POLICY FORUM

GLOBAL HEALTH

Global Fund lessons for Sustainable Development Goals

Transparency and independence underpin successes

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The Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria (GF) was launched in 2001 in the context of the AIDS pandemic and the Millennium Development Goals (MDGs). Thanks in large part to key design principles (DPs), the GF public-private partnership has played a major role in advancing public health science and in scaling up and strengthening evidence-based public health efforts in developing countries. As world leaders prepare to advance international development finance at the July 2017 Group of 20 (G20) Summit, we suggest the GF as a template for funding research, development, and scale-up of interventions in both health and non-health areas of the Sustainable Development Goals (SDGs), which replaced MDGs in 2016.

As of 2000, there was little effort or consensus for deployment and scale-up of proven interventions against HIV/AIDS, TB, or malaria. Spending by affected countries was a fraction of the need; international aid for health was inadequate; and there was little implementation research on how to scale up complex health programs. Amid calls for increased action, United Nations Secretary-General Kofi Annan called in 2001 for creation of the GF. Leaders of the Group of Seven (G7) countries endorsed the GF; the first round of proposals was approved in April 2002; and first disbursements were made in January 2003.

Between 2003 and 2015, the GF had disbursed $35 billion, accounting for 16.4% of international funding for HIV/AIDS, 44.5% for TB, and 81.4% for malaria bed nets (*1*). By the end of 2014, GF-supported programs had provided 8.1 million people with antiretroviral drugs (ARVs), distributed 548 million bed nets, treated 515 million people with artemisinin-based combination therapy, and treated 13.1 million people for TB (*2*).

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EIGHT DESIGN PRINCIPLES

Eight DPs (*3*) have made the GF an innovative financing institution:

1. *Country-led*. Until 2010, countries submitted proposals outlining their financing needs rather than applying for funds allocated ex ante for each country. Since 2010, they apply for ex ante country allocations and modest incentive funding.
2. *Multistakeholder*. Each country submits proposals through its Country Coordination Mechanism (CCM), comprising representatives from government, civil society, business, development partners, and persons living with the diseases.
3. *Independent, transparent, technical review, and evaluation*. Proposals are reviewed by an independent Technical Review Panel (TRP) of scientific experts from public health and other disciplines. The GF's independent Technical Evaluation Reference Group (TERG) and Office of the Inspector General (OIG) conduct audits and reviews of the GF and its impact. Reports by the OIG, TRP, and TERG are made public, as are the Board's reactions, which is unique among bi- and multilateral financing institutions (*4*).
4. *Political independence*. The Governing Board—a body of donors, recipients, experts, civil society, and businesses—considers programs recommended by the TRP as a bloc to avoid political interference targeting individual countries.
5. *Needs-based pooled financing*. Donors pool resources into a single self-governing fund without earmarking and are expected to meet financing needs of Board-approved proposals through periodic replenishments.
6. *Funding is for disease-specific programs but is implemented in broader health systems*.
7. *Performance-based funding*. Continued funding is conditional on successful program execution and independent audits.
8. *Financing only*. As a financing instrument rather than an implementing agency, the GF relies on technical partners [e.g., World Health Organization (WHO) and UN Programme on HIV/AIDS] for technical advice or implementation support to countries.

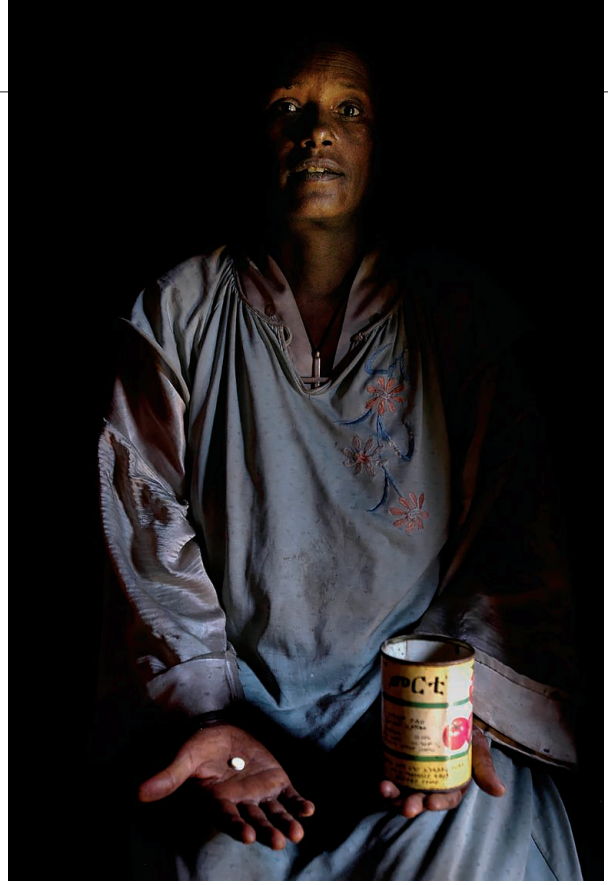
The 2008 financial crisis led to a GF funding crisis and the New Funding Model based on ex ante country allocations. The shift from "demand-led" to "allocation-based" funding brought the GF more in line with practices at the World Bank and other donors. This has reduced allocations to some countries and slowed down financial scale up that had been under way until 2010 (*1*), a worrisome weakening of a central pillar of GF success.

INITIAL DOUBTS, LESSONS LEARNED

In light of calls for new global funds for SDGs, we revisit five early arguments against the GF, and link subsequent evidence to key DPs.

First, it was widely deemed difficult or impossible to scale up proven but complex health interventions in resource-poor settings, and there was strong opposition to financing them publicly. In fact, the GF generated large volumes of high-quality, country-led proposals recommended for funding by the TRP, particularly from poor countries. All TRP-recommended proposals were fully funded. Countries thus learned that rigorous programs would be funded, which spurred increased high-quality demand for funding [DPs 1, 4, and 5]. GF-supported programs have performed well in complex operating environments of fragile countries (*5*). Evaluations by the TERG supported implementation research by technical partners to fill knowledge gaps, such as the design of outcome and impact criteria in malaria-control programs (*6*). Assessments of proposals by the TRP identified gaps in available interventions, such as rapid diagnostic tests for malaria [DP 3]. The GF contributed to economies of scale, learning by doing, and price reductions (*7*), which made free mass distribution of key commodities affordable. On the basis of GF-funded implementation research, free mass distribution became the WHO standard for some commodities (e.g., ARVs) (*8*) [DP 8].

Second, some feared that CCMs were externally driven and that they and the technical review process would undermine country ownership. Initial experiences were mixed, but CCM performance improved (*4*). Civil society involvement has improved the design and performance of many programs (*9*) [DP 2]. The GF's ability to disburse funds to a range of CCM-approved stakeholders (national and local governments, civil society organizations, international organizations, and businesses), combined with independent evaluation, has accelerated innovation and propagation of best practice (*10*).



An HIV-positive woman with free ARV in Addis Ababa, Ethiopia, May 2005.

PHOTO: GIANLUIGI GUERCIA/AFP/GETTY IMAGES

Third, many argued that the "vertical" focus of the GF on specific diseases would undermine broader health systems strengthening (HSS) and distort health spending. But GF-supported programs have been credited with contributing to HSS, although disease programs need to be better integrated into health systems. GF funding does not appear to have reduced domestic or international spending on health systems (*11*–*13*). Additional resources are needed to accelerate HSS (*2*, *13*) [DP 6].

Fourth, some argued that the health sector did not need a new financing institution and resisted calls for pooled international financing. Yet no multilateral institution was providing large-scale performance-based funding for disease control to a wide range of government and nongovernment parties. Today, most major donors contribute without earmarking, despite the preference of parliaments and governments for bilateral channels. The GF, shown by independent evaluations to provide good "value for money" [e.g. (*4*, *12*)], has mobilized large volumes of additional aid for health [DP 5].

Fifth, many were concerned that the GF's light-touch business model and reliance on external audits and technical partners would prove an easy target for corruption and poorly designed programs. In response, the GF expanded staff in the mid-2000s to ensure better program oversight. In 2011, OIG flagged misuse of funds in several programs; less than 0.4% of resources had been misused (*14*). The GF recouped a large share of the loss and tightened corruption controls. Performance-based funding and low tolerance for corruption appear to improve programs [e.g., (*15*)] [DP 7]. Transparency of funding decisions, disbursements, reporting, and evaluations contributes to success (*4*).

After initial difficulties (*4*, *12*), the GF improved cooperation with technical partners by promoting implementation research and assisting countries in preparing, implementing, and monitoring GF-supported programs. In contrast to other financing mechanisms, the GF makes all grant-related data and audits public (*16*). It works with partners to improve the quality and availability of data for disease and implementation metrics [DP 8].

In addition to successes, the GF has experienced challenges (*4*). Countries and independent evaluations point to high transaction costs in accessing funding and a high reliance on consultants for proposal preparation and reporting. The GF needs improved oversight of program implementation. This should include more explicit reporting on outcomes beyond the number of services provided, and transparent benchmarking to ensure effective use of resources and encourage performance-based funding. In addition to evaluations by GF bodies and donors, monitoring by independent civil society organizations can play a role. The GF should improve access to evaluation reports and country reporting and performance metrics. If the GF remains committed to transparency and independent evaluations, these and other challenges can be addressed.

FUNDS FOR ACHIEVING THE SDGS

The GF should serve as the primary funding vehicle to implement strategies to break the three epidemics (90-90-90 Strategy for HIV/AIDS, the Global Plan to End TB, Global Malaria Action Plan) and to achieve SDG Target 3.3. The fact that the GF was able to meet its $13 billion target for the 2017–2019 replenishment is testament to broad support and perceptions of its success. Far greater resources will be required to fully implement recommended strategies against these diseases (*2*), so donors should expand their support.

The GF should broaden its business model to increase investments and implementation research for HSS (SDG Target 3.8), reducing preventable deaths (Targets 3.1 and 3.2), access to sexual and reproductive health services (Target 3.7), responsiveness to disease outbreaks such as Ebola (Target 3.d), and tackling noncommunicable diseases (Target 3.4). As the main pooled financing vehicle for health systems and SDG health priorities, the GF should work with Gavi, the vaccine alliance; World Bank; and others.

The GF model can help meet investment needs in nonhealth SDG areas where proven interventions need to be scaled up with the help of public (co-)financing: e.g., smallholder farming (SDG 2), improved nutrition (SDG2 and SDG3), education (SDG 4), water supply and sanitation (SDG 6), and distributed rural electrification (SDG 7). The GF model is not suited for investment areas, such as large-scale infrastructure, that require more market- and project-based financing solutions.

The recently announced Global Emergency Education Fund could be a step in the right direction. Together with the underfunded Global Partnership for Education, they should transform into a Global Fund for Education. Similarly, lessons from the GF can inform the work and resource mobilization of existing multilateral financing institutions, e.g., the Green Climate Fund for climate change adaptation and mitigation, the Global Environment Facility for biodiversity and ecosystem management, and the International Fund for Agricultural Development. ■

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