

Opinion piece

The Global Fund to fight Aids, Tuberculosis and Malaria (GFATM)

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Most diseases can be controlled. With adequate investment, short-term success can almost always be guaranteed in any setting. In the poorest countries however, such success will be limited unless the more fundamental causes of poverty and inequity are also addressed. This requires that the world's poorest be freed from the cycle of debt, unfair trade restrictions and undemocratic international policymaking that protects the wealthy at the expense of the poor.

The GFATM was created in 2002 in response to growing international concerns about the global impact of these diseases. It is a new financial instrument, not an implementing agency. "Its purpose is to attract, manage, and disburse additional resources through a new private/public initiative that will make a sustainable and significant contribution to the reduction of infections, illness and death from these diseases, thereby contributing to poverty reduction as part of the Millennium Development Goals." It is intended to target people and countries in greatest need and supports programmes that have been designed collaboratively, involving government, donors, the private sector and civil society. To date it has disbursed over US\$113 million to programmes in 53 countries and committed \$1.5 billion over 2 years to 154 programmes in 93 countries (see www.globalfundatm.org).

In the lowest income countries, there have been many attempts over the last few decades to galvanize political commitment and financial support for the control of specific diseases, for example vaccine preventable disease, malaria, TB, AIDS, guinea worm etc. Almost all have been successful in improving health services and controlling specific diseases for as long as that commitment and that financial support has lasted. Few if any have had continued success beyond that commitment and that financial support, either because it was not sustained or was insufficient to reach all of those in need.

The GFATM is a new financial instrument with innovative approaches to project approval and the management of resources. But let us be clear about the real problem that the GFATM is addressing. Firstly, it is not a technical problem. The knowledge, the techniques and the medicines for the prevention, treatment and effective management of AIDS, tuberculosis and malaria, are available and they work. In the wealthier parts of the world, these diseases have been contained. Secondly, it is not a financial problem. In a world

enjoying unprecedented wealth, the cost of prevention, treatment and the management of the impact of these diseases is a small fraction of the world's resources (CMH 2002). The real problem lies in a culture of self-interest where international aid and investment is designed in the interests of the donor, and where the donors' conditions take precedence over the recipients' needs.

Despite billions of dollars having been spent in aid over the last few decades, it has been insufficient to the needs of the poorest countries, insensitively invested and frequently inappropriate to local context. As a result, it has also been largely ineffective in reducing poverty in these countries. The gap between rich and poor continues to widen (UNDP 2003); under-5 mortality rates in Sub-Saharan Africa have been rising since 1990; and high maternal mortality rates have not changed (World Bank 2001). Past policies have clearly been failing the poorest. Something new is required. Additional money is certainly essential. Health expenditure per capita in the lowest income countries is around US\$13 per capita annually, compared with the US\$30–40 estimated as the minimum to cover essential interventions (CMH 2002). The gap between the financial need and the available resources in the lowest income countries is large and growing (CMH 2002).

However, money alone is not enough. Of greater importance is finding ways to spend it in the interests of the recipient, according to their needs and in line with their capacity to absorb these additional funds over time. The last 40 years has seen many approaches. Often the focus has been on short-term investment and time-limited projects to control specific diseases over defined periods of time. Failure to sustain investment hit precisely those countries that were least able to afford continuing costs. In response to these limitations, many donors and governments moved to support longer-term investment through sector-wide approaches. Such an approach focuses on establishing and maintaining effective systems of delivery, including the recruitment of properly trained and supported staff, common to all diseases. However, the level of funds is still not sufficient and clearly a new (or additional) funding strategy is required.

The Global Fund seeks donations from all sources, including the traditional donors, in theory without the limits and conditions imposed by individual governments and

institutions. It can disburse those funds indefinitely, provided it can continue to attract funds, and become the first initiative that is truly 'financially sustainable'. However, as with other initiatives, it expects others to take up the 'challenge of future financing'. So, the Global Fund (GF) is new, but how will it be different? Another recent global initiative, the Global Alliance on Vaccines and Immunization (GAVI), has devoted much time and effort to address the issue of financial sustainability. However, a recent report from the Financing Task Force of GAVI concludes, 'managing the transition of financial responsibility from the Vaccine Fund to governments and their partners will be complex and is in no way assured' (GAVI 2003). The President of the Vaccine Fund is quoted as saying '... we all underestimated the difficulties that we would face when we started.'

Two features are common to many disease specific campaigns. The first is that most claim that whilst reducing disease, they act as 'catalysts' to attract continuing support for successful interventions. A laudable aim, but too often in the past, large projects designed in the wealthy countries have been 'kick started' with large international grants, with little attention to local contexts, only to leave the recipients to pick up the recurring bills when the initial investment runs out. The second is that they claim that they will 'spearhead' the development of comprehensive health care systems on the back of successful disease control and in the process contribute to economic development and poverty alleviation. There is very little evidence of this having happened in the poorest countries up to now (World Bank 2001; UNDP 2003).

Many successful proposals to the GF to date have come from projects where an existing programme will be complemented by, and will be able to absorb, the additional GF grant; where there is a sound technical approach and evidence of sustainability; and where monitoring, evaluation and the capacity to analyze progress is well founded. However, it is the lowest-income countries, where the need is greatest, that are least likely to have existing programmes; to have the capacity to absorb large grants over short periods of time; and to possess adequate technical resources. The 'sustainability' of these

projects is likely to be dependent upon external support over decades rather than years.

Although there is no doubt that many people will benefit from the GF, it seems likely that it will face the same limitations of all short-term project-based attempts to address the fundamental problems underlying the prevalence of these and other poverty-related diseases in the poorest countries. In other words benefits will be real, but will last only as long as the project is adequately funded, and only reach those within the project area. At the same time there is a risk that well-funded projects can distort the more comprehensive provision of care by attracting staff and other resources to the project area. They can also distort government efforts at planning for long-term solutions to national health care needs. If the GFATM aims to ensure that investment remains adequate over time and is also sufficient to reach all of those in need for as long as is necessary, then it must establish a monitoring process that reflects this aim. Relevant indicators that go beyond recording funds disbursed and the number of diseases avoided will be crucial.

'Health' as defined by WHO is a human right, and it is much more than just disease control. Our willingness to ensure access to the highest quality of health care, for all disease, as one of the determinants of 'health', especially for those who cannot afford it, is a measure of both our humanity and our commitment to equity and social justice globally.

References

- CMH. 2002. Improving Health Outcomes of the Poor. Report of working group 5 of the Commission on Macroeconomics and Health presented by Prabhat Jha and Anne Mills to Jeffrey D. Sachs, Chair of the Commission on Macroeconomics and Health and Gro Harlem Brundtland, Director General of the World Health Organization. April 2002.
- GAVI. 2003. *Immunization Focus*, July 2003. Geneva: Global Alliance for Vaccines and Immunization.
- UNDP. 2003. Human development report 2003. New York: United Nations Development Programme.
- World Bank. 2001. *World Development Indicators 2001*. Washington DC: World Bank.

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Responses

The Global Fund to Fight AIDS, Tuberculosis and Malaria: what makes it different

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In an opinion piece in this issue of *Health Policy and Planning*, Peter Poore raises several thought provoking questions about the fundamental nature of the present development assistance paradigm in solving public health problems. Its externally driven agendas; its often inadequate relationship to the needs of the poorest countries; its short-term nature; its insensitive and often inappropriate orientation to the local context; its focus on specific diseases rather than on systems; and its lack of attention to the critical determinants of poverty – unfair trade, high debt burden, and unfair global level policymaking – undermine success. So, what is different about the Global Fund that might make a difference?

The Global Fund is about shifting the present paradigm. First, it is demand-driven. Countries develop and submit proposals to the Global Fund that provide creative solutions to critical gaps in their existing national strategies; solutions that integrate responses to HIV/AIDS, tuberculosis and malaria with poverty reduction; and solutions that aim to strengthen the health infrastructure and human resource capacity to ensure sustainability.

Secondly, the Global Fund is an inclusive partnership, reflected at country level by the idea of a Country Coordination Mechanism (CCM). The role of CCMs is to bring together government, non-governmental organizations (NGOs), faith-based organizations, bilateral and multilateral technical agencies, academia, the private sector, labour, the media, and people living with these conditions. Creating opportunity for participation by the stakeholders in the fight against the three diseases is the kingpin of the new paradigm. Constituted in a representational manner, the partnership should give adequate voice to each stakeholder group, with members nominating their representatives.

Thirdly, the disbursement of funds to countries is to be performance based, linking financial accountability to

programme performance. The different interests within the CCMs should make it possible for performance to be measured in a transparent and accountable manner. Furthermore, Local Fund Agents, appointed by the Global Fund to serve as its ears and eyes on the ground, will monitor and verify country processes. Through the joint effort of bilateral, multilateral and UN technical partners, poorer countries are being assisted to prepare proposals to the Global Fund and to implement, monitor and evaluate funded programmes. The joint efforts are also strengthening national monitoring and evaluation systems.

Fourthly, the Global Fund underlines the need to coordinate donor input at country level, regardless of source, to achieve synergy. Existing national coordination structures and systems, such as the National AIDS Councils, Roll Back Malaria, and Stop TB partnerships, should be enhanced by the umbrella forums provided by the CCMs. Linking the three disease-specific partnerships to health systems, human resource development, poverty reduction strategies and sector-wide approaches is the strength of CCMs. But CCMs are still evolving, as partners begin to re-align and re-adjust.

In conclusion, a paradigm shift is possible. But, strengthening the health systems, developing human resource capacity, addressing poverty, and achieving outcome and impact level results will take time. Moreover, resources through the Global Fund should be additional to, and not a substitution for, existing allocations for HIV/AIDS, tuberculosis, malaria and systems development, as this is a fundamental principle of the Global Fund. Moreover, recipient countries should be exploring innovative ways for scaling up existing activities and addressing absorptive capacity issues. This could be addressed through engaging multiple stakeholders at country level, including multiple principal recipients and sub-recipients.

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Global Funds: scaling up through linking efforts

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During the last decade, much attention has been given to health sector reform and to the need for improved funding instruments and coordination. In spite of broad agreement on essential service products and the basic structural elements for a health service to provide critical access, many countries demonstrate deterioration rather than improvement.

While definitely worth critical analysis, it is a rather simplistic explanation to refer to a 'culture of self-interest' of donors and ineffective investments of international aid as the main cause for this situation. The factors that limit policy options and space for governments to sustain delivery of essential health services are certainly more complex.

In a similar way, 'the interest of the recipient' is referred to as if such interest is without dilemmas and contradictions. Recipients of external aid have conflicting interests, as do recipients of health services. Diseases of poverty compete for resources with diseases of affluence.

Global Funds, such as GFATM and GAVI, are neither 'short-cuts' to global justice in health, nor are they alternatives to best practice partnerships for health sector development. Rather, they are conceived to be adding value and driving performance. There are examples of misguided efforts, duplication and fragmentation. But there is also growing experience to show how the new opportunities are used to speed up, innovate and overcome barriers.

Mainstream health sector development collaboration has not succeeded in building health services delivery that can cope with the health sector challenges of the HIV/AIDS pandemic. Neither has it achieved sustained immunization coverage. It is not obvious that just more of the same will

achieve the Millennium Development Goals, given the challenges we now face. What we need is not more ideological debate where the best becomes the enemy of the good. We need to act strategically; maximizing opportunities, bridging gaps and building mutual accountability. We need both best practice mainstream action and focused initiatives to scale-up and overcome barriers. As long as they have appropriate linkages.

Capacity to respond must be mobilized in health systems where households, communities, private and public actors take each other seriously as partners. The 'Health for All' model of the eighties indicated this path, but never succeeded on a large scale. The response to HIV/AIDS has no other option but making this model work. The GFATM can contribute if it does not act in isolation, ensuring that additional inputs fit into a national framework where capacity can be built to sustain action. Focus must be on national coordination of the response to the three diseases, coping with diversity and maximizing on synergies.

GAVI together with the Vaccine Fund has created new partnerships and alliances that not only mobilize resources but also drive national ownership, service quality, long-term donor predictability, more research on vaccines relevant to the poorest and lower prices of vaccine products. This adds value long term, and is not mere short-term results that will fade out. The GFATM as a global partnership has the same potential, as already demonstrated in its agreed procurement policies. It is not the solution, but an important contribution to an effective global response, also beyond the value of its finance.

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The Global Fund: preparing for the Messiah?

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Peter Poore highlights two fundamental assumptions underlying the GF. One, that it is possible to mobilize sufficient funds from traditional donors and the private sector to tackle the three diseases of focus on a charitable, predictable and sustainable basis. Two, that it is possible to make a significant difference to the occurrence of these diseases without addressing poverty as a whole.

Yet in terms of funding, the predictable appears to have occurred. Despite the good intentions of the Fund's architects, the massive gap between what has been committed to countries to date (US\$1.5 billion) and what has been disbursed (US\$113 million) raises concerns about the feasibility of its plans for rapid disbursement. It remains unclear what strategy will be used to bridge this gap.

In addition, the greatest fear expressed about the Fund is whether it will be sustainable. Sustainability inherently requires building the local capacity that will, in the long term, allow a problem to be managed with little or no external assistance (Hiscock et al. 1993). But, for the Fund, sustainability seems to be seen as the perpetual support, on a charitable basis, of poor countries by rich nations. Such an approach means that it is highly unlikely that the poorest countries will, through the GF, develop their own internal capacity to deal with their own problems. Yet the most important lesson from previous experience with donor-driven initiatives is, as Peter Poore notes, the need for the genuine development of local initiatives and capacity. Unless this lesson is addressed, the fate of the Fund is already sealed.

A second major concern about the Fund is its short-term and largely bio-medical focus. Yet history has shown us that there is no quick fix for disease. Although short-term benefits have been achieved with technologies such as condoms and anti-retroviral drugs, sustainable disease control requires a comprehensive approach to development and poverty reduction. Deep-rooted developmental constraints and enduring cultural and societal constructs underlying sex, disease and health make a broad developmental approach to disease control essential.

Finally, Uganda's 2-year experience with the Fund provides indications of the difficulties to be faced in developing country-level operations. This experience has left a bitter taste for Ugandans.

Although the country has now benefited from the Fund, it took 2 years to secure its first funding allocation because of the rigour of proposal development and presentation. The first year's proposals were rejected as being unsatisfactory. Other problems encountered were the incompatibility of the Fund's requirements with Ugandan Government procedures and with existing donor-funded programmes such as Roll

Back Malaria and Stop TB. But the fiercest disagreement on the Fund was between Uganda's Ministries for Health and Finance on the additionality of GFATM funds to the health budget. Against the position of well-known international economists such as Jeffrey Sachs (Sachs 2002), the Finance ministry argued that inflows of donor funds above its Medium Term expenditure Framework ceilings would upset macro-economic stability. The matter was only resolved by the intervention of the President, Mr Yoweri Museveni, who accepted the principle of additionality. Finally, it has become clear that the country's institutions are currently too weak to manage the wide variety of public and private players linked to the Fund. Unless specific attention is paid to this broad range of issues, the Fund may only undermine existing capacity.

The initiative to mobilize funds from rich charitable governments, organizations and individuals should be saluted. However, disease burden cannot be reduced sustainably without addressing poverty and development as a whole. To do this, efforts should primarily be focused on encouraging local initiatives and capacity, and ensuring that any new initiative is compatible with the national development goals and frameworks. Development efforts should be consistent, persistent and long term, and should be aimed at genuinely improving the welfare of the people. Although a new mechanism of international support, it is unlikely that the GFATM can achieve this goal. It seems we still await the messiah that will deliver the poor from poverty.

References

- Hiscock J, La Fond A, White J. 1993. Sustainability in the health sector: Uganda case study. London: Save the Children Fund, UK.
- Sachs JD. 2002. The need for increased investment in health. *Uganda Health Bulletin* 8 (2): 113-4.

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