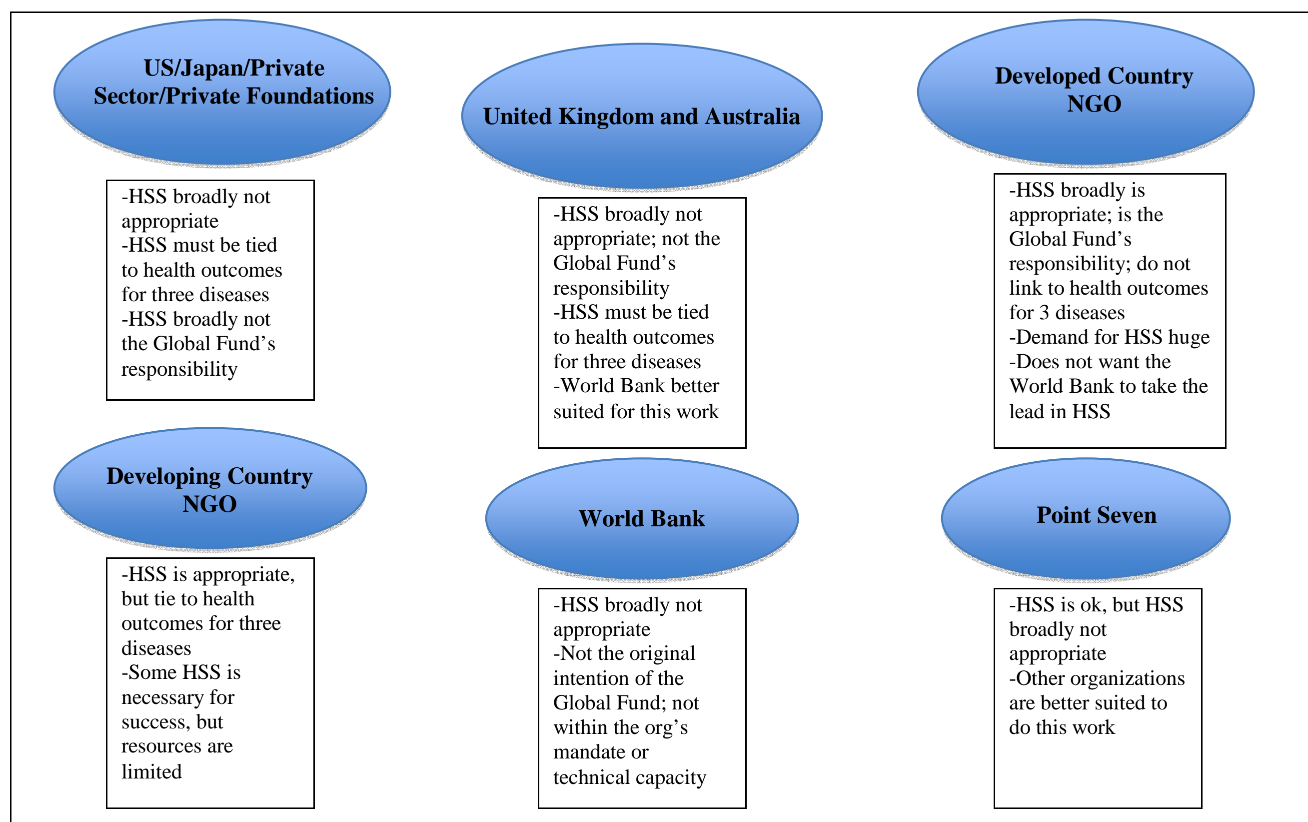

Figure 8 presents a summary of key cultural-cognitive beliefs about health system strengthening in the context of the Global Fund by Board delegation. Not all Board delegations are represented here, but many of the key delegations who shaped the Global Fund's policies on health system strengthening are represented in this figure. The figure shows that a spectrum of beliefs exists across Board delegations.

Part Four: Overarching Patterns

In addition to the results described by Board delegation, there are five overarching patterns.

(1) Health system strengthening is a vague concept.

Health system strengthening is a vague concept, and the vagueness of this concept is not specific to the Global Fund. According to several subjects, in the global health environment, there is not a tight definition, nor is there agreement, on what health systems strengthening means and what constitutes acceptable health systems work.

> *"I think generally health systems hasn't been well defined. It's kind of a vague concept . . . there hasn't been a lot of intellectual rigor around it, or, you can say, there hasn't been a lot of agreement, either way. There isn't a tight definition." (Board-Government-4)*

> *Subject: "Because health systems, to put it mildly, was diluted – not a simple thing to understand. It was much easier also to get politicians in rich countries to provide money to something that they did understand, like a disease, than something completely amorphous like health systems, which is gobbledygook to most people."*
>
> *Interviewer: "Right, the black box."*
>
> *Subject: "Exactly. The black box, which even proponents of black box have difficulty in defining." (Board-Multilateral-2)*

> *"Again, as I told you, health systems is a political beast in the context of the Global Fund. So, it's really, if you take health systems as one term, it's hard to relate that." (Secretariat-Past-5)*

(2) Depending on the context, there are two meanings – a technical one and a political one.
For the technical meaning, the Global Fund uses the six building blocks of health systems developed by WHO (see Chapter 2 for an explanation of the building blocks). This use is evident in its guidelines and is confirmed through interviews with Board members and members of the Secretariat. In the political context, however, the meaning varies more widely.

> *"In a more political context . . . [i]t becomes a little bit, kind of – a – almost a stand-in for the discussion around budget support versus vertical support, where you have under one extreme - you know, just funding governments to do their health budget however they so chose versus others who want to have, you know, a very formal project-based proposal with specific deliverables, milestones, etc, etc." (Board-Private Foundations-1)*

In the political context, health systems strengthening can mean an approach to development work typified by transfers of money to Ministries of Health to spend how they see fit. This meaning is contrasted with an approach to development that is project-based and tied to specific deliverables, milestones, timelines and health outcomes. In the first meaning, health systems strengthening is associated with supporting the public sector. However, the Global Fund has stakeholders beyond the public sector – including the private sector and nongovernmental organizations. The Global Fund gives a significant amount of money to what is called "the nonstate sector." In the political context, health systems strengthening also means, *"using money for things that are not the three diseases;"* as well as, *"consequences of funding" (Secretariat-Past-5)*. This distinction was made clear in the definition of health systems strengthening put forth by a former member of the Secretariat.

(3) There is dispute over what constitutes acceptable health systems strengthening work.
There were a number of comments on activities the Global Fund currently supports and defines

as health system strengthening that certain technical partners, as well as one Board member, do not see as health system strengthening.

> *"The biggest part of their investment is in salary top-ups and training. That is not an investment in the health system." (Technical Partner-Multilateral-3).*
>
> *"[I]n Malawi, a lot of the health systems strengthening grant is to go for salary top-ups, so is that health system strengthening?" (Board-Private Sector-2)*
>
> *"[P]roviding the resources that a system needs isn't quite the same as strengthening the capacity of the system to become effective." (Technical Partner-Multilateral-4)*

According to one technical partner, *"Health systems strengthening is more closely linked to public sector management type of stuff (policy changes)" (Technical Partner-Multilateral-3),* and another, *"the point about strengthening a system is to make it work as a system, i.e. for primarily levels to refer to secondary levels and for them to be supported by supervision and to have money and people and, you know, the whole systemic approach to . . . looking at how health care works" (Technical Partner-Multilateral-4).*

However, there is agreement that purchasing of commodities, such as AIDS drugs, is not considered health system strengthening.

(4) Health system strengthening is essential for the success of the Global Fund, but there is disagreement over whether or not the Global Fund should engage in health system strengthening; and, if it does, how, and to what extent.

Across all interviews, there was agreement that the success of the Global Fund is contingent upon the strength and functionality of countries' health systems. However, there was disagreement over whether or not Global Fund should engage in health system strengthening. As discussed earlier, some delegations see health system strengthening as an appropriate activity for the Global Fund because strong health systems are necessary to achieve health outcomes. Additionally, these subjects believe health system strengthening supports the mission of the Global Fund and contributes to sustainability of Global Fund investments.

These views are contrasted by those who do not think health system strengthening is an appropriate activity for the Global Fund. These subjects believe health system strengthening dilutes the Fund's resources, is a distraction from the Fund's core mandate, and does not play to the Global Fund's advantages. These subjects believe the Global Fund is not well-suited to do this type of work because it lacks the technical capacity and it does not work at the country level. Subjects also believe there are other organizations better suited to do health system strengthening work. Additionally, subjects argue that resources are limited and as such they should not be used for activities that are beyond the mandate of the Fund.

For those who agree, or at least consent, to using Global Fund resources for health system

strengthening, there is a lack of agreement over what the term means, what the Fund is willing to support, and the best mechanism for allowing countries to apply for the support. Some delegations feel the Fund ought to support any health systems strengthening activity. Other delegations believe the Fund can support any activity, so long as the country applicant can relate the activity back to improved health outcomes for the three diseases. Still other delegations believe it is not the Fund's responsibility to support health systems. There is also disagreement over the mechanism. Developed Country NGO delegations believe an open window (i.e. a standalone component) is essential for encouraging expressions of quality demand, whereas many other delegations believe applicants ought to apply for funding as part of their disease specific proposals.

(5) Linking funding to measurable health outcomes is essential for legitimacy.
One of the overarching themes to emerge from this research is that measurable health outcomes are critical to the Fund's ability to get future resources.

> *"Everybody wants attribution. I've done this, and I've done this well."*
> *(Technical Evaluation Reference Group-1)*

Health systems strengthening is problematic for this trend because its indicators are process related, not impact related. One reason certain donors were hesitant to use Global Fund resources to invest in health systems is because it would be very difficult to measure results in terms of health outcomes. According to several subjects, proving results is critical to mobilizing future resources. This trend is not specific to the Global Fund–it affects all categorical initiatives–and some donors are calling for it to apply to organizations whose work is not necessarily disease or intervention specific, such as the World Bank.

> *The Global Fund should stick to the – more of a vertical approach and let the World Bank do the longer-term, horizontal stuff. . . . [T]hey've certainly got the horsepower to figure out how to measure the stuff in a smarter way than has been done in the past. And, frankly, I think they're gonna need to do it for their own folks because the days of people just sending checks over for IDA and not paying attention to the results, I think, are over. So, they have their own need to be able to show how investments, if they're gonna make it health systems – is actually resulting in improved health for people." (Board-Private Foundations-1)*

Conclusion
Health systems strengthening is a vague concept, and the vagueness is not specific to the Global Fund. There is not a tight definition, nor is there agreement, on what health systems strengthening means and what constitutes acceptable health system strengthening work. Depending on the context, health systems strengthening has two meanings – a technical one and a political one. In the political context, the meaning varies widely. Although health systems strengthening is essential for the success of the Global Fund, there is not agreement over how the Global Fund ought to engage in health systems strengthening.

Chapter 5

A Way Forward: The Global Fund's Role in Health System Strengthening

This chapter discusses the implications of the results presented in Chapter 4 and addresses the four research questions from Chapter 2. This discussion also considers the limitations of the research. The chapter concludes with thoughts on what the Global Fund can do about health systems strengthening going forward.

Discussion

The Global Fund was established in 2002 out of a need for innovation. The urgency of the HIV epidemic required a new mechanism and a new way of doing business. G8 donors were looking for a way to ramp up their spending on AIDS, TB and malaria, but were reluctant to give this money to existing agencies. Donors were not convinced that putting money through existing systems was going to work. Certain G8 donors, such as the US, were skeptical of multilateral entities, such as the WHO and UNAIDS, and felt their own bilateral programs could not manage such large amounts of money successfully. Additionally, donors had lost confidence that existing investments – many of which were 'horizontal investments' – were addressing urgent health needs of countries. There was no evidence – or not enough, anyway – that health systems investments had resulted in improved health outcomes. As a result, there was considerable skepticism among donors that existing organizations had been as effective as they could have been with the money already given to them. Northern European donors were looking for a way to increase their commitment to HIV/AIDS, but also play a role in the governing of that entity.

There was also a desire to channel money to civil society and partner with the private sector to make the money work better. The Global Fund was devised as a public-private partnership with the intent to tap the private sector – not just for money, but also for ideas. As such, the Fund was a unique and new development mechanism that would provide money in a different, more accountable way. It was intended to be a quick disbursing, non-bureaucratic mechanism to get money out to public and private destinations for treatment of the three diseases. From certain quarters, this approach was seen as circumventing the public health system. However, at the time, many donors thought governments might not be the best conduits to reach populations marginalized by the epidemic.

The Global Fund was not intended to have much of a role in health systems. The intent was for the Global Fund to be a quick way of financing increased commodities to allow government and non-government partners scale up disease programs rapidly. Funding recipients were expected to have on hand the "hardware," or capacity, needed to implement the program, such as health workers. For those who did not have capacity, the *Framework Document* of the Global Fund allowed applicants to use Global Fund resources to build capacity – but the language was vague and scope unclear.

> "[The Fund] will support programs that address the three diseases in ways that will contribute to strengthening health systems." (GFATM, 2002a)

These words around health system strengthening were included to reassure the Northern

European development orthodox folk and WHO, but for many on the Board and Transitional Working Group, these words did not mean much. At that time, the focus was on commodities. The rest was trimmings.

Consequently, when the Global Fund was created, legitimacy was rooted in the Fund's focus on three diseases, not health systems; emphasis on accountability through results-based financing; partnership with public and private actors; and organizational design as a financing mechanism, not implementing agency. Advocates in the universal access to AIDS treatment movement knew that building a health system was important for the long-term sustainability of providing antiretroviral therapy, which is a lifelong intervention; however, at the political level, health systems was not the 'lead flag.' The 'lead flag' – or advocacy tool – was HIV/AIDS. Activists used HIV/AIDS to generate the resources to create the Fund. Public health experts at bilateral and multilateral organizations also knew that strong health systems were important for implementation and sustainability. However, many felt a Global Fund for health systems would be a black hole in which it would be nearly impossible to measure results; and if they could not measure results, they would not get resources in the future. In this way, showing health impacts (i.e., results) established how the Global Fund was new and different and became a critical component of the Fund's legitimacy.

Research questions

What does the Global Fund mean by health systems strengthening?

Health systems strengthening in the context of the Global Fund has multiple meanings depending on whom you ask and when you ask them. As described in previous chapters, health system strengthening in the context of the Global Fund has a technical meaning as well as a political one; however, untangling the two is nearly impossible, as the technical meaning is shaped by politics. This is evident when one looks at the origins of the Global Fund and understands why it was set up as a fund for three diseases, not health systems. Additionally, the language around health systems used in the *Framework Document* is there to appease stakeholders, not to apply a rigorous definition of the term.

Over time, as issues around health systems constraints and Global Fund grants came to light, the Global Fund tried to put forward a clearer conception of what it meant by health systems strengthening. It provided examples of acceptable health systems activities, but struggled to provide a clear and concrete definition because of the politics around health system strengthening. On one hand, the Board tried to honor the demand-driven approach of the Global Fund by offering a conception of health system strengthening that was broad and flexible, as a flexible definition would allow countries to determine what works best for them. Ultimately, though, this conception was not useful, as it resulted in proposals that were too broad, too ambitious, unfocused and vague in their objectives and proposed activities. In Round 8, to improve upon and clarify its conception, the Global Fund adopted the WHO Health System Framework, which is composed of six system building blocks (see Chapter 2). However, the WHO Health System Framework targets all health services and health outcomes, many of which are beyond the scope of the Global Fund's mandate. Additionally, WHO focuses on the public sector or "state sector." The Global Fund has a variety of stakeholders on its Board – many who are from the "non-state sector" – as such, health systems strengthening for it has to mean more

than the public sector. Consequently, the Global Fund kept the broad and flexible components – "money to remove bottlenecks in the delivery of services and address health system constraints" – but restricted it to the bounds of its mandate – "to achieving outcomes in the three disease areas." The official definition reads: "Health systems strengthening in the context of the Global Fund consists of investing in **activities** to help health systems overcome **constraints** to the achievement of improved outcomes for HIV/AIDS, TB and malaria."

Implications

(1) This definition maintains the focus on the three diseases and accountability through performance measures, but also appeases those stakeholders who want an explicit recognition of the Fund's willingness to support health systems strengthening more broadly. In practice, the policy is confusing, as it does not give a clear indication affirming system-wide health systems strengthening activities, nor does it state explicitly what is and is not allowed. The policy allows a little bit, but is ultimately restrictive. As a result, there is an artificial distinction between health systems strengthening for AIDS, TB, and malaria and health systems strengthening in general.

(2) The Global Fund spends a significant amount of its resources on health systems strengthening. However, the general vagueness around the concept, disagreement over the definition and what constitutes health system strengthening work, and the political sensitivities around health systems strengthening make it difficult to capture accurately what the Global Fund finances in health systems strengthening.

What have been the organizational policies and activities of the Global Fund towards health systems strengthening?

Chapter 3 presents a detailed account of the Global Fund's organizational policies and activities around health systems strengthening over time. The summary answer to this question is that throughout ten funding rounds, there has not been a shift in policy *per se* over health systems strengthening; rather, there has been a shift in the willingness to provide explicit opportunities for countries to use Global Fund resources for health systems strengthening activities. Currently, the Global Fund is piloting a joint assessment of national health strategies in four countries through its work with the Health Systems Funding Platform. The Platform was described in Chapter 3 and is discussed further later in this chapter.

Implications

The Global Fund's history with health system strengthening shows that achieving consensus among many different stakeholders on the Board is a struggle and its governance structure does not make it easy to reach conclusions. When the board is debating controversial topics, such as health systems strengthening, resulting policies often produce the lowest common denominator approach. As discussed previously, with health system strengthening, the Global Fund's definition has been vague and its approach confusing. This has led to frustration at the country level and missed opportunities. However, examining the Global Fund's history but health system strengthening revealed that producing results in terms of health outcomes is an important component of legitimacy. Consequently, any strategy that the Fund takes must allow it to signal

compliance to this cognitive belief.

What has been the role of various Board delegations in shaping the Global Fund's policies and activities around health system strengthening?

The Global Fund was created using principles of 21st-century governance, which means it brings together a wide and diverse group of stakeholders. This innovative governance allows for greater numbers of under-represented interests in decision-making and means governments and international organizations no longer have the sole or leading role in governance anymore. Actors such as NGOs, private companies, private foundations and developing countries now have leverage to influence development policies and strategy. As such, their beliefs influence what it means to be legitimate.

In the debate over health systems strengthening, developed country NGOs and developing countries used their position on the Board to attempt to expand legitimacy to include broader health systems strengthening activities, not just the three diseases, and disconnect it from indicators for health outcomes. Civil society and developing countries believed health systems were a significant barrier to universal access to AIDS treatment and desired to see the Global Fund give countries more explicit opportunities to address these problems. Their argument was three-pronged: systems issues constrained the ultimate achievement of the Fund's goals; the vertical approach created negative externalities; and a separate health systems strengthening category would encourage a more integrated approach to health systems strengthening.

In response, the Global Fund examined how it invested in health systems and considered how it could do it in a smarter way. The Fund experimented with different modalities to encourage demand – signaling compliance to the beliefs of developed country NGOs and developing countries – but struggled considerably with finding the right modality. Early guidelines and proposal forms were not clear about what health systems strengthening meant and the scope of what was fundable. This opaqueness led to confusion at the country level and unfocused proposals, low-quality proposals with a high rate of rejection. Efforts to correct these problems over succeeding Rounds never resulted in approval ratings as high as disease-specific proposals.

These technical failures can be attributed in part to the general confusion over what health systems strengthening means and what constitutes acceptable health systems work. However, with the Global Fund, a more comprehensive explanation of the technical failures lies in politics and conflicting views of legitimacy. As described in previous chapters, health systems strengthening is a highly politicized term. The politics around it stem from issues deeply rooted in the history of different agencies and how they do business. What ought to be the role of the Global Fund in health systems strengthening is a question where there are multiple issues at the heart of the debate, issues which overlap each other and reinforce diametrically opposed opinions. For example, the donors most willing to put their funding into health systems strengthening in a fairly general way are those countries with publicly funded national health services. In contrast, in the United States, health care is delivered primarily by the private sector and health insurance is mostly privately operated, with the exception of programs such as Medicare and Medicaid. Therefore, it is not surprising that a US government official working in development would not necessarily advocate for use of US taxpayers' money to build a national health system. Linked to these philosophical differences are operational differences. In Northern

European countries, government assistance has tended to be transfers of money to countries. Often, governments transfer money to countries that used to be their colonies, but not always. The US, meanwhile, has traditionally funded the US private sector – largely, not-for-profit organizations – to carry out its work. In addition, the US Government Accounting Office closely scrutinizes how the US spends its development assistance – much more closely than what happens in other countries. This leads to a form of development assistance more focused on individual diseases and results rather than a broader, more general 'horizontal' approach where it is difficult to say what "strengthening a health system" means in terms of health results.

Juxtaposed to the differences between donors are the views of civil society, which is a diverse set of actors whose views run the gamut. In addition to differences between civil society and the donors has been the political horse-trading between development organizations around a "division of labor." This debate considers the organizational design of the Global Fund and its comparative advantage. Those not in favor of expanding the Global Fund's mandate to include health systems strengthening, broadly defined, believe this type of work requires a technical capacity and organizational design the Global Fund does not have, nor should it. Other organizations are better suited to do this work and have been doing it for years, they argue. They want to see the World Bank have greater prominence in health systems. Meanwhile, developed country NGOs, along with the US delegation, reject this view, each for different reasons. The compromise to come out of the political back and forth was the Global Fund supporting health systems activities that could be linked to improved health outcomes for two or more of the three diseases.

Implications

The Global Fund's legitimacy is influenced by a diverse set of stakeholders. To appease this diverse set of stakeholders, the Global Fund has adopted an approach to health systems strengthening that is neither technically sound nor entirely rational.

What does the Global Fund need to do in the future to improve its health system strengthening policies while maintaining its legitimacy as an organization?

This research has shown that legitimacy for the Global Fund is anchored in its focus on three diseases, the results-based approach, and an organizational design as a funding mechanism, not implementing agency. Each of these aspects of legitimacy is important for the Fund, but the most important aspect of legitimacy is the results-based approach. It is what differentiates the Fund from other organizations in its industry and what made the Fund "new and different" when it was created 10 years ago. Further, the Fund's ability to generate future resources is linked intrinsically to measuring performance in health outcomes around these specific diseases. This theme recurred in this research and is the most fundamental reason the Fund was set up with an orientation towards three diseases.

Nonetheless, an emphasis on health results is problematic, as the Fund's success is contingent on the strength and functionality of countries' health systems. To this end, the Fund necessarily has to support some system strengthening work to achieve its goals, but the questions remain, "How much should it support?" and "What is the scope of allowable activities?" The Board has struggled to answer these questions for the last six years. Answering definitively with clear

boundaries is truly challenging, as the Fund's stakeholders represent a variety of viewpoints and philosophical approaches, and the topic itself has eluded consensus in the broader global health environment.

What can the Fund do about health system strengthening in the future? Health systems strengthening broadly defined is beyond the scope of the Fund's mandate. It is also beyond the Fund's current technical capacity and organizational design. Any expansion of the mandate to include health systems strengthening broadly defined would require an accompanying organizational transformation to expand significantly technical capacity at the Secretariat and establish an in-country presence, at least regionally, to provide ongoing technical assistance to countries. Such an organizational transformation is problematic, as it undermines three key principles on which the Fund was founded – namely, to operate as a financing mechanism, not implementing agency; to be quick and non-bureaucratic; and to focus on three diseases only. Moreover, this type of organizational transformation would compromise the Fund's legitimacy in the eyes of key donors on the Board, such as the United States, Japan, the United Kingdom and Private Foundations (i.e., the Gates Foundation).

The Fund can avoid this organizational transformation yet still participate in health systems strengthening in a meaningful way by doing two things:

(1) The Board, collectively, ought to recognize and agree that health systems strengthening broadly defined is beyond the Fund's current technical capacity and organizational design. Although this type of work is an important activity in global health, other organizations are better suited to do it. Undergoing an organizational transformation to accommodate health systems strengthening would jeopardize the Fund's legitimacy to key stakeholders named above and call into question its ability to secure future resources. Rather, the Fund ought to focus on what it does well, which is financing scale up of essential inputs – such as anti-retrovirals, bed nets, and human resources for health. Countries need these inputs to control and eradicate the three diseases, and the Fund has a proven track record of success in this area of work. As such, any system strengthening activity the Global Fund supports ought to be included as part of disease-specific proposals so as to keep the system strengthening activities narrowly defined, focused, and linked to health outcomes for the three diseases. To understand the scope of these activities, the Fund should continue to use the Health System Framework put forward by WHO in 2007, which includes six building blocks of the health system. These building blocks are: service delivery; health workforce; information system; medical products, vaccines and technologies; health financing; and leadership/governance. For a more detailed explanation of these building blocks, see Chapter Two. Of the six building blocks, the ones most relevant and appropriate for the Global Fund are the health workforce; information system; and medical products, vaccines, and technologies. Supporting systems strengthening work in these three areas as it relates to disease-specific program goals is essential for the Global Fund to achieve its organizational goals, and the Global Fund is well suited to do this kind of work. The Global Fund should support activities in these areas to the extent the activities are directly related to the disease-specific program goals and result in improved health outcomes for one or more of the three diseases. Classic examples of these systems strengthening activities are training public and private sector health workers in the three disease areas and topping up the salaries of public and private sector health workers supporting programs in the three diseases. Some stakeholders, such

as the World Bank, do not consider these activities health systems strengthening, however, if we use Berman's framework of Two Dimensions (see Chapter 2), these activities are considered health systems strengthening.

The process for reaching agreement among the Board about this scope of work would center on getting buy-in from the Developed Country NGO delegation and the various Developing Country delegations. There are two ways to secure buy-in from the Developed Country NGO delegation and Developing Country delegations, and both must be pursued simultaneously. First, after presenting a persuasive argument explaining the rationale for narrowing the scope of health system strengthening activities to essential inputs for the three diseases, the US delegation – or another delegation, such as the UK, Japan or Private Foundations – ought to offer the Developed Country NGO delegation and Developing Country delegations an alternative. One alternative is to encourage developed country NGOs and developing countries to lobby key actors in the broader global health community – such as the World Bank, the Gates Foundation, and donor governments, such as the United States, Japan, the United Kingdom and Germany – to support more of the broader health systems work through their agencies. Examples of this work include financial risk protection and coverage for vulnerable groups; development of systems and capacity for management and oversight of health services; support for developing country nationals to pursue Masters degrees in various public health disciplines; pre-service training of community health workers; and strengthening general Health Information Systems. These agencies and donors understand the importance of system strengthening work, as all of them already do some form of health systems strengthening broadly defined.

One critical area of need – and a key area where developed country NGOs and developing countries could focus their advocacy – is increased technical assistance for health system strengthening. For example, countries need help developing robust national health strategies based on sound situation analyses that take into account the countries' political and social contexts. The Global Fund cannot do this type of work, nor should it. Yet the work the Global Fund does ought to be based on robust national health strategies. Bilaterals, the World Bank, WHO and even some private foundations, such as the Clinton Health Access Initiative, are much better positioned to engage in this type of broad health systems work that requires an in-country presence and longer-term engagement. In their advocacy efforts, developed country NGOs and developing countries ought to lobby these organizations to support this type of work by allocating significantly more resources to this work. Additionally, to the extent possible, developed country NGOs and developing countries ought to advocate for these organizations to include civil society and developing countries in the discussions and implementation of this work. Inclusion could be in the form of joint planning meetings held in country, for example.

The second way to secure buy-in from developed country NGOs and developing countries is for the Global Fund to put money behind its involvement in the Health Systems Funding Platform. Initially conceived, the Health Systems Funding Platform was perceived to be a source of new funding. After the economic and financial crisis of 2008, new funding seemed unlikely and has turned out not to be the case. As such, participating in the Health Systems Funding Platform will cost money, as participation requires manpower, and costs could escalate as the scope of work gets more complicated; however, the Global Fund's involvement in the Health Systems Funding Platform is very important for reassuring developed country NGOs, developing countries, and

even the Northern European donors, that the Global Fund is supporting the strengthening of public health systems and will help with securing their buy-in for a more narrow scope of work at the Fund. The Health Systems Funding Platform has a public sector oriented approach – one that focuses on jointly assessing a country's national health strategy. The development of the national health strategy will be carried out by other organizations that have the capacity to work in-country and provide technical assistance, as described previously. However, through the joint assessment process of the national health plan, the Fund will work closely with country governments and other development agencies (GAVI, the World Bank and WHO) to support the aspects of the national strategy that are relevant to its mission.

(2) With this agreement in place, the Fund will be able to clarify its definition of health systems strengthening and the scope of what it is willing to fund. Specifically, it will support essential inputs related to the prevention, treatment, control and eradication of the three diseases. It can also support "capacity building" to the extent that capacity building activities relate to effective use of these inputs. For example, training health workers on how to use medical equipment, laboratory equipment and supplies, administer drug regimens, monitor adherence, provide voluntary counseling and testing, and manage programs. Capacity building can also include providing information technology to public and private health centers and training health workers to use this technology. The information technology would need to benefit the three diseases primarily, but could also benefit other diseases as well. In this way, the Global Fund is able to explain better what it means by "activities" in its definition of health system strengthening: "investing in **activities** to help health systems overcome **constraints** to the achievement of improved outcomes for HIV/AIDS, TB and malaria."

A clarified definition also provides a framework and common ground for the future should there ever be any expansion of the mandate to include other health issues or diseases, such as maternal and newborn child health; immunizations; non-communicable diseases; or neglected tropical diseases. A clarified definition will also lead to less confusion at the country level and higher approval rates for health systems activities, as they will be embedded in disease specific proposals.

Limitations
This study is subject to several limitations. First, the Global Fund is a highly politicized organization and health systems strengthening is a controversial topic. As a result, many subjects felt they could not express their views openly without fear of retribution – either personal or organizational. Consequently, all subjects chose not to be identified in the write up of this research. Extra precautions were taken to protect subject identity, particularly with Board members. Board members were not identified as current or former Board members, as this would be too personally identifying. This lack of specificity did not affect the quality of the write up, although it would have been preferable to say whether someone was a current or former Board member. Instead, the limitations arose around subjects who refused to be audiotaped, which meant taking notes by hand and likely missing some of the richness of detail in quotations. However, out of 31 interviews, only six subjects refused audiotaping, so this limitation did not have a significant impact on the quality of the research.

The most significant limitation of the work is that not every Board delegation was interviewed, most notably the African delegations. These delegations were recruited multiple times but never responsed. This lack of response is likely because members of these delegations are high level government officials – often times the Minister of Health or Vice Minister. Consequently, they are extremely busy and difficult to reach. The current Executive Director of the Global Fund was also not interviewed. However, the former (and first) Executive Director of the Global Fund and three current high-level managers in the Secretariat were interviewed. These interviews compensated for not being able to interview the current Executive Director.

Another limitation, though less significant, is that all but two interviews were conducted over Skype rather than in person. This made building rapport with some subjects challenging, which could have affected how open they were willing to be. Additionally, in interviews it was sometimes challenging to get some subjects to describe clearly what they think. Some subjects were more comfortable discussing the debate more generally and presenting various sides of the argument, rather than telling me what they think. As a result, clarifying questions were asked often to understand the subject's own view, as opposed to what other people thought.

A limitation related to the document review is that Board meeting notes record the decisions taken and present them as decision points. They do not give a detailed description of the discussion leading up to the decision point nor do they include comments attributed to specific delegations. Comments made by the Technical Review Panel are attributed, but the Technical Review Panel is not a voting member of the Board.

One last limitation is that a Board meeting was not observed in the course of this research. The United States delegation was contacted to request attendance to the upcoming Board meeting in May 2011, but e-mails requesting permission to attend did not receive a response. Phone calls were not returned.

One challenge in this research is that health systems strengthening policy at the Global Fund is a fast-moving target. Keeping up-to-date on the latest changes and where the Global Fund is going is difficult. Documents from the last Board meeting in December 2010 were reviewed, but there will be interesting changes to note after the next Board meeting May 11-12, 2011.

Conclusion

Health systems strengthening in the context of the Global Fund has multiple meanings depending on whom you ask and when you ask them. Health system strengthening has a technical meaning as well as a political one. Untangling the two, however, is nearly impossible, as the technical meaning is shaped by politics. Various Board delegations, such as Developed Country NGOs and Developing Countries, have tried to expand the mandate of the Fund to include health system strengthening broadly defined. Other delegations, such as the United States, Japan, the UK and Private Foundations have resisted this expansion, often for different reasons. Members of the United States delegation believe health system strengthening ought to be done through disease specific programs, while members of the UK delegation think the Global Fund is not the right organization to do health systems strengthening work. Other organizations, they argue, are better suited to take on this type of work, as it requires an in-country presence and long-term engagement.

Throughout ten Rounds of funding, there has not been a shift in policy *per se* over health systems strengthening; rather, there has been a shift in the willingness to provide explicit opportunities for countries to use Global Fund resources for health systems strengthening activities, as they are related to improved health outcomes for the three diseases. In this way, legitimacy for the Global Fund has remained a focus on improved health outcomes for the three diseases. Currently, the Global Fund is piloting a joint assessment of national health strategies process in four countries through its work with the Health Systems Funding Platform. This approach could provide the best opportunity for the Global Fund to engage in strengthening of public health systems while still remaining within the bounds of its mandate.

From examining the Fund's history with health systems strengthening, it can be concluded that legitimacy for the Global Fund will always mean a focus on improved health outcomes, whether for the three diseases, the Millennium Development Goals, or something entirely new, such as diabetes. Any additional activities the Fund takes on will have to show results in improved health outcomes. In the case of the Global Fund, the three diseases will always be a focus, as there are powerful, entrenched interests on the Board. Nonetheless, the Board must recognize that any expansion of the mandate will increase organizational complexity and, inevitably, create competition for the health issues on which it was founded. In conclusion, the Global Fund's overall successful performance in the three disease areas is the key reason it continues to raise such large amounts of money. Abandoning this approach could jeopardize its ability to secure future resources. It should remain a Global Fund for AIDS, TB and Malaria.

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Appendix 1: List of Board Constituencies

Voting Members (n=20)
*Canada, Germany, Switzerland
*Communities (NGOs representative of the Communities Living with the Diseases)
* Developed Country NGO
* Developing Country NGO
* Eastern Europe and Central Asia
* Eastern Mediterranean Region
* Eastern & Southern Africa
* European Commission (Belgium, Finland, Portugal)
* France and Spain
* Italy
* Japan
* Latin America & Caribbean
* Point Seven (Norway - Denmark, Ireland, Luxemburg, Netherlands, Sweden)
* Private Foundations
* Private Sector
* South East Asia
* United Kingdom and Australia
* USA
* West and Central Africa
* Western Pacific Region

Ex Officio Members without Voting Rights (n=6)
* UNAIDS
* WHO
* The World Bank
* Board-Designated nonvoting Swiss Member
* Partners
* The Global Fund

Appendix 2: Interview Guide

Introduction and Purpose

Thank you very much for taking the time to talk with me. As you know, I am a doctoral student at the School of Public Health at UC-Berkeley, and I am studying the Global Fund to Fight AIDS, TB and Malaria. I am looking at the Global Fund's policies on health systems strengthening and how these policies have evolved over time and why.

Before we begin the interview, I would like to go over the consent form I emailed to you. I want to emphasize that your participation in this interview is voluntary and you may stop the interview at anytime for any reason. With your permission, I would like to audiotape the interview. The taping is to accurately record the information you provide and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable at any time during the interview, I can turn off the tape recorder at your request. Or if you don't wish to continue, you can stop the interview at any time.

Your interview data will be handled confidentially. If results of this study are published or presented, your name or other personally identifiable information will not be used, unless you give explicit permission for this. Let's look at the consent form.

[Review consent form and obtain oral consent]

I expect to conduct only one interview; however, I may need to follow-up with you for additional clarification. If so, I will contact you by e-mail to request this. This follow-up will take place in the spring of 2011 and will entail a question or two to clarify anything I may not have understood from your initial interview. Is this ok with you?

Is it ok if I turn on the audio recorder now?

Questions

1. Please tell me about your role with the Global Fund. When were you there and what did you do?

2. Please tell me about the motivation to create the Global Fund. What problems – social, organizational – were the creators trying to address?

3. From your experience, what does health systems strengthening mean in the context of the Global Fund?

    a. Tell me about Round Five. What happened?
    b. Tell me about Round Eight. What happened?

4. What ought to be the role of the Global Fund with regard to health systems strengthening?

5. What can the Global Fund do that the World Bank and GAVI cannot do?

6. Is there anyone else you think I should talk to?

Appendix 3: Key of Interview Subjects

B = Board Member or Delegate
S = Secretariat
TERG = Technical Evaluation Reference Group
TP = Technical Partner
TWG = Transitional Working Group

CS = Civil Society
G = Government
M = Multilateral
O = Observer
PF = Private Foundations
PS = Private Sector

Pa = Past

Appendix 4: Codes for Analysis

Definition – This code tags definitions of what health systems strengthening means in the context of the Global Fund. (Research Question Three)

Comment – This code tags comments about health systems strengthening in the context of the Global Fund and more generally. (Research Question Three)

Critique – This code tags critiques of the Global Fund given in response to research question four.

Suggestion – This code tags suggestions for how the Global Fund can improve. Suggestions were given in response to research question four.

Disease Specific – This code tags definitions or comments that specify that Global Fund resources for health systems strengthening must address AIDS, TB and Malaria primarily, and indicators for Global Fund HSS support must be linked to improved health outcomes for the three diseases. The resources may also benefit other diseases or health problems, as long as the measures of performance show improved health outcomes in the three disease areas.

Not Tied to 3 Diseases – This code tags definitions or comments that Global Fund resources for health systems strengthening should not be tied to improved health outcomes for the three diseases necessarily.

Accuracy – This code tags comments on the accuracy of the Global Fund's definition of health systems strengthening.

Appropriateness – This code tags comments on the appropriateness of health systems strengthening in the context of the Global Fund.

Effectiveness – This code tags comments on the effectiveness of health systems strengthening in the context of the Global Fund.

Efficiency – This code tags comments on the efficiency of Global Fund engagement in health systems strengthening. This code also tags comments on the efficiency of the Global Fund more generally.

Impact of Fund – This code tags comments on the impact of the Global Fund. This code tags comments on the impact of the Global Fund in relation to health systems and the impact of the Fund more generally, such as lives saved, infections averted, etc.

Measures – This code tags comments on measuring the impact of Global Fund investments, both in relation to health systems strengthening and more generally.

Operation of the Fund – This code tags comments on the processes and procedures of the Global Fund.

Resources – This code tags comments on the Global Fund's financial resources and health systems strengthening.

Responsibility – This code tags comments on which agency is responsible for health systems strengthening. "Responsible" can mean paying for health systems strengthening, carrying out health systems strengthening activities, or both.

Structure – This code tags comments on the organizational structure of the Global Fund.

Sustainability – This code tags comments that link health systems strengthening to the sustainability of the Fund's investments. For example, "The Global Fund needs to invest in health systems for its results in AIDS, TB and Malaria to be sustainable." This code does not indicate comments on whether or not investments in health systems are a financially sustainable activity.

Usefulness – This code tags comments on the usefulness of the term health systems strengthening.

Value – This code tags comments on the value of health systems strengthening.

Appendix 5: Decision Point GF/B16/DP10 (GFATM, 2007b)

The Board refers to the principles set forth in its decision GF/B15/DP6 and reaffirms that the Global Fund should continue to support the strengthening of public, private and community health systems by investing in activities that help health systems overcome constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria ("ATM").

The Board decides that the Global Fund shall provide funding for health systems strengthening ("HSS") actions within the overall framework of funding technically sound proposals focused on the three diseases and that such funding shall be based on the following principles:

1. The Global Fund shall allow broad flexibility regarding HSS actions eligible for funding, such that they can contribute to system-wide effects and other programs can benefit. With this principle in mind, the Global Fund shall develop guidance with few prescriptions for applications for HSS funding, which may take the form of the following:

a. the specification of categories of HSS actions that the Global Fund recommends applicants consider when developing applications for funding;

b. the specification of principles to guide applicants in deciding which categories of HSS actions to apply for; and

c. the specification of any category of HSS actions that may not be financed by the Global Fund.

2. The Global Fund shall encourage applicants, wherever possible, to integrate requests for funding for HSS actions within the relevant disease component(s). Such HSS actions will be assessed by the Technical Review Panel ("TRP") as part of its review of that disease component.

3. Recognizing that some HSS actions ("cross-cutting HSS actions") may significantly benefit more than one disease, the Global Fund shall allow applicants to request funding for such HSS actions by completing a distinct but complementary section (a "cross-cutting HSS section") within a disease component, provided that:

a. An application shall not contain more than one cross-cutting HSS section.

b. Where cross-cutting HSS actions are proposed, the applicant shall articulate how they address identified health systems constraints to the achievement of improved ATM outcomes.

4. In reviewing a disease component which contains a cross-cutting HSS section, the TRP may recommend for funding either:

a. The entire disease component, including the cross-cutting HSS section;

b. The disease component excluding the cross-cutting HSS section; or

c. Only the cross-cutting HSS section if the interventions in that section materially contribute

to overcoming health systems constraints to improved ATM outcomes.

The Global Fund shall also:
a. Recommend that proposals containing material HSS actions be based on the results of a recent assessment (the coverage of which need not be limited to ATM) identifying health systems constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria; and

b. Recommend that applications provide evidence of the involvement of relevant HSS stakeholders in the Country Coordinating Mechanism – including at least one non-government in-country representative with a focus on HSS and one government representative with responsibility for HSS planning.
The Board requests the Portfolio Committee to modify future application forms and guidelines (including for the Rolling Continuation Channel), effective from 1 March 2008, to incorporate the above principles and propose for approval at the Seventeenth Board Meeting any modifications to the Terms of Reference of the TRP (including with respect to the composition of the TRP) that are required in light of the strategic approach reflected in this decision point.

The Board requests the Secretariat to provide to the TRP information on the principles that are set forth in this decision. The Board also requests the Secretariat to communicate clearly, working closely with relevant partners, to country stakeholders the Global Fund's amended strategic approach to HSS – including the flexibilities inherent within it.

The Board requests the Secretariat and the TRP to review the results of the Round 8 proposals with regard to HSS actions, and to report to the Eighteenth Board Meeting on the impact of this decision on the application and review process. The report should discuss the quality of proposals that include HSS actions, the proportion recommended by the TRP for approval, and the extent to which applicants have articulated how cross-cutting HSS actions address identified health systems constraints to the achievement of improved ATM outcomes.

The budgetary implications of this decision point in 2008 amount to US$ 235,000.

Appendix 6: Decision Point GF/B22/DP4 (GFATM, 2010b)

Implementing the new grant architecture for health systems strengthening activities

To provide for a technical change in grant application and management policy so as to align Global Fund funding for crosscutting health systems strengthening actions (HSS) with the Global Fund new architecture as approved by the Board at the Twentieth Board Meeting (GF/B20/DP31), the Board decides as follows:

1. Individual proposals requesting Global Fund funding can address one of the following three components: HIV/AIDS, tuberculosis, or malaria, as well as requests to support related cross-cutting health systems strengthening (focusing on system-wide approaches and actions that significantly benefit more than one of HIV/AIDS, tuberculosis and malaria components) ("cross- cutting HSS component").

2. The Board reiterates that applicants are encouraged, wherever possible, to integrate requests for funding for HSS actions within the relevant disease component(s). Such HSS actions will be assessed by the Technical Review Panel (TRP) as part of its review of that disease component. The Board clarifies that the crosscutting HSS component is for those activities that inherently are more appropriately addressed in a crosscutting or cross-disease manner. When requesting funding for such crosscutting HSS actions applicants are still required to articulate how they address identified health systems constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria.

3. The Board requests the Secretariat to measure, monitor and report – as part of the Key Performance Indicators related to funding for HSS - to the Policy and Strategy Committee (PSC) on funding provided for cross-cutting health systems strengthening proposals.

4. The Board requests the joint Portfolio and Implementation Committee and PSC Eligibility, Cost Sharing and Prioritization Working Group to develop specific criteria for cross-cutting HSS applications as part of the eligibility and prioritization scheme to be approved by the Board in time for the launch of the Round 11 call for proposals.

5. Board policies and decisions that apply to proposals and grants for all three diseases shall apply equally to proposals and grants for the crosscutting HSS component. The Board decision titled "Architecture Review – Transition Provisions" (GF/B20/DP31) shall apply to proposals and grants for the cross- cutting HSS component subject to the amendments outlined in Annex 2 to the PSC s report to the Twenty-Second Board (GF/B22/4).

6. The aspects in the Board decision on Strategic Approach to Health Systems Strengthening (GF/B16/DP10) that relate to funding requests for "cross- cutting HSS actions" (in particular paragraphs 3 and 4) and/or are inconsistent with this decision are revoked.

7. This decision does not change the existing scope of Global Fund support to crosscutting HSS activities or create a new funding window for these HSS activities.

Appendix 7: Decision Point GF/B22/DP5 GFATM, 2010b)

Health Systems Funding Platform:
Pilot for funding requests based on jointly assessed national health strategies (p6)

The Board:

1. Notes that further to the Board decision on the Health Systems Funding Platform (GF/B21/DP5) the Policy and Strategy Committee (PSC) has approved, in principle, the design of a pilot for 4 to 5 countries for Track 2 Option 2 (the "Pilot");

2. Clarifies that the Pilot shall be conducted in accordance with the Board decision on "Implementing the new grant architecture for health systems strengthening activities" taken at its Twenty-Second Meeting; and

3. Authorizes the Secretariat to make exceptions to existing policies and procedures to the extent necessary and within the parameters described in the paper titled „Health Systems Funding Platform – Pilot for funding requests based on jointly assessed national health strategies (GF/PSC14/04) as presented at the 14th PSC to implement the Pilot.

The Board notes that any exceptions to existing policies and procedures made in connection with the Pilot shall be consistent with the Framework Document of the Global Fund, including the principle that the Global Fund supports activities that help health systems overcome constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria.

Appendix 8: Sign on Letter from Developed Country NGO Delegation

January 24, 2006

Dear Members of the Global Fund Board:

We write to you as individuals and organizations committed to defeating AIDS, tuberculosis, and malaria. We believe it is critically important that the Global Fund retain its Health systems strengthening (health systems strengthening) proposal category. We urge you to ensure that health systems strengthening remains a category in Round 6 and beyond, and to take the steps necessary to enable the success of health systems strengthening proposals.

There is much debate as to whether the Global Fund is the right mechanism to finance health system strengthening or whether this area represents an inappropriate expansion of the Global Fund's mission. We are convinced that financing health systems strengthening proposals will not expand the Fund's mission; it will enable the Fund to achieve it. We believe that not only is the Fund the right mechanism for health system strengthening, but it is crucial that the Fund engage in this task.

Many countries are experiencing difficulties and delays in scaling up AIDS, tuberculosis, and malaria programs because they depend on national health systems that are too weak to effectively deliver on these new demands. The multitude of Round 5 requests for funds to support health workforce strengthening, for example, reflects the recognition of African health ministers that, as stated in their October 2005 Gaborone Declaration on a Roadmap Towards Universal Access to Treatment and Care, "the human resources for health crisis affecting the continent is a severe impediment to health system strengthening and a constraint to accessing prevention, treatment and care."

The health systems strengthening category enables the Fund to support activities that are tied to the needs of the entire health system and the full range of national health goals, not only needs and goals specific to one disease. This financing capacity is important both to address the health system needs necessary to scale up AIDS, tuberculosis, and malaria interventions and to ensure that the Fund's activities do not inadvertently harm health systems. Providing support for disease-specific programs without also supporting the underlying systems risks reducing the capacity of those systems to deliver other vital health services.

The health systems strengthening category should encourage Global Fund applicants to locate their AIDS, tuberculosis, and malaria programs in existing systems wherever possible instead of creating a new, parallel infrastructure. This integrated approach to health system strengthening is more sustainable than a vertical approach, and avoids duplications, health system distortions, and inefficient use of resources. It also meets the expressed goal of African Union health ministers, who committed themselves to "the development of an integrated health care delivery system" in the Gaborone Declaration.

The health worker crisis is one of the most prominent of the health system deficiencies that the Global Fund will need to address if it is to fulfill its mission. Health worker wages and working

conditions do not meet their basic needs or those of their patients, so many migrate, leaving behind a demoralized workforce too small to meet health needs.

There are other such issues as well. For instance, even if a country has the resources to offer HIV, tuberculosis, and malaria services, the impact will be severely restricted if people lack financial access to any health services. The impact will also be limited where managers lack basic skills in areas like financing, supervision, and monitoring and evaluation. A health system requires strong financial management to ensure that funds reach the proper destination, and an effective procurement and distribution system to ensure that medicines and other essential supplies reach their destination quickly. The Global Fund can help by, for example, supporting community health insurance schemes as it is for Rwanda, training mangers, and improving inventory control systems.

Retaining a separate category for health systems strengthening is the best way to meet these needs. It will encourage countries to take a systemwide, integrated approach to scaling up health interventions and is the best way to support systemwide strategies, such as Malawi's Emergency Human Resource Programme and Rwanda's health insurance program, that are required to scale-up AIDS, tuberculosis, and malaria services.

The Global Fund's experience with health systems strengthening proposals thus far has been both disappointing and encouraging. Thirty countries applied for health systems strengthening assistance from the Global Fund in Round 5, demonstrating that the Global Fund's health systems strengthening category is helping fill a significant gap in international funding and that many countries believe the Global Fund is an appropriate mechanism to help fill this gap. They recognize that the Global Fund is an appropriate mechanism for activities that require long-term external support, as many health systems strengthening activities will need. Already, for example, the Global Fund is a major financer of anti-retroviral therapy, which will require long-term external support. And the Fund's results-based financing will help ensure that grants for health system strengthening translate into positive health outcomes, successes that will attract additional donor support.

However, only three of the Round 5 health systems strengthening proposals were approved. Fortunately, the Global Fund, the World Health Organization, and other partners can take steps to ensure that the next round of health systems strengthening proposals is far more successful. WHO and the Fund's Technical Review Panel have outlined many of these steps. We urge the Fund and other partners to take such the necessary measures, including immediately beginning to work with countries that applied for but were denied health systems strengthening funding in Round 5 to develop Round 6 proposals. We ask the Fund to consult national stakeholders, including health workforce representatives, when making decisions that will most directly impact Global Fund applicants.

Health system strengthening has been a neglected area of international health spending, even though strong health systems are vital for the success of a broad array of health programs, including those to fight AIDS, tuberculosis, and malaria. The Global Fund took the enlightened step of permitting Health systems strengthening proposals in Round 5. This process should continue, expand, and improve. The need is too great, and the Global Fund's potential

contribution to save lives in the short and long term too significant, for the Fund to follow any other path.

Sincerely,

Organizations

Action Group for Health, Human Rights and HIV/AIDS (AGHA) (Uganda)
Addis Development Vision (Ethiopia)
Africa Action (USA)
African Council for Sustainable Health Development (ACOSHED) (Africa)
African Council of AIDS Service Organizations (AfriCASO) (Africa)
AIDES Federation (France)
AIDS for AIDS International (USA)
AIDS Law Project (South Africa)
AIDS Law Unit, Legal Assistance Centre (Namibia)
American Medical Students Association (USA)
American Nurses in AIDS Care (ANAC) (USA)
British Medical Association (United Kingdom)
Campaign for Female Education (CAMFED) (Zimbabwe)
Christian Health Association of Kenya (Kenya)
Churches Health Association of Zambia (Zambia)
Coordination Council of the All Ukraine PLWH Network (Ukraine)
Copilarie pentru toti (Women and Children Living with HIV/AIDS) (Moldova)
Credinta PLWHA (Moldova)
Delhi Network of Positive People (DNP+) (India)
East, Central and Southern Africa (ECSA) Health Community (Africa)
East European & Central Asian Union of PLWH Organisations (Eastern Europe/Central Asia)
Ecuadorian Coalition of PLWHA (Huellas+) (Ecuador)
EQUINET: Regional Network for Equity in Health in East and Southern Africa (Africa)
European AIDS Treatment Group (EATG) (Europe)
Freedom Foundation (India)
Gay Men's Health Crisis (USA)
Global AIDS Alliance (USA)
Global Network of People living with HIV/AIDS (GNP+) (Global)
Grupo Português de Activistas sobre Tratamentos de VIH/SIDA (Portugal)
Health Gap (USA)
Healthpartners (Kenya)
Interagency Coalition on AIDS and Development (ICAD) (Canada)
International Community of Women Living with HIV/AIDS – Namibia (Namibia)
International Council of HIV/AIDS Service Organizations (Global)
International Council of Nurses (Global)
International Planned Parenthood Federation (Global)
Joint Clinical Research Centre (Uganda)
Journalists Against AIDS (JAAIDS) (Nigeria)

Kenya AIDS International Prevention Project Group (KAIPPG) Kenya (Kenya)
Kenya AIDS International Prevention Project Group (KAIPPG) International (Kenya/International)
Kenya AIDS NGOs Consortium (KANCO) (Kenya)
Kenya Network of HIV Positive Teachers (Kenya)
Kenya Network of Women with AIDS (KENWA) (Kenya)
Latin American and the Caribbean Council of AIDS Service Organizations (LACCASO) (Latin America & Caribbean)
Latin American Network of People Living with HIV and AIDS (RedLa+) (Latin America)
Lawyers Collective HIV/AIDS Unit (India)
Manipur Network of Positive People (MNP+) (India)
Movement of Men against AIDS in Kenya (MMAAK) (Kenya)
Mozambican Youth National Council (Mozambique)
National Union of the Organizations of People Affected by HIV/AIDS (Romania)
Nurses and Midwives Council of Malawi (Malawi)
Osservatorio Italiano sulla Salute Globale (Italian Global Health Watch) (Italy)
Pangaea Global AIDS Foundation (USA)
Partners in Health (USA)
Physicians for Human Rights (USA)
Pinoy Plus Association (HIV+ organization) (Philippines)
Positive Generation (Cameroon)
Positive Malaysian Treatment Access & Advocacy Group (MTAAG+) (Malaysia)
Public Services International (Global)
Regroupement des Communautes des PVVIH DRC (Gathering of Communities of People Living with HIV/AIDS of the DRC) (RENACO+) (Democratic Republic of Congo)
Southern African Development Community (SADC) (Africa)
Southern African Network of AIDS Service Organizations (SANASO) (Africa)
Tanzanian Essential Strategies Against AIDS (TESAA) (Tanzania)
Thai AIDS Treatment Action Group (TTAG) (Thailand)
The AIDS Service Organization (TASO) (Uganda)
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