german cooperation
DEUTSCHE ZUSAMMENARBEIT

The German BACKUP Health Initiative:

Learnings from 20 years of working for – and between – the Global Fund and recipient countries

A publication in the German Health Practice Collection

Implemented by

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

GERMAN HEALTH PRACTICE COLLECTION

Working together to generate and share learning

The German Health Practice Collection (GHPC) is a joint initiative of the German Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing agencies, the *Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH* (GIZ) and the KfW Development Bank (KfW), which are known collectively as German Development Cooperation (GDC). Since 2004 the Collection has involved experts working in German-supported health and social protection programmes in a collaborative knowledge management process, seeking to identify, document and share knowledge generated during the implementation of programmes around the globe.

From 'good practice' to learning from implementation

In 2015 the Collection shifted its focus from aiming to capture 'good practice' towards generating new knowledge on the delivery of development interventions. Guided by two to three key questions, each case study in the Collection analyses how German programmes and their partner institutions have approached a specific development challenge, how they have dealt with difficulties and accordingly adapted their approaches, and what they learned in the process about effective implementation.

www health.bmz.de

@HealthyDEvs

fb.com/HealthyDEvs

More information about the German Health Practice Collection can be obtained by contacting the Managing Editor at editor@healthy-developments.de or by visiting the Collection's homepage (health.bmz.de) where all case studies, as well as related materials, are available for download.

Front cover photo: *BACKUP Health worked with Aidspan, a Kenya-based Global Fund watchdog organisation, to strengthen the role of national Supreme Audit Institutions in overseeing Global Fund grants (see p.26), an important step towards country-owned and -led accountability mechanisms for global health financing. The cover photo shows a roundtable with Auditor-Generals (seated in front row) from seven national Supreme Audit Institutions in an Aidspan workshop on auditing Global Fund grants (Accra, December 2019).*

Contents

Acronyms and abbreviations

ACT-A	Access to COVID-19 Tools Accelerator
AFROSAI-E	African Organisation of English-speaking Supreme Audit Institutions
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BACKUP	Initiative to 'Build Alliances, Create Knowledge and Update Partners'
BMZ	Federal Ministry for Economic Cooperation and Development, Germany
CCM	Country Coordinating Mechanism
CICDoc	*Centre d'Information, de Conseils et de Documentation sur le Sida et la Tuberculose*
COVAX	COVID-19 Vaccines Global Access
COVID-19	Coronavirus SARS-CoV-2
CSAT	Civil Society Action Team
CSO	Civil Society Organisation
EANNASO	Eastern Africa National Networks of AIDS and Health Service Organizations
ECI	Enhancing Care Initiative
ECF	Enhancing Care Foundation
FCDO	Foreign, Commonwealth and Development Office, United Kingdom
G8	Group of Eight
GAP	Global Action Plan for Healthy Lives and Wellbeing for All
Gavi	Global Alliance for Vaccines and Immunisation (now Gavi, the Vaccine Alliance)
GDC	German Development Cooperation
GFF	Global Financing Facility
GHI	Global Health Initiative
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH*
GMS	Grant Management Solutions
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit GmbH* (now GIZ)
HAART	Highly Active Antiretroviral Therapy
HBF	Health Basket Fund
HIV	Human Immunodeficiency Virus
ICASO	International Council of AIDS Service Organizations
KfW	KfW Development Bank
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
OIG	Office of the Inspector General
P4H	Providing for Health – Global Network for Health Financing and Social Health Protection
PEPFAR	United States President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
RSSH	Resilient and Sustainable Systems for Health
SAI	Supreme Audit Institution
SDC	Swiss Agency for Development and Cooperation
SDG	Sustainable Development Goal
STAGE	Strategic Technical Assistance for Grant Excellence
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WTO	World Trade Organization
ZYP	Zambian Youth Platform

Executive Summary

BOX 1. KEY LEARNINGS

Since 2002, the BACKUP Health initiative has been a key intermediary between the Global Fund and recipient countries. On BACKUP's 20th anniversary, this review of experiences and learnings presents several insights into where and how providers of technical assistance and the Global Fund may wish to focus their efforts to achieve greater equity in health outcomes and health governance.

- **Agility, flexibility and recognising windows of opportunity are essential for impactful technical assistance.** BACKUP Health's support to its partners has been most successful where the initiative was able to spot openings in political space or administrative process and was quick to deploy the right mix of subject matter expertise and knowledge of the local context. BACKUP has thus at times fulfilled the role of 'honest broker' between the Global Fund and recipient countries, for example, in their advocacy for stronger support to Country Coordinating Mechanisms (CCMs) – which ultimately contributed to setting up the Fund's dedicated CCM Evolution project in 2018.

- **Several of the Global Fund's core principles, such as civil society participation and accountability, still depend on external support by partners like BACKUP Health to be fully operationalised.** This dependency will persist so long as the Global Fund does not internalise the necessary investments in technical support and capacity development for country partners. BACKUP has demonstrated that sustainable, inclusive solutions are possible. Its work with Supreme Audit Institutions in Africa has shown that the Fund's accountability processes can be fully localised, signifying a strong move towards sustainability and alignment.

- **Despite the Global Fund's stated ambition to align itself with recipient country systems and priorities, concrete opportunities such as investing in a country's pooled fund have been left unexploited. BACKUP Health has shown** that it can deliver crucial preparatory work and prepare the way technically, though it cannot precipitate the requisite political will on the part of the Fund.

- **The Global Fund and BACKUP Health were created to tackle inequities in global health *outcomes*. Today, twenty years later, they must tackle inequities in global health *governance*.** Through more equitable distribution, the Fund's resources have enabled remarkable successes in the fight against HIV, tuberculosis and malaria, particularly in the world's poorer countries. But the Global Fund's modus operandi has fallen short of the ambition expressed in its 'partnership principle', with CCMs maintained as structures parallel to countries' existing health governance systems, with complex administrative procedures that are not harmonised with those of other Global Health Initiatives, and with the additional transaction costs that this entails. BACKUP Health can help by feeding its implementation experiences – via Germany's representation on international boards – into the much-needed political discussion on the Global Fund and global health governance.

THE CHALLENGE: TACKLING INEQUITIES IN HEALTH OUTCOMES, GLOBAL HEALTH FUNDING RAISES ISSUES OF HEALTH GOVERNANCE

The Global Fund to Fight AIDS, Tuberculosis and Malaria (or simply Global Fund) was created in 2002 in response to what Kofi Annan called a 'worldwide revolt of public opinion'. In the context of a growing global social justice movement, people demanded that governments deliver on health equity in the face of the raging epidemics of AIDS, TB and malaria that were killing an estimated 6 million people each year. The brunt of the suffering was borne by those who were too poor or too marginalised to access the effective treatment and care that were already available in affluent countries.

The Global Fund has become the world's largest financier of prevention, treatment, and care for the three diseases and has begun to invest more broadly in overall health systems strengthening. Germany has been one of the largest contributors to the Global Fund from the start, with a pledge of €1 billion for the latest 2020–2022 funding round and €1.26 billion expected for the next phase. Through its immense grant resources – around $4 billion annually – the Global Fund has become one of the most powerful actors in global health, alongside other Global Health Initiatives (GHIs). GHIs wield significant influence over health sector policies and programmes in many low- and lower middle-income countries.

In theory, the partnership principle espoused by the Global Fund aspires to ensure equity, not only in health outcomes but in health governance: i.e. that all those involved in the response to the three diseases have a voice in the Fund's decision-making processes – including governments, civil society, communities affected by the diseases and technical partners. The Global Fund has also vowed to align itself with countries' systems and priorities so that, at the least, accessing grant funding does not come at the expense of countries' ownership over health policies and programmes and does not cause inordinate transaction costs.

In practice, the Fund's insistence on parallel coordination mechanisms at country level in the form of CCMs, its complex administrative procedures and the power dynamics of grant governance, which determine who gets to sit at the decision-making table, run counter to its partnership principle. The Global Fund's own reviews have diagnosed its limited alignment with national priorities, high transaction costs for recipient countries and shortcomings in adequately and consistently engaging and representing civil society and key populations in the pivotal CCMs (The Global Fund, 2016a, 2019a; The Global Fund/World Bank Group, 2020). Unsurprisingly, recipient countries have often found it difficult to navigate the Global Fund's complex processes and requirements to access and implement grant funding. The demand for technical assistance (TA) has been immense from the start.

THE RESPONSE: TECHNICAL ASSISTANCE TO ACCESS FUNDING AND STRENGTHEN CAPACITY, PARTICIPATION, ACCOUNTABILITY AND ALIGNMENT

To meet this need, in 2002, the *Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH* (GIZ) set up its largest self-financed project in the history of the organisation, committing €30 million for the first three years of the BACKUP Health initiative. From then onwards, the Federal Ministry for Economic Cooperation and Development (BMZ) has been funding BACKUP Health. The overarching objective was to help countries access and use Global Fund resources effectively in the fight against the three diseases. Over time, BACKUP has increasingly focused on helping its partners operationalise meaningful civil society participation, localise and strengthen the ownership of the Global Fund's accountability mechanisms, and work towards greater alignment of the Fund with national priorities and systems.

Over the past 20 years, BACKUP Health has financed over 800 TA measures in around 90 countries. It has become an integral part of the Global Fund's support ecosystem, also thanks to the significant contributions of its donor partners. Since 2013, BACKUP has been co-financed by the Swiss Agency for Development and Cooperation (SDC). In 2020, both Expertise France and the UK Foreign, Commonwealth and Development Office (FCDO) signed a co-financing agreement.

THE RESULTS: WHAT HAS BEEN ACHIEVED?

The mainstay business of BACKUP Health has been to use its relatively limited project resources to help recipient countries access and implement disproportionately larger Global Fund grants. Its support to countries in making funding requests to the Global Fund embedded in the national dialogue, generally with the assistance of experienced consultants hired for this task, has led to hundreds of successful grant applications over the past 20 years, ranging from funding for health systems strengthening in Angola, to combined HIV/TB programming in Uzbekistan, to accessing the COVID-19 response mechanism in Sierra Leone, to name but a few. A recent Global Fund audit report on capacity building and technical assistance recognises BACKUP's approach as good practice, emphasising its fully transparent communication with the Global Fund, from the initiation of in-country technical assistance to assessing impact and reporting results.

Beyond access to funding, BACKUP Health has strengthened the capacity of governments and civil society to implement grant-funded interventions and to participate in the governance of Global Fund programmes at country level. Such effects have been multiplied by BACKUP's support to regional knowledge hubs in Eastern Europe and in Eastern and Southern Africa. Between 2017 and 2019, BACKUP developed a new modular approach called Strategic Technical Assistance for Grant Excellence (STAGE), combining specific TA for grant management with organisational development support. Initial reports from the selected countries where STAGE has been deployed are promising.

Other capacity development efforts by BACKUP have focused specifically on enabling and empowering civil society organisations (CSO) and key populations to engage in CCMs, the main governance arena of the Global Fund at country level. This support has contributed to making Global Fund processes more inclusive and anchored in a practical human rights-based approach. Through its work with a broad range of partners, from grassroots community organisations to national Supreme Audit Institutions, BACKUP has helped to demonstrate how the Fund's accountability mechanisms can be grounded in local ownership, instead of continuing to rely on multinational accounting firms.

But BACKUP's experiences also reveal that several of the Fund's core principles and functions, from partnership to civil society engagement and accountability, appear to be dependent on external support to be fully operational, raising crucial questions regarding their sustainability and alignment. The parallel structure of CCMs and the administrative procedures of the Fund, which are not harmonised with those of other GHIs, limit the Fund's integration with national systems and impose significant transaction costs on recipient countries.

For BACKUP Health it is important to consider where their efforts to strengthen GHI coordination and alignment are likely to be impactful. Certain country examples give promising signs that inroads can be made at country level. However, a sustainable solution – making alignment the norm rather than the exception – is likely to require structural changes at a central, policy level of the Global Fund.

Why this case study?

By the turn of the millennium, over 95% of the world's 36 million people living with HIV resided in low- and lower middle-income countries, most of them in Sub-Saharan Africa (UNAIDS/WHO, 2000). While antiretroviral therapy (ART)[1] had become widely available to people living with HIV in high-income countries, ART remained impossible to obtain for citizens of poorer countries, where nine out of ten AIDS-related deaths occurred (Reich & Bery, 2005). Similar discrepancies existed in TB and malaria control.

What today is regarded as 'unfair and remediable inequality' (WHO, 2021a) between rich and poor, 20 years ago was commonly defended as inevitable because treatment was considered too costly for low-income countries. It was also said that they lacked the health infrastructure to use modern therapies effectively. Without close follow-up by trained health professionals, it was expected that patients would not take their medications regularly and consistently as prescribed, with interruptions in treatment regimens leading to dangerous drug resistance.

Twenty years of fighting epidemics and strengthening health systems: The Global Fund and Germany's BACKUP Health

When the Global Fund to Fight AIDS, Tuberculosis and Malaria (or simply Global Fund) was finally established in 2001 and became operational in 2002, it constituted a sea change in how the world thought about health equity and the funding that was made available for fighting these diseases. The creation of the Global Fund was the result of relentless civil society advocacy and the strategic and visionary leadership of the UN Secretary-General Kofi Annan, backed by the governments of several leading industrial nations as well as private sector corporations, foundations and non-governmental organisations.

BACKUP Health and partner staff discuss support to Kyrgyz Republic's Centre for Immunoprophylaxis in Bishkek, 2021.

Since the beginning, Germany has been one of the Global Fund's foremost supporters, with a pledge of €1 billion for the latest 2020 to 2022 funding round. The German BACKUP Health initiative (BACKUP for short)[2] was established in 2002 to support countries in accessing Global Fund resources and to strengthen implementation of programmes financed by the Global Fund.

BACKUP Health's 20th anniversary occurs at a tumultuous time in global public health. The Coronavirus (COVID-19) pandemic continues to lay bare critical vulnerabilities in countries' health systems and demands collective action.
It also raises questions about global health governance and the role of Global Health Initiatives (GHIs) such as the Global Fund and supporting actors such as BACKUP. For example, are the powerful GHIs adequately aligned to national health systems and priorities? And how can a relatively small bilateral initiative such as BACKUP Health – whose budget of €40 million over three years is dwarfed by the Global Fund's $4 billion *annually* – make best use of its scarce resources for the benefit of the people it serves?

[1] Until the late-1990s/early-2000s, ART was commonly referred to as highly active antiretroviral therapy (HAART).

[2] BACKUP is a project implemented by the *Gesellschaft für Internationale Zusammenarbeit GmbH* (GIZ) on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ).

Reflecting on the role of BACKUP Health in a changing context

Over the years, the BACKUP Health initiative has accumulated a wealth of experience with the processes involved in providing, receiving, effectively using and accounting for large grants in low- and lower middle-income countries.

Working in the space between country partners and the Global Fund, at the interplay of joint objectives but also differing interests, has granted BACKUP unique perspectives and opportunities to facilitate and help shape the interaction between the two parties in a constructive, learning-oriented manner.

Therefore, BACKUP's 20th anniversary is a timely occasion for critical reflection. This study aims to bring out the insights BACKUP has generated from its unique position as intermediary between a multilateral organisation and recipient countries; and to contribute to a vision for how BACKUP can continue to play its role as innovator, facilitator and mediator.

This study seeks to answer three overarching questions: 'How has BACKUP Health used its position between the Global Fund and recipient countries to:

a. Leverage Global Fund resources for greater impact?
b. Support inclusive coordination, planning and implementation of Global Fund grants?
c. Strengthen in-country actors, institutions and systems for overseeing implementation, ensuring accountability and aligning international financing with national priorities?'

Approach and methodology

To answer these questions, the study draws on a series of in-depth interviews with 24 key informants: current and former BACKUP project leads, partners, funders and Global Fund staff who were asked to share their experiences and reflections. The study builds on a review of BACKUP documentation – proposals, progress reports and independent evaluations – and external literature.

This study has followed an inductive approach to sourcing and analysing information. Semi-structured interviews have allowed for a range of issues to emerge, pertaining to country or implementation-level experiences as well as to global or strategic considerations. The insights generated through this process have lent themselves to clustering into three thematic areas: governance at country level; health system strengthening and coordination; and BACKUP's approach. This thematic arrangement also informs the structure of the report.

One caveat applies: One reflection paper cannot possibly do justice to 20 years of work by countless individuals. The fact that BACKUP Health has managed to finance over 800 technical assistance (TA) measures with dozens of partners in nearly 90 countries is testament to the dedication and commitment of its staff and affiliates. It has resulted in successful Global Fund applications and better organisational capacity to coordinate and manage these grants. Instead of attempting a synopsis of all that has been achieved, this study draws on select experiences and elicits critical reflections on pertinent topics that have been – and currently are – on the minds of BACKUP Health staff and partners. While not exhaustive, the list of issues raised appears timely and will hopefully prove useful in stimulating discussion about the way ahead for the BACKUP initiative.

Structure of the study

This paper is structured as follows. The next chapter briefly retraces the social and political dynamics that precipitated the creation of the Global Fund as a powerful new actor in global health and the rationale for establishing BACKUP Health alongside it. The following chapter reviews some of the results of BACKUP's core business model, which is to use its limited project resources to help countries access and implement disproportionately larger Global Fund grants. The ensuing section examines BACKUP's efforts to help operationalise and strengthen a key element of the Fund's partnership principle, namely the participation of civil society in implementing Global Fund programmes and in the governance of the Fund at country level. The final chapter discusses two issues at the heart of the current discourse on global health governance and equity: accountability and alignment, both of which have been central in the work of BACKUP Health. The paper concludes with reflections on what it might take to move towards a more equity-oriented configuration in global health governance and specifically the steps that powerful GHIs like the Global Fund could take, and how BACKUP could support this.

The Global Fund and BACKUP Health: Signs of a turning point in global health equity

By the late 1990s, the raging epidemics of AIDS, TB and malaria were killing an estimated 6 million people each year (Kapp, 2002). In many countries, AIDS devastated an entire generation, leaving countless orphans and shattered communities. TB alone caused nearly 1.9 million deaths in 1999, with some African countries registering disastrous case fatality rates of well over 50% (the proportion of people infected with the disease who end up dying of it), especially where HIV infection rates were also high (Dye et al., 1999). Of the 736,000 malaria deaths recorded in the year 2000, 92% occurred in the Africa region, killing young children and pregnant women unable to protect themselves from mosquitoes or access life-saving medicine (WHO, 2020).

Unequal access to treatment

Even though developing countries bore the brunt of the disease burden, advances in therapies and financing to access them remained out of reach for people in poorer countries. Effective treatment remained the privilege of wealthier states. In the United States, AIDS mortality rates decreased by 75% between 1994 and 1997 – a decline largely attributable to the intensive use of antiretrovirals (ARVs) which could cost up to $21,000 per person per year (Reich & Bery, 2005; Freedberg et al., 2001).

At the same time, the annual 'AIDS epidemic updates', jointly issued by UNAIDS and WHO, did not even consider therapy a possibility for use in low- and lower middle-income countries (UNAIDS/WHO, 1998). For them, the narrative was almost exclusively focused on prevention: mass media campaigns for health education, promoting and distributing condoms, voluntary counselling and testing, among other strategies, all of which were of little consolation to the over 36 million people already infected with HIV/AIDS.

In what would sound cynical today, the UNAIDS/WHO AIDS epidemic update of December 2000 suggested that 'scaling up the response to Africa's epidemic is imperative and affordable. Setting ambitious but achievable targets for coverage, countries would need at least $1.5 billion a year for *prevention measures* [emphasis added]. (...) The bill for palliative care for pain and discomfort, the treatment and prevention of opportunistic infections, and care for orphans would come to at least $1.5 billion annually' (UNAIDS/WHO, 2000). The option of providing ART was seemingly waved aside with an indication that it 'would cost several billion dollars more a year' (Ibid.). The primary emphasis on prevention is all the more striking because there was little evidence to suggest that the prevention campaign worked to lower infection rates (Mayaud, Hawkes & Mabey, 1998).

The push for health equity – showing that it could be done and the reasons it wasn't

At the time, the main objections to the use of ARVs in developing countries were their high cost and the perceived lack of health infrastructure necessary to use them, as was argued in international fora that were dominated by the Global North (Farmer et al., 2001). However, successful pilot projects had shown that it could be done. A prominent example was the 'AIDS Equity Initiative' in rural Haiti, led by the late Paul Farmer, founder of Partners in Health, who subsequently joined the faculty of Harvard's Medical School.

The initial Haiti project provided free ARV treatment to 60 people living with HIV/AIDS and paired each patient with an *accompagnateur*, often a community health worker, who observed ingestion of pills and responded to patient and family concerns. The striking success of the

pilot, which had been implemented in the poorest and most deprived of settings, was documented in *The Lancet* and showed that arguments of unfeasibility did not hold true. Farmer and his co-authors wrote: 'We believe that if [community-based HIV treatment] can be implemented in the devastated Central Plateau of Haiti it can be implemented anywhere' (Ibid.). The use of community health workers could partly make up for limitations in health infrastructure and the cost of treatment could be lowered by nearly 90% when relying on generic drugs instead of sourcing from manufacturers in North America or Europe.

The results of the Haitian AIDS Equity Initiative and the assertion that the same could be done elsewhere were met with a barrage of criticism. Authors in the WHO Bulletin argued that Farmer and colleagues 'may be right in a moral sense, but it is not practical. To advocate the impossible is to put at risk the achievement of more limited objectives' (Feachem, 2001).[3] They also contended that 'this success story must be classified as non-proven. (...) Replication is something else entirely. (...) Important lessons that might have been applied in other settings simply cannot be drawn from this study' (Gilks, AbouZahr & Türmen, 2001).

A growing movement for global social justice

Meanwhile, the Haiti AIDS Equity Initiative and similar, concrete examples of extending high-quality medical care to the poor gained international prominence. The Harvard 'Consensus Statement', signed by 140 faculty members, cited Farmer's project in its argument for worldwide treatment (Faculty of Harvard University, 2001). The economist Jeffrey Sachs, then a Harvard professor, a Special Advisor to UN Secretary-General Kofi Annan and Chair of the Commission on Macroeconomics and Health for WHO from 2000 to 2001, wrote: 'I was able to use the example of [Paul Farmer's] work in many key fora around the world in the past few years. (...) When I worked with the Secretary General to help launch the Global Fund to Fight AIDS, Tuberculosis and Malaria, Paul's work was a key example' (Kidder, 2003).

Beyond academic circles and policy conference rooms, vocal AIDS activists on the streets of many capitals drew attention to issues of access to and affordability of treatment around the world, for example, in the United States (U.S. Department of Health and Human Services, 2022) and in South Africa (Powers, 2020). Momentum was building for an agenda that was much broader than HIV/AIDS.

→ *Mother and child visit the Makorora Centre for HIV training in rural Tanzania, 2011.*

[3] Ironically, merely one year after his critique of Farmer's work had been published, Feachem went on to become the first Executive Director of the Global Fund. Feachem's job was now to do what he had previously dismissed as being 'not practical' in Farmer's Haiti project. The legacy of his four-year tenure as Executive Director is characterised by somewhat mixed reviews (*The Lancet*, 2006).

The turn of the millennium marked the confluence of multiple strands of activism and social movements that demanded, broadly speaking, a new approach to global social justice in the face of rapid economic globalisation and rising inequalities. In the fall of 1999, thousands of protesters blocked off the World Trade Organization's (WTO) ministerial meeting in what became known as the 'Battle of Seattle'. At this 'founding event in the history of transnational social movements' (Hadden & Tarrow, 2007), the activists demanded that states focus on development policies that would combat gross inequalities between countries and peoples.

From Seattle onward, virtually every international summit of any importance – on themes ranging from trade and economics to health and the environment – has been accompanied by counter-summits and protest demonstrations that often got wider press coverage than the official agenda did: for instance, in 2000 at the World Economic Forum in Davos; at the IMF and World Bank meetings in Washington; at the UN summit on poverty in Geneva, and at the European Union (EU) summit in Nice (della Porta, 2005).

In April 2000, Kofi Annan's report 'We the Peoples: The Role of the United Nations in the 21st Century' framed the questions of UN reform within the world's larger challenges. The most important task was identified as 'to ensure that globalisation becomes a positive force for all the world's people, instead of leaving billions of them behind in squalor' (Annan, 2000). In the fall of that year, the launch of the Millennium Development Goals marked the political commitment to change. What was missing, especially in the combat against HIV/AIDS, malaria and TB (Goal 6), was money.

From 'a worldwide revolt in public opinion' to a Global Fund to finance the combat against HIV/AIDS, TB and malaria

It is against this backdrop that Kofi Annan, addressing the African Leaders Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases in Abuja, Nigeria, in April 2001, summarised the global sentiment: 'There has been a worldwide revolt of public opinion. People no longer accept that the sick and dying, simply because they are poor, should be denied drugs which have transformed the lives of others who are better off' (Annan, 2001). He therefore proposed 'the creation of a Global Fund, dedicated to the battle against HIV/AIDS and other infectious diseases. This Fund must be structured in such a way as to ensure that it responds to the needs of the affected countries and people' (Ibid.).

Annan already knew that he could count on the Group of Eight (G8)[4], representing the world's leading high-income countries, to provide the necessary start-up funding. The G8 leaders had gathered in Okinawa in July 2000 and, in the summit communiqué, signalled their commitment to 'implement an ambitious plan on infectious diseases, notably HIV/AIDS, malaria and tuberculosis' and to 'mobilise additional resources (...) to the maximum extent possible' (G8, 2000).

BOX 1. HOW DO COUNTRIES GET MONEY FROM THE GLOBAL FUND?

Since 2014, the Fund's new funding model operates in three-year cycles of raising and investing resources for country-level programmes to combat the three diseases. The current cycle runs from 2020 through 2022. Countries are assigned an indicative three-year allocation up front to ensure predictability. The Global Fund calculates the amount based on a country's disease burden and economic capacity, refined to account for important country-specific factors.

The Global Fund Secretariat is located in Geneva without any physical presence in partner countries. Applying for funding allocated to countries is the responsibility of the Country Coordinating Mechanism (CCM), which is a national committee that should include representatives of all relevant sectors, including people affected by the diseases. Each country that receives an allocation can submit funding requests for eligible disease components through the CCM on behalf of the country as a whole. Over the course of the three-year cycle, there are multiple time 'windows' (nine in the current period) within which countries can submit their requests.

Applications are reviewed by a Technical Review Panel, an independent body that assesses the quality of the application and may ask for changes or make recommendations for improvement. The Grant Approvals Committee – made up of senior management at the Global Fund and representatives of technical, bilateral and multilateral partners – reviews the final grant before recommending it to the Board of the Global Fund for approval. Following Board approval, grant disbursement begins.

The CCM as multi-stakeholder platform also selects the principal recipients of the grants – typically government and civil society organisations – and oversees the implementation of the funded programmes. (The Global Fund, 2021b, 2013)

[4] Since 1998, the Group of Seven (G7) – comprising Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States – had included Russia as an eighth member. Russia's membership was suspended in March 2014 in response to its annexation of Crimea, and Russia announced its permanent departure from the group in 2017.

Following Annan's address to African leaders, the political will to launch the Global Fund coalesced at the United Nations General Assembly Special Session in June 2001 and was finally endorsed by the G8 at their summit in Genoa, Italy, in July 2001. While some of the initial discussions had considered making the fund a vehicle against a wider range of 'diseases of poverty', including, for example, acute respiratory infections and measles, others had suggested to focus exclusively on HIV/AIDS. A Transitional Working Group was established to determine the principles and working modalities of the new organisation, and the Global Fund came into being in January 2002 with a mandate to fight AIDS, TB and malaria (The Global Fund, 2021a).

The Global Fund epitomised what Paul Farmer and his colleagues, in their article documenting the Haiti experience, called for: the much-needed 'political will at high government levels' for 'sustained commitment to uninterrupted care' everywhere (Farmer et al., 2001).

While the world finally had a mechanism to tackle three of its worst epidemics, even in settings of great privation, it had also gotten a powerful new institution, only the second major GHI following the creation of the Global Alliance for Vaccines and Immunisation (Gavi) in 2000. While not meant to be an instrument of the North or South but one of universal partnership, the Global Fund – by virtue of its role as health financier – became a new force in its own right. The Fund could support the applicant countries' existing health priorities, but it also required them to comply to its administrative procedures and programme areas, giving it considerable influence over the scope and scale of health interventions in recipient nations.

The creation of BACKUP Health: an ingenious idea at an opportune moment

Following the establishment of the Global Fund, requests for technical support started to emerge from recipient countries that were confronted with the Fund's complex application procedures. Moreover, once grant resources had been awarded, it was up to the country to prove that they could use the money effectively and in accordance with the Global Fund's administrative requirements. For the Global Fund as the financing mechanism, it would not have been appropriate to provide the implementation support solicited by the recipient countries: It would have been like managing the programmes they funded – a clear conflict of interest.

At Germany's *Deutsche Gesellschaft für Internationale Zusammenarbeit* (GIZ)[5], Rolf Korte, the long-time head of the health department, realised that the demand for third-party technical support was immense. Also, there was a unique window of opportunity for his organisation to respond. At the time, GIZ had €30 million in unearmarked funding that 'needed spending', so Korte proposed using the money to support recipient countries in accessing and using Global Fund grants: The GIZ initiative to 'Build Alliances, Create Knowledge and Update Partners' (BACKUP) was born.

Typically, self-financed projects undertaken by GIZ without a specific commission from the German Federal Ministry for Economic Cooperation and Development (BMZ) – referred to as '*Eigenmaßnahmen*' in GIZ jargon – were equipped with around €100,000, rarely more. An endeavour worth €30 million was unheard of.

Michael Adelhardt, who worked in Korte's team, was put in charge of BACKUP Health for the first three-year project phase. He describes the original motivation and approach as follows:

> *"Korte's idea was ingenious. We had decades of experience working with country partners bilaterally, so we understood their perspectives and needs. We were also acutely aware of the dynamics in national health sector planning and decision-making, having had a seat at the table as a development partner for a long time. There are times when things barely move, but when an opportunity presents itself, for example, to provide technical support in drafting a policy or preparing a grant proposal, time is of the essence. You cannot say: 'We will make an internal request and get back to you in six months on whether or not we can hire a consultant for this.' If support is needed now, you must be able to respond immediately. And that's what we did.*
>
> [Michael Adelhardt, first head of project, BACKUP Health][6]

Initially, the idea was for BACKUP to support partner countries more broadly in 'dealing with' global health financing mechanisms. Adelhardt recalls that 'we could also have assisted on matters around Gavi or World Bank funding processes. Eventually, we decided to focus on the Global Fund because, first, it was a major player in terms of funding volume, and second, it was a brand-new mechanism with administrative and application procedures that were quite complex for recipient countries to navigate.'

[5] Until 2011, GIZ was known as GTZ (*Deutsche Gesellschaft für Technische Zusammenarbeit GmbH*). This text uses 'GIZ' across all time periods for consistency and readability.

[6] All quotes are taken from the author's interviews, unless stated otherwise.

Over the past 20 years, BACKUP Health has undergone several smaller and larger reconfigurations as it adapted to changes in context, partners' needs and priorities, but the ultimate goal has remained the same: to enable state and civil society organisations in partner countries to access and make efficient use of the resources provided by global financing mechanisms in the area of health.

For most of its history, BACKUP's focus has revolved around the Global Fund as the primary financing mechanism to fight the three diseases. To this end, BACKUP further specified three strategic aims in its most recent project phase:

1. Strengthen the governance of CCMs, their efforts to manage Global Fund applications and oversee implementation, and their coordination and alignment with other health sector entities
2. Enhance the management capacity of grant recipients to ensure that programmes are implemented in line with agreements and to maximise their impact
3. Support partners in mainstreaming health systems strengthening in the funding applications and implementation plans for the Global Fund (GIZ, 2018).

In the latest project phase that began in 2020, BACKUP Health has returned to its initial idea and broadened its scope, supporting countries to engage not only with the Global Fund, but with global health financing mechanisms in general.

Over the past 20 years and through its different project phases, BACKUP Health has financed over 800 TA measures in around 90 countries (Figure 1). It has become an integral part of the Global Fund's support ecosystem, also thanks to the significant contributions of its donor partners. Since 2013, BACKUP has been co-financed by the Swiss Agency for Development and Cooperation (SDC). In 2020, both Expertise France and the UK Foreign, Commonwealth and Development Office (FCDO) signed co-financing agreements.

BOX 2. HOW DOES BACKUP HEALTH SUPPORT ITS PARTNERS?

The desire to be agile has guided the design of BACKUP as a highly flexible instrument to respond to the needs and demands for support of Global Fund grantees.

Three BACKUP instruments were made available to partners:

1. The 'fast access mode' could disburse up to €10,000 at very short notice for ad-hoc needs such as convening important meetings or urgent, small-scale requests for subject-matter expertise.
2. A 'consultancy mode' furnishes up to €40,000 to deploy national or international technical experts in response to specific requests, in some cases as quickly as within two weeks.
3. The main 'project mode' provides proposal-based support of up to €150,000 to country-level stakeholders in applying for and implementing Global Fund grants to maximise their effectiveness in fighting the three diseases and to strengthen health systems.

In 2015, BACKUP decided to discontinue the fast access modality because it was challenging to keep the mosaic of small-scale, short-term activities in alignment with broader strategic objectives.

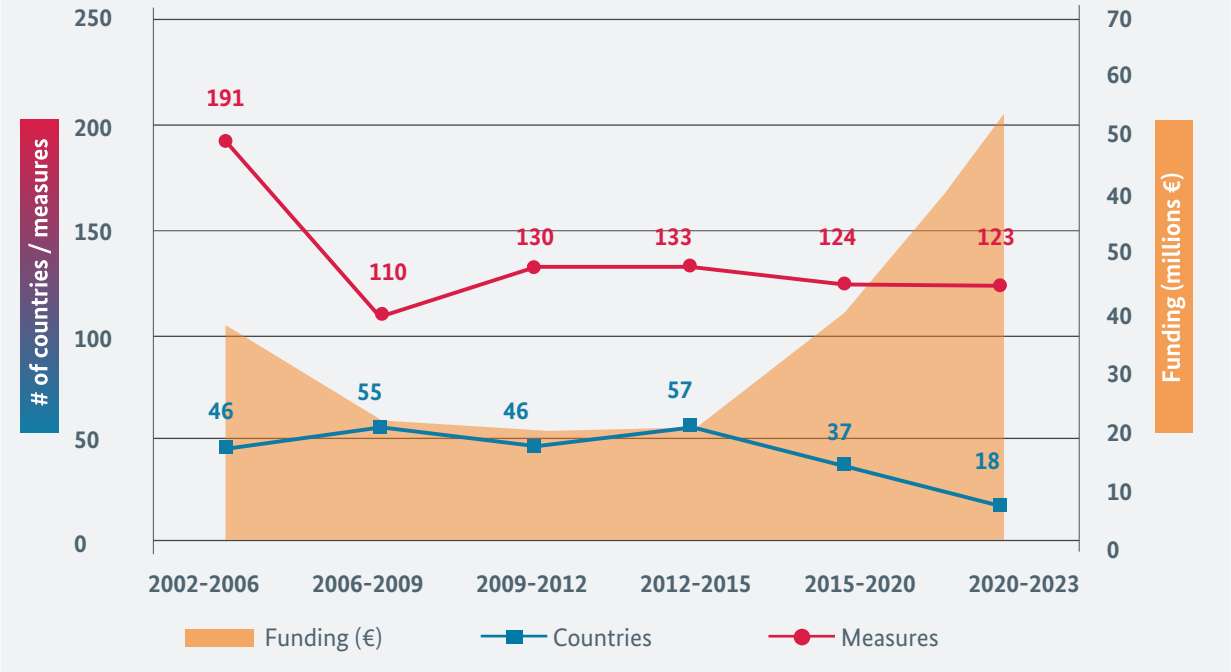
Beginning with the latest project phase that started in 2020, BACKUP introduced two strategic changes:

First, BACKUP decided to prioritise 12 countries, while an additional nine countries are also eligible to submit support requests. The move is guided by the assumption that working in fewer countries would allow BACKUP to more effectively concentrate its efforts and financing, leaving more time and resources for each individual case, which should increase the likelihood of achieving results.

Second, rather than operate with a central secretariat and no in-country presence like the Global Fund, BACKUP now has small teams of two to four advisers based in nine out of the 12 focus countries. This approach had already been piloted in four countries in the preceding project phase, partly because the evaluation of the 2012–2015 phase had found that BACKUP's capacity development efforts had been more effective where they could build on existing bilateral health sector cooperation programmes (GIZ, 2015a).

By moving closer to its partners, BACKUP hopes it can better understand their needs and design more effective TA measures.

FIGURE 1: OVERVIEW OF FUNDING VOLUME, NUMBER OF COUNTRIES SUPPORTED AND MEASURES FINANCED[7]



Twenty years of progress in the fight against AIDS, TB and malaria, and much left to do!

After 20 years of efforts financed by the Global Fund and supported by BACKUP Health, there is reason to celebrate significant progress in tackling the three diseases. Deaths linked to AIDS, TB and malaria have been cut by two thirds, from six million in 2001 to slightly over two million in 2020.

Yet, 1.1 million people still died from causes linked to TB in 2020; AIDS claimed 600,000 lives; and malaria was responsible for 400,000 deaths (The Global Fund, 2021b). Achieving the Sustainable Development Goal (SDG) target of ending the epidemics of AIDS, TB, malaria by 2030 is still a considerable distance away, not least because the global COVID-19 pandemic has severely disrupted testing and treatment for the 'old' epidemics of HIV, TB and malaria.

COVID-19 has served the world a powerful reminder that collective action is integral to tackling global health challenges.

GHIs have a decisive role to play because of their financial power and their influence over policies and programmes. What gets funded gets done. When major players like the Global Fund align with the priorities and policies of recipient countries, their support can propel a given agenda forward. Conversely, limited alignment in priorities or processes can result in significant transaction costs and inefficiencies, diverting resources and attention away from equally valid priorities.

In the following chapters, we review BACKUP's core business – helping countries access and use Global Fund resources – before exploring how the BACKUP Health initiative has manoeuvred between the Global Fund and recipient countries to add value on both sides, strengthening inclusive decision-making, accountability and alignment.

[7] Author's illustration based on GIZ data sources (GIZ, 2015b, 2020, 2021a).

The leverage effect: Helping countries unlock and use Global Fund resources

The mainstay business of BACKUP Health has been to use its relatively limited project resources to help recipient countries access and implement disproportionately larger Global Fund grants. Ida Hakizinka, the executive director of Aidspan[8], an independent observer of the Global Fund, summarises BACKUP's contribution as follows:

> *"The Global Fund's processes are complicated. BACKUP has supported countries – with advice, funding, consultants – to understand these processes and to make successful funding requests.*
>
> [Ida Hakizinka, Executive Director, Aidspan, Kenya]

> *"In essence, the motivation behind BACKUP was to be a financing instrument that, instead of showing itself off as a project, asks partners: 'What do you need to get this done?' Therefore, administrative procedures to apply for BACKUP support were kept comparatively light. A five-page proposal could be reviewed swiftly and promptly by GIZ colleagues in the partner country, based on the content of the application and the trust relationship already established with the partner.*
>
> [Cornelius Oepen, former head of project, BACKUP Health]

Alois Dörlemann, Managing Director of Health Focus *GmbH*, is one of the consultants who, with funding from BACKUP, supported numerous CCMs in their proposal-writing efforts to the Global Fund. He recalls why the initiative was a sought-after partner: 'BACKUP's responsiveness and flexibility was crucial. Everyone appreciated that there was very little bureaucracy involved in getting support from us through BACKUP. This, in turn, allowed us to be flexible, to respond to the demand of partners and to react to any sudden changes on the ground.'

Cornelius Oepen, former head of project for BACKUP, explains why and how the initiative managed to keep operations nimble:

A striking example of BACKUP's leverage: the expansion of social health insurance in Rwanda

BACKUP's engagement in Rwanda provides an early example of how the initiative's flexibility and responsiveness, combined with GIZ's experience and relationships in the country, proved to be a decisive advantage for a country wanting to advance its health agenda with a strategic, well-aligned pitch to the Global Fund.

In 2005, Andreas Kalk, then GIZ's health programme leader in Rwanda, had been participating in CCM meetings for some time. That year, with the deadline approaching to submit applications to the Global Fund's fifth round of grants, the discussion turned to community-based health insurance for the informal sector. In Rwanda, insurance schemes had enjoyed steady growth since about 1999, but it was estimated that 1.6 million extremely poor people still lacked coverage, constituting a major barrier to accessing health services (Kalk et al., 2009).

[8] On Aidspan's work with BACKUP Health, see cover picture and p. 26-27.

The CCM gave Kalk the green light to explore options for getting the Global Fund involved. That is when Kalk turned to BACKUP Health. 'I was sceptical at first,' he admits. 'But when they gave me the go-ahead just two weeks after I had asked for support, I was positive that this would work.'

Kalk used BACKUP's consultancy mode (see Box 2) to hire two experts, one international and one Rwandan. Given the Global Fund's disease-specific mandate, their job was to make the case for investing in expanded insurance coverage as a 'missing link' to combat AIDS, TB and malaria. Based on this argument, they developed a grant proposal which the CCM successfully submitted to the Fund's newly created health systems strengthening window.

With less than €100,000 in project funding from BACKUP Health, the initiative helped the Rwandan CCM secure a Global Fund grant worth $34 million over five years, one of only three health systems strengthening grants worldwide to be approved by the Fund up to that time (The Global Fund, 2005). The bulk of the grant was used to subsidise the health insurance premiums for 1.3 million people living in extreme poverty, and a smaller portion went towards working out the administrative and legal procedures to get this done. The result was a dramatic increase in access to primary health care for the most vulnerable (Kalk et al., 2009).

`This was very much a Rwandan success,' concludes Kalk. 'After the Global Fund grant had enabled us to demonstrate that it worked, the government truly owned and modified the model so the expanded insurance scheme could be continued with public funds.' Today, community-based health insurance covers 86% of the Rwandan population in the informal sector (Ministry of Health Rwanda, 2021).

As in Rwanda, BACKUP Health has supported numerous countries – and specifically their CCMs – to develop funding requests to the Global Fund. Hundreds of successful grant applications over the past 20 years range from funding for health systems strengthening in Angola, to combined HIV/TB programming in Uzbekistan, to accessing the COVID-19 response mechanism in Sierra Leone, to name but a few.

But is continued high demand for BACKUP support a sign of trouble?

On the other hand, the fact that country-level demand for BACKUP's support to develop Global Fund grant proposals is as strong today as it was 20 years ago could be interpreted as a sign of trouble. If after two decades of operation, countries are still not able to access funding without external assistance, it is necessary to take a critical look at the Global Fund itself. Might the Fund have under-invested in the requisite capacity of its recipient countries?

→ *Participants in a CCM workshop supported by BACKUP Health in Douala, Cameroon, November 2021*

Might it have maintained application procedures that are too complex? Or might it have insufficiently aligned its processes with the systems of the countries the Fund aims to support?

Current BACKUP staff suggest that the initiative's continued technical support to develop the *content* of grant applications together with partner countries is a form of capacity development well spent. In contrast, the ability to navigate the Global Fund's complicated formal *procedures* of application is considered to be 'knowledge that is not very useful for anyone to acquire for any other purpose than Global Fund grant applications.' Therefore, to avoid the ever-present risk of an application's being rejected on formal grounds, BACKUP also supports countries with external experts to prepare the application documents, at times containing dozens of annexes, thereby shouldering for its partners the 'hidden transaction cost' of dealing with the Global Fund.

While BACKUP has steadily increased its efforts to strengthen the alignment of the Global Fund with recipient countries, as will be further discussed below, the initiative has continued to respond to the immediate demands from partners, providing TA for accessing and implementing Global Fund grants. Capacity development support has been one of the most sought-after types of technical assistance since the beginning.

Comprehensive support for grant management and organisational development

Many CCMs, principal recipients and even sub-recipients of Global Fund grants relied over the years on the support of Grant Management Solutions (GMS), a major TA project financed by the United States from 2007 until 2017. The demand for comprehensive organisational development support has remained strong even after the end of GMS. Therefore, the BACKUP initiative wanted to step in with a solution for its partner countries that would build on its wealth of country-level experience as well as its strong relationship with and knowledge of the Global Fund.

Between 2017 and 2019, BACKUP invested significant resources in developing Strategic Technical Assistance for Grant Excellence (STAGE).[9] STAGE is a modular TA approach that combines specific technical assistance with in-depth, medium- to long-term organisational development for six to 18 months. It is geared towards implementers of international financing mechanisms. This means that the concept and contents are applicable beyond just the Global Fund: for example, to institutions engaging with Gavi or the Global Financing Facility (GFF).

→ *The NGO Speranta Terrei opens a renovated centre for tuberculosis patients in Bălți, Moldova, as part of a project supported by BACKUP Health, April 2015.*

The eight STAGE modules cover a diverse range of topics such as planning and programme revision, financial management and meaningful community engagement. Each module contains up to 13 thematic 'units', many of which are tagged as being 'particularly relevant for Global Fund recipients'.

While STAGE is still a relatively new addition, considering BACKUP's 20-year trajectory, the approach has already been tried in at least five countries, with encouraging results. It builds on the initiative's long-standing track record of successful capacity development, an early priority of BACKUP when the STAGE model had not yet been developed.

Large-scale capacity development to maximise the impact of Global Fund grants

Immediately following the creation of the Global Fund, the BACKUP Health initiative entered into a partnership with WHO to set up regional HIV Knowledge Hubs. The objective was to help countries be ready to fully exploit the unprecedented wave of funding that was soon to be expected from the Global Fund.

Three hubs were established at respected institutions to serve eastern Europe and central Asia: The Knowledge Hub on HIV/AIDS Surveillance at the Andrija Štampar School of Public Health in Zagreb (Croatia); the Harm Reduction Knowledge Hub for Europe and Central Asia, hosted by the Eurasian Harm Reduction Network in Vilnius (Lithuania); and the Regional Knowledge Hub for the Care and Treatment of HIV/AIDS in Eurasia, based originally in Kiev (Ukraine) and later in Saint Petersburg (Russia).

[9] The STAGE approach is described in detail in the guidelines for STAGE applicants and an FAQ document that can be accessed here: https://www.giz.de/expertise/html/60457.html

The hubs assembled regional pools of experts who trained thousands of health workers, epidemiologists, and health managers, often in multi-country sessions. The trainings covered practical aspects of surveillance, testing and counselling. The three knowledge centres also provided direct technical assistance and helped adapt generic WHO guidelines to local needs, as documented in an earlier publication in the German Health Practice Collection (Boothroyd, 2011).

The trajectory of the knowledge hub in Zagreb is particularly remarkable. Established in 2003 with support from BACKUP through WHO, the hub continued to receive financial and technical assistance until 2008 (Božičević et al., 2009). In March of the same year, the hub was recognised as a WHO Collaborating Centre for HIV surveillance and renamed the Centre for HIV Strategic Information. Collaborating centres are an important pillar of WHO's support infrastructure on the ground, designated by the Director-General to help carry out the organisation's mission by strengthening country capacity, providing training, information and research services.

The designation of the Zagreb knowledge hub as a WHO collaborating centre – renewed three times, most recently in October 2021 – is an important recognition of the expertise, professionalism and dedication of the team in Zagreb and the significant coverage of their work. With support from BACKUP Health, the hub started in 2003 as a bold endeavour to help countries in Eastern Europe make optimal use of Global Fund resources. The hub's work has evolved and continues to this day, expanding well beyond what anyone would have imagined possible at the time. By 2018, the hub – now Centre for HIV Strategic Information – had already trained over 2,300 participants from 105 countries, from Ukraine to Papua New Guinea.

Ivana Božičević, involved in the Zagreb knowledge hub from its inception and now Director of the Centre for HIV Strategic Information , summarises BACKUP's role in the hub's trajectory as follows

> *"Without the funding from BACKUP Health, there would have been no knowledge hub. And without the hub, this type of continuous availability of capacity building activities in the region would not have happened. When BACKUP's funding was about to wind down in 2008, they encouraged us to develop our own business model. The goal was to make our hub – and the collaborating centre – sustainable. That's what we did. We successfully applied for our own funding from other sources. Without BACKUP Health, this journey and the vast capacity we helped build would have never even started.*
>
> [Ivana Božičević, Director, Centre for HIV Strategic Information, Croatia]

While the knowledge hub in Zagreb provided capacity development services for governments and non-governmental stakeholders alike, over the years BACKUP has increasingly focused on strengthening civil society organisations (CSO) because of their important contributions in providing health services, and because they are meant to play an active role in the governance of Global Fund processes at country level. This is what we turn to next.

A seat at the table: Supporting civil society participation in Global Fund implementation and governance

In many countries, faith-based and other civil society organisations were pioneers in providing health services. Even where governments have expanded access to core health services, CSOs often continue to play important roles in ensuring that those services are extended to poor and otherwise marginalised and vulnerable populations.

This chapter reviews the experiences of the BACKUP Health initiative in helping civil society partners reach their full potential in contributing to the fight against the three diseases, and in strengthening their participation in Global Fund governance at country level.

Broad-based capacity development to strengthen civil society participation in grant implementation

Back in 1991, the International Council of AIDS Service Organizations (ICASO) became the first international body dedicated to promoting and supporting the participation of CSOs in the response to AIDS at the global, regional, national and local levels. They were soon joined by others and, together, these organisations played key roles in the conception and setup of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 and later the Global Fund.

In 2007, five years after the Global Fund had commenced operations, ICASO received support from the Fund, BACKUP Health and other partners to initiate a six-month consultation process. The aim was to identify the specific needs of community-based CSOs for building their capacity to participate in and benefit from Global Fund processes. This fed into a proposal for a five-year project (2008-2013) to establish and operate a Civil Society Action Team (CSAT) hosted by ICASO. BACKUP Health and UNAIDS provided most of the support to implement the proposal, along with several other development partners, as has been documented in an earlier publication of the German Health Practice Collection (Adams, 2012).

Through CSAT, BACKUP supported the creation of seven regional hubs across Africa, the Caribbean, the Middle East, Asia-Pacific, Eastern Europe and Central Asia, based on its experience with the HIV knowledge hubs in Eastern Europe, discussed above. The hubs' role was to advocate for technical assistance for capacity development and to broker and coordinate that TA. To equip the hubs and the CSOs they served with a handy resource, BACKUP Health developed the Accelerating Action Toolkit. The toolkit was a set of nine comprehensive yet practical booklets covering all key aspects concerning CSOs wanting to work in the Global Fund ecosystem: planning for technical support; strategic planning; accessing financial resources; national coordination and management; developing human resources for health; empowering civil society; improving health financing systems; procurement and supply management; and monitoring and evaluation (GTZ, 2007).

As a result of CSAT and BACKUP activities, the hub in Eastern Africa was able to develop guidelines on CSO representation in CCMs. In Tanzania, these were used by the civil society delegation to the CCM to develop a code of conduct which helped improve the coordination of CSO activities, expanded consultation and feedback among constituencies and raised civil society's ability to speak with one voice and advocate for its own agenda. The Southern Africa hub supported the Zimbabwe proposal drafting team to integrate community systems strengthening into their grant application. The CSAT hub for Asia-Pacific worked with the CCM in Indonesia to facilitate the selection of civil society Principal Recipients for the 2008/09 grant application which included a community systems strengthening component. As a result, the Network of People Living with HIV was invited to join the CCM and added to the proposal (Adams, 2012).

Pioneering innovations in engaging at-risk populations and e-learning

In addition to the seven regional CSAT hubs, each of which was run by a single host organisation, BACKUP subsequently supported the creation of the Eastern and Southern African HIV/AIDS Knowledge Hub Network in 2011-2012, which promised to deliver a transformational change in the reach and impact of member organisations' activities. The network brought together four academic and civil society entities from South Africa, Kenya, Uganda and Sudan. One of the regional network's main objectives was to provide a platform for compiling, exchanging, synthesising and disseminating relevant knowledge in each country.

BACKUP Health partnered with the International Planned Parenthood Federation (IPPF) to strengthen service providers in addressing the sexual and reproductive health needs of key populations in Cameroon, Uganda, Kenya and India, particularly for those at increased risk of HIV, as here in Uganda in 2016.

The flagship activity was developing a training module and a training of trainers on the WHO guidelines for the prevention and treatment of HIV and other sexually transmitted infections (STI) among men who have sex with men (MSM) and transgender people. The South African Enhancing Care Initiative (ECI), then based at the Nelson Mandela School of Medicine at the University of KwaZulu-Natal, took on the technical lead role, working closely with BACKUP Health and the other three network partners. ECI later became the Enhancing Care Foundation (ECF).

Sandy Pillay, who led this work as the director of ECI and is still with ECF today, remembers the joint effort with BACKUP Health and the network. It is worth quoting him at length:

"The financial and technical assistance from BACKUP planted the seeds and set the tone for much of the capacity development work we [ECF] have done for the last ten to twelve years.

BACKUP did not shy away from innovation. They helped the knowledge hub use video-conferencing technology – still a novelty in 2011, especially in our context – so we could reach a multiple of trainees in Kenya, Uganda and Sudan. Thinking of the latter: working with the LGBT [lesbian, gay, bisexual, transgender] community was really frowned upon in Sudan at the time. BACKUP supported us to send two people over there repeatedly to hold workshops for the LGBT community on STI prevention and treatment.

The teaching and remote learning skills which we acquired in our collaboration with BACKUP in many ways laid the foundation for the e-learning platform which ECF runs today.

BACKUP's engagement was a real investment in what was happening in the country and in the health sector. The money was important, but BACKUP was always involved as a technical partner to get things done, without ever micromanaging us.

[Sandy Pillay, Director, Enhancing Care Foundation, South Africa]

As a result, the Eastern and Southern African HIV/AIDS Knowledge Hub Network was able to produce a comprehensive face-to-face and e-learning training package with a peer-reviewed trainee's manual, a facilitator's manual and an e-tutor's manual based on the WHO guidelines mentioned above. A cohort of 16 master trainers from the four countries – Sudan, Kenya, Uganda and South Africa – were mentored to be competent in the delivery of this programme. Subsequently, the master trainers trained an initial group of 60 health workers in the Eastern and Southern Africa region using the comprehensive module. The e-learning module made it possible to reach health workers even in remote facilities.

The examples of the knowledge hubs – whether in Africa or Eastern Europe – underscore the potential of empowering motivated non-governmental stakeholders to play a leading role in the fight against the three diseases. When given trust and space, they can become proactive change agents who enhance service delivery and push for health equity, as the bold engagement with the LGBT community in Sudan illustrates. In this sense, BACKUP's strategic support to regional hubs and civil society actors has yielded a remarkable return on the initial investment.

CSOs are not only crucial for providing health services in many contexts, but their voice and participation are important to ensure that Global Fund processes and programmes serve those who need them most. The following sections explore the challenges involved before discussing how BACKUP has used its position between the Fund, recipient countries and civil society to help.

Country Coordinating Mechanisms: ambition and reality of the partnership principle

One of BACKUP's main concerns has been to ensure that everyone who is meant to have a seat at the decision-making table – as per the Global Fund's 'partnership principle' – is empowered to participate meaningfully in the Fund's management and coordination processes at country level.

This brings CCMs centre stage because of their central role in the Global Fund's business model at country level (Box 1). These coordination mechanisms are the platforms on which the Fund's governance processes unfold. Thus, they potentially have sizeable influence over health sector coordination and programming in recipient countries. However, the inner workings of CCMs also illustrate an inherent tension in the way the Global Fund operates.

On the one hand, CCMs are meant to embody the partnership principle. They are a manifestation of the idealistic pursuit of inclusive decision making, intended to bring together representatives of all sectors involved in the response to the three diseases: academic institutions, civil society, faith-based organisations, government, multilateral and bilateral agencies, nongovernmental organisations, people living with the diseases, the private sector and technical agencies. This ambition for participation and inclusion is fraught with numerous challenges that BACKUP Health has sought to mitigate, as will be discussed below.

On the other hand, the Global Fund's decision to maintain its separate coordinating mechanism in each country – in theory allowing everyone to participate – can be interpreted as a decision *against* using the recipient country's existing governance arrangements. This was not meant to be the case. The foundational Framework Document of the Fund envisaged CCMs to 'include broad representation from governments, nongovernmental organizations, civil society, multilateral and bilateral agencies and the private sector. (...) It should preferably be an already existing body' (The Global Fund, 2001).

At the time of the Fund's creation in 2001, the CCM idea was an innovative and perhaps overly ambitious proposal, raising hopes that grant preparation and accountability would be a truly participatory process that would engage all relevant actors at country level. By relying on existing institutions or mechanisms, it was meant to be efficient.

Over time, it became clear that the concept of CCMs was not only innovative, but also challenging to operationalise. Several reviews have shown that in many countries the mechanisms have partially or entirely duplicated other structures, with limited integration into national systems or coordination with these parallel entities. Civil society and key populations have not been adequately and consistently engaged and represented on CCMs (Brugha et al., 2004; Desai et al., 2010; Mounier-Jack et al., 2010; The Global Fund, 2016a, 2019a). Community-based CSOs in particular struggled to participate meaningfully in Global Fund processes. Research identified the key challenges as limited capacity to develop grant proposals; lack of adequately trained project managers to implement approved proposals; and skill gaps in financial management, monitoring and evaluation and reporting (Adams, 2012).

Using its role as 'honest broker' between the Global Fund and recipient countries, BACKUP Health strongly advocated for using the Fund's resources to provide systematic support to CCMs. This ultimately contributed to the creation of the Global Fund CCM Evolution initiative in 2018. This project focused on sustainably strengthening CCM performance in four areas: overseeing grants, ensuring linkages with national structures, engaging key stakeholders and improving how CCMs function. [10]

More specifically, the BACKUP initiative has sought to empower civil society organisations to engage more meaningfully in CCM processes, to ensure that community voices are heard in Global Fund governance and to empower them to contribute to the fight against the three diseases.

Enabling civil society engagement in Global Fund governance

The basic prerequisite for any organisation or individual wanting to participate substantively in the CCM is understanding how the mechanism works. BACKUP Health has registered constant and high demand from CCMs for trainings on the fundamentals. BACKUP's Huzeifa Bodal explains:

> *"The membership of the Country Coordinating Mechanism changes with every two- to three-year term. The Global Fund's procedures also change from time to time. That's why we are being asked to provide this type of 'recurring' TA: orienting CCM members on Global Fund processes, ensuring that civil society can play an impactful and meaningful role, explaining how the funding cycle works and how they can engage in the process and with each other. We have been doing this type of work for a long time.*
>
> [Huzeifa Bodal, BACKUP Health Initiative, Tanzania]

It is surprising that, after 20 years of CCMs being the linchpin of the Global Fund in recipient countries, there has not been a Global Fund-internal, durable solution to the need for orientation and guidance of CCM members, or a simplification of processes. Therefore, BACKUP has continued responding to the requests for administrative support. Box 3 provides an illustration of what this entails.

Beyond this type of foundational support to CCM operations, BACKUP Health has sought to strengthen the link between affected communities, key populations and the CCM at national level.

BOX 2. AN EXAMPLE OF BACKUP'S SUPPORT TO CCMS: GUINEA

In 2017, BACKUP Health was approached by partners in Guinea to provide process and organisational capacity development support to the CCM, with special attention to civil society members. Using its consultancy mode, BACKUP engaged two international consultants from the region and one local consultant to provide this support.

The main activities included:

- Taking stock of training needs and knowledge gaps
- Reviewing the performance of the strategic oversight function of the CCM and its CSO members
- Providing an overview and informing all stakeholders about their roles in the upcoming CCM proceedings
- Coaching the members of the permanent CCM secretariat and civil society representatives
- Guiding and preparing the civil society members on how to engage in the CCM process and fulfil their strategic oversight roles.

The consultants prepared a range of tools to assist in this process and to ensure that CCM members had technical resources to rely on even after the end of their consulting assignment. These products included:

- Documentation of the processes and responsibilities relevant to civil society in CCMs, with special emphasis on strategic oversight
- An overview of the strategic oversight process
- An improvement plan for strengthening strategic oversight of CSOs
- Training manuals adapted to the Guinean context.

(Laison, Sy & Dieng, 2017)

[10] The Global Fund launched CCM Evolution as a pilot project in 18 countries in 2018. The goal was to enhance CCM performance across four core responsibilities of health governance: (a) oversight of existing and emerging investments; (b) meaningful, inclusive and active engagement of key stakeholders; (c) positioning to work within national structures and existing emerging platforms to increase efficiency of health investments; (d) strengthening operations of CCM secretariats' core functions (including the code of conduct). In 2019, the Global Fund Board approved a US$15 million strategic initiative to support the implementation of CCM Evolution in 2020.

Strengthening community participation and feedback loops

The Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO) is a regional umbrella body with the mission to bring together CSOs and community groups to improve the programming of HIV, TB, malaria and other health services relevant to community-level concerns. The organisation has significant reach, being made up of seven national networks of AIDS and health promotion service organisations in Burundi, Ethiopia, Kenya, Rwanda, South Sudan, Tanzania and Uganda. BACKUP's partnership with EANNASO dates back to 2008 when the network became one of the first seven regional CSAT knowledge hubs.

In 2019 and 2020, emerging from the CCM Evolution pilot project, BACKUP partnered with EANNASO again to induce a transformational change in how communities and key populations participate in CCM processes in Malawi, Nigeria, Tanzania, Uganda and Zambia.

Through its work with grassroots constituencies, EANNASO had realised that CCMs – although meant to be inclusive and democratic coordination and decision-making bodies – tended to be dominated by their secretariats that were typically run by government representatives, particularly from ministries of health or the entities responsible for running the national disease-specific programmes. This was partly because of the CSOs' and key populations' lack of expertise. Their representatives often could not summon the same subject matter proficiency and thematic depth that government representatives could harness thanks to the institutional machinery behind them. The other, more mundane reason was money. The coordinating mechanism typically meets in a country's capital. Organisations and individuals who are not based there require resources for travel and accommodation – not an issue for government, private sector or donor staff whose institutions have budget lines to support their travel when needed.

Although the Global Fund tends to equip CCMs with dedicated financing for facilitating community and civil society participation, in practice this has tended to remain confined to individual representatives of 'constituencies', with limited engagement and feedback loops to the populations they are meant to represent. This is particularly problematic in contexts where highly diverse key populations across the three diseases – ranging from sex workers to people who inject drugs to people in prison – are 'represented' on the CCM by only one constituent representative for all groups. As a consequence, concept notes and grant proposals prepared by CCMs across the different countries vary widely in the extent to which

→ *Community dialogue promoting the use of mosquito nets in Malawi, 2022.*

they incorporate civil society priorities, as BACKUP-supported studies show (EANNASO, 2015; Oberth et al., 2016). Therefore, closing the feedback loop and linking the representatives back to their constituencies has been important to ensure meaningful participation.

With support from BACKUP, EANNASO worked with civil society and community groups in Malawi, Nigeria, Tanzania, Uganda and Zambia. They devised several inspiring approaches to strengthen the coordination and representation of these groups in Global Fund processes and fund requests, helping to shape health service access for their constituencies. Onesmus Mlewa Kalama, the interim executive director of EANNASO, summarises the core idea as follows:

> *"We wanted to help communities put their constituent representatives to task, engaging them before and after CCM meetings. We helped to create the feedback loop.*
>
> [Onesmus Mlewa Kalama, interim executive director, EANNASO, Tanzania]

In Malawi, EANNASO contributed to establishing a multi-stakeholder civil society and private sector consortium. They arranged for CCM meeting agendas to be shared well in advance with all consortium members and held pre- and post-CCM meetings, giving constituent members the opportunity to call on their representatives to share their concerns and priorities and to know what had been discussed and decided relevant to them. This resulted in a more active and diverse representation of civil society and key populations on the CCM and enabled them to join the grant proposal writing team to include their priorities in the funding request.

In Zambia, EANNASO helped to establish a network of health sector professionals willing to provide pro bono advice and technical assistance to civil society and community groups, in order to equip them with the requisite technical knowledge and understanding of Global Fund and national health system processes that would enable them to follow and shape CCM discussions and decisions. In Tanzania, a platform to coordinate CSO engagement in the CCM was created with BACKUP Health seed money and has since been institutionalised and fully funded directly by the Global Fund. In Nigeria, EANNASO's work to connect and strengthen CSOs to engage in the CCM resulted in an increasing number of key population organisations being admitted to the CCM as observers (EANNASO, 2020a–c). Kalama summarises:

> *"All the countries we worked with showed significant improvement in how civil society was able to engage in the CCM. The Global Fund's later performance assessments confirmed this.*
>
> [Onesmus Mlewa Kalama, interim executive director, EANNASO, Tanzania]

The approaches to community engagement and CSO participation in CCMs that were set up with support from BACKUP show great promise for making Global Fund governance more inclusive and transparent at the country level. The question for sustainability is whether and how such participatory practices can be permanently integrated into how CCMs do business.

Sustainable civil society engagement in CCM processes

For most CSOs wanting to contribute to the fight against AIDS, TB or malaria or who strive to strengthen community health systems, engaging with the Global Fund is not about connecting to headquarters in Geneva. For them, the CCM in their country is the primary reference point. The coordinating mechanism is responsible for orchestrating development of the funding request, selecting the principal recipients and overseeing grant implementation.

Therefore, the vibrancy of the Global Fund partnership at country level depends on how the CCM is managed. Filling the partnership principle with life is demanding on both sides: On the one hand, the CCM – and its secretariat – should encourage and nurture civil society participation. On the other hand, CSOs must familiarise themselves with Global Fund rules and processes. They have to possess the subject matter expertise to engage in technical discussions. And they must be able to attend meetings.

A CICDoc-facilitated training for community-based health service providers in Burkina Faso.

Any stakeholder who wants to engage meaningfully in Global Fund processes and be taken seriously in the discussion surrounding and informing CCM decisions needs to be able to maintain a consistent physical, or at least virtual, presence. Even virtual participation requires skills, technical means and connectivity, all of which cost money to sustain. This is a barrier for many – especially smaller – CSOs.

The Global Fund's CCM funding policy allows CCMs to pay for 'processes to promote and improve the quality of stakeholder participation, including travel costs for civil society participation' (The Global Fund, 2016b). However, EANNASO's Onesmus Kalama, who has worked with CCMs in many countries, indicates that 'these budget lines are not sufficiently considered in CCM work plans and funding applications. The funds are not consistently and proactively made available to facilitate civil society participation.'

In short, there is supposed to be Global Fund money to enable CSOs to engage in CCMs, but it is difficult for CSOs to access it. Kalama's assessment resonates with the 2016 audit finding that about half of civil society and key population organisations felt they were not adequately represented on the CCM and could not engage meaningfully with it (The Global Fund, 2016a).

Without financial resources to organise meetings and to facilitate travel, many CSOs – particularly grass-roots organisations – will be unable to maintain their involvement in CCM processes. The Global Fund should be held to the responsibility it has assumed to ensure reliable funding for civil society participation, through CCM budgets or otherwise.

BACKUP's experience shows that organisational capacity development can go a long way in enabling CSOs to remain independently engaged in Global Fund processes. This type of foundational TA allows the organisations to become more self-sufficient and to acquire additional technical capacity.

To mention just one of numerous examples: In 2014, BACKUP Health began working with the *Centre d'Information, de Conseils et de Documentation sur le Sida et la Tuberculose* (CICDoc) in Burkina Faso. CICDoc is a network of 22 CSOs dedicated to HIV/AIDS and TB management and health systems strengthening. BACKUP's organisational development support helped the network professionalise its operations, with training in strategic planning, personnel and financial management, advocacy, and monitoring and evaluation (M&E). In 2015, just one year after BACKUP's TA, CICDoc was selected as a Global Fund sub-recipient in the area of Resilient and Sustainable Systems for Health (RSSH) to strengthen community-based health service providers. Ever since, CICDoc has remained a sub-recipient and managed to attract a range of third-party funding, becoming more independent and vocal. Athanase Zagaré, the coordinator and head of CICDoc came to the following conclusion:

> *BACKUP Health really strengthened the civil society structure in Burkina. There is a lot of talk about it, but there aren't many organisations offering this type of foundational support. Most development partners go straight to the big principal recipient organisations who can process larger budget volumes right away. BACKUP was willing to work with a small organisation like ours, guiding us through many steps without substituting our work. They lifted us onto a different trajectory.*
>
> [Athanase Zagaré, CICDoc coordinator, Burkina Faso]

By providing capacity development support to a wide array of CSOs, from grassroots organisations to regional umbrella entities like EANNASO, and by working directly with CCMs – as discussed above – in the last 20 years BACKUP has significantly contributed to making Global Fund processes at country level more democratic and inclusive.

The examples above also illustrate what appears to be a structural mismatch between the Global Fund's all-embracing policies and procedures – calling on CCMs to be inclusive and participatory mechanisms – and the support to and capacity of country stakeholders to put these into practice. Given the Global Fund's lack of country presence, there is an implicit reliance on development partners such as BACKUP Health to help with funding or TA to operationalise some of the Fund's core values and policies. This becomes particularly necessary in cases where CCMs do not take the initiative, for example, to release funding to facilitate CSO participation or to establish processes for community engagement. Yet, this is a crucial issue because research has shown that donor-supported CSOs often cannot keep up their engagement and accountability when funding transitions are not worked out sustainably in advance, particularly in environments of limited national political commitment (McDonough & Rodríguez, 2020).

The role of civil society in Global Fund decision-making processes and in holding the Fund to account is vital for the partnership principle. It links to the bigger question of how the Global Fund has organised its accountability functions. The final chapter discusses how the Fund's accountability mechanisms have, for most of its history, appeared to be dominated by the Global North. This has hampered more holistic country ownership of Global Fund processes and systems. BACKUP Health has sought to tackle this and other issues where the Fund's alignment with national systems and priorities seems to have been limited.

Accountability and alignment: Grounding a global institution in local structures

Given the vast sums of money invested and the health outcomes at stake, accountability is instrumental for ensuring that the Global Fund's grants deliver results to the individuals and communities whom they are meant to serve.

This chapter reviews the extent to which the Global Fund's accountability mechanisms are grounded in the recipient countries' structures, and how several initiatives supported by BACKUP Health have sought to nurture ownership and foster alignment not only of the Fund's accountability functions but of its business model as a whole.

Enabling supreme audit institutions to review Global Fund grants

Auditing Global Fund grants is an important pillar of the Fund's accountability and risk management. It is also meant to enhance the transparency and efficiency of grants. To strengthen ownership and alignment, one would expect the Global Fund to have encouraged countries' national audit bodies to take the lead instead of resorting to 'the usual' multinational accounting corporations.

As early as 2009, a Global Fund review of Principal Recipient audits had shown that, while a wide variety of audit institutions was used, the involvement of the host countries' principal government audit agencies – often referred to as Supreme Audit Institutions (SAIs) which exist in most countries – was by no means a given (The Global Fund, 2009). The review further indicated that the audit arrangements were not even documented for about 50% of the grants under review. The Fund's 2014 audit guidelines placed no special emphasis on ensuring the participation of SAIs in auditing grants.

As a result, most countries in Sub-Saharan Africa have contracted private accounting firms to audit Global Fund grants rather than putting their own SAIs in charge – a missed opportunity for country ownership. Relying on private corporations also consumes scarce grant resources that are needed for the fight against AIDS, TB and malaria.

In 2018, the BACKUP initiative supported Aidspan, the Kenya-based Global Fund watchdog organisation introduced above (p.15), to undertake a study on the involvement of SAIs in overseeing Global Fund grants. SAIs are government entities whose external audit role is established by a country's constitution, endowing them with the official mandate to oversee public expenditures. Accordingly, each SAI is a central element of its country's accountability chain and should therefore play a role in the auditing of Global Fund grants. The Aidspan study found that only eight anglophone SAIs audited Global Fund grants in Sub-Saharan Africa. Furthermore, they conducted purely financial audits and did not address programmatic issues, missing an opportunity to strengthen accountability for results (Amendah & Ithibu, 2018; Muniu, 2021).

Ida Hakizinka, Aidspan's executive director, argues that engaging SAIs is important for several reasons:

> *First, ownership at country level means that, when issues arise with grant implementation or financial management, the team from the [Global Fund's] Office of the Inspector General shouldn't have to travel from Geneva to wherever the issue occurred. The country system must be involved. Second, working with Supreme Audit Institutions is more sustainable because they can draw on government funding and don't have to rely exclusively on Global Fund money.*
>
> [Ida Hakizinka, Executive Director, Aidspan, Kenya]

Informed by its in-depth assessment, Aidspan collaborated with the African Organisation of English-speaking Supreme Audit Institutions (AFROSAI-E) from 2018 to 2020 to design country-specific capacity development measures, including a toolkit on Global Fund Financial and Programmatic Audits procedures. The toolkit was then used for training workshops held in each of the participating countries, including field visits to health facilities.

As a result, the SAIs of Ghana, Kenya and Rwanda have started to conduct programmatic audits of Global Fund grants, while Sierra Leone, Burkina Faso, Malawi and Togo initiated special audits of the Fund's grants in 2020 (AFROSAI-E, 2021).

Building on their successful collaboration that started with BACKUP support, Aidspan and AFROSAI-E have entered a new partnership with the Global Fund Secretariat and the Fund's Office of the Inspector General (OIG) to engage with and train an additional five SAIs in Sub-Saharan Africa in the 2020–2022 period. The objective is to strengthen not only their existing financial audits but to empower them to perform programmatic audits of Global Fund grants to strengthen accountability for results.

It is encouraging to note that, in 2019, the Global Fund changed its audit guidelines and made SAIs the preferred auditors for grants managed by a governmental Principal Recipient (The Global Fund, 2019b).

Community-based monitoring for grassroots accountability

At the other end of the accountability chain and at the centre of the Global Fund's mission, the voices of individuals and communities are essential to determine if the Fund's programmes deliver tangible results for better health services and improved health outcomes.

→ *Community-based monitoring in action in rural Zambia, 2019.*

In 2018, the Zambian Youth Platform (ZYP), the country's largest organisation of and for young people, with over 10,000 individual members, noted breaks in the accountability chain that were not exclusive to the Global Fund. 'Our work was driven by the realisation that youth participation in planning and decision-making was often a box-ticking exercise because it was a formal requirement,' says Sibu Malambo, ZYP's national coordinator. 'For example, the Global Fund requires youth to be part of the country funding request preparation, so young people participate. But once the grant is signed and the country has money, youth issues are forgotten until the next funding request. We wanted to ensure that young people's participation is valued and taken seriously throughout the process.'

Determined to make a difference, ZYP secured a small grant from the Global Fund's Communities, Rights and Gender Department to develop a 'Youth-Led Accountability Framework' that revolved around community-based monitoring. In 2019, BACKUP Health provided the resources to pilot the approach in two districts. Young people were trained to investigate the quality of health services in their area using 'social audit' techniques, such as key informant interviews and focus group discussions. ZYP then helped them to report back to key policy forums, such as the National Technical Working Group on Adolescent Health, for example, on barriers to accessing health services for youth with disabilities. The youth platform also used this evidence in its work as a member of the CCM. ZYP's national coordinator summarises the experience:

> *The evidence we collected gave us voice and gave us weight at the table. During the funding request preparation for the current Global Fund grant, we had the facts that helped us make youth participation more effective than ever.*
>
> [Sibu Malambo, ZYP National Coordinator, Zambia]

BACKUP Health has renewed its commitment and provided funding for a second phase of the 'Youth-Community Accountability Project' to be implemented in an additional three districts. It has also provided a small grant to strengthen ZYP's financial management, financing two qualified finance staff and a M&E team member, thereby enhancing the organisational capacity of the fledgling organisation.

This type of organisational development support – for project and financial management, human resources and M&E – is typical of the TA that BACKUP has provided to its partners, as already described for CICDoc in Burkina Faso. In the case of ZYP, it allowed the youth-led organisation to demonstrate its project management ability – which resulted in successful applications to other development partners, including the United States President's Emergency Plan For AIDS Relief (PEPFAR).

Malambo describes BACKUP's approach with its partners:

> *BACKUP is one of the best partners I have seen because they treat partners as equals. They don't give orders. We have the room to discuss and adjust. When we get new ideas that can make our implementation more effective, BACKUP is flexible to accommodate this, allowing us to make course corrections along the way.*
>
> [Sibu Malambo, ZYP National Coordinator, Zambia]

The above experiences illustrate how BACKUP Health has helped not only to strengthen the organisational and technical capacity of partner organisations, but also to operationalise mechanisms for civil society participation, community engagement and accountability that are grounded in country ownership.

The persistent demand for this support gives an indication that the Global Fund has not yet managed to anchor and localise participation and accountability – core elements of its ambition – in its day-to-day operations. This raises a bigger question about the extent to which the Global Fund – like other GHIs – has been willing and able to align itself with countries' needs, priorities and systems. The following section discusses opportunities for alignment, the extent to which the Fund has used them, and the role of BACKUP Health.

Coordination, alignment and integration of GHIs with national priorities and systems

Alignment is not merely a fashionable buzzword. Its crucial importance becomes particularly evident in its absence.

The Global Fund, Gavi, and the GFF are the three largest GHIs, collectively referred to as the '3Gs'. Through the volume of their grant programmes, their mandates and decisions, they wield considerable influence over the health sectors and policies in many low- and lower middle-income countries. They shape which health areas are funded, thereby setting the countries' health agenda. The GHIs' results frameworks and the indicators to be met create powerful financial and political incentives because 'what gets measured gets done' (Khan et al., 2018).

The financial and technical assistance of the 3Gs is indispensable for many countries. But to benefit from this assistance, governments are expected to be flexible and adapt to the important differences in how these institutions operate – not the other way around. In addition to each financing institution's having its distinct mandate and policy priorities, they also require the government to adhere to their respective administrative, financial management and reporting procedures.

Having to deal with multiple GHI systems can add up to 'excessive transaction costs on recipient governments' (Spicer et al., 2020). The 3Gs themselves came to the sobering conclusion, in a stocktaking and discussion paper on sustainable health financing, that their approach to investing and aligning with national health priorities remained fragmented, not optimally coordinated, and imposed high transaction costs on the country (The Global Fund/World Bank Group, 2020). BACKUP's experience confirms this. Several of its country teams indicated that their government and CCM counterparts were at times – depending on the phase in the funding cycle – so absorbed with the Global Fund's administrative and reporting procedures that they found it difficult to make time for substantive programmatic discussions regarding health sector support needs (GIZ, 2021a).

Therefore, at the request of Germany, Ghana, Norway and later the UN Secretary-General, the 3Gs and eight other global health actors launched the Global Action Plan for Healthy Lives and Wellbeing for All (GAP) in 2019. In the GAP, the agencies vow to align their support around national plans and strategies that are country-owned and -led. However, when launching the GAP, the agencies did not put in place most of the strategic and technical underpinnings required to make coordination work in practice (York, Hofer & Watkins, 2020). In its 2021 progress report, the GAP noted that transformational change was unlikely to happen 'in the absence of a broader reflection by the Boards and donors on how the overall incentive structure for collaboration in the global health eco-system could be better aligned' (WHO, 2021b).

Huzeifa Bodal (left) of the BACKUP Health Initiative with colleagues in the GIZ office in Dodoma, Tanzania.

Beginning with the latest project phase that started in 2020, BACKUP Health has made 'improving national coordination of global health financing' one of its core objectives (GIZ, 2021b). The expanded scope – now also including Gavi and GFF – is reflected in BACKUP's now supporting Providing for Health (P4H), the Global Network for Health Financing and Social Health Protection. P4H is active in many countries with the objective of helping to put alignment and coordination into practice. Established at the initiative of Germany and France in 2007, P4H brings together 11 bilateral development partners and eight multilateral organisations, including the Global Fund, to coordinate and align health financing. GIZ has advisors working with and for the P4H network in 15 countries. The P4H–BACKUP integration promises synergies in coordinating the work of GHIs locally, working towards greater alignment of their portfolios with national priorities and their integration into national health systems rather than creating or maintaining parallel structures.

In Tanzania, BACKUP Health has already contributed to a first, promising example of how greater alignment of the Global Fund could be achieved – until it hit a sudden stumbling block.

New and old experiments with alignment, with very different results

Tanzania's Health Basket Fund (HBF), established in 1999, is a pooled funding mechanism to support the implementation of the country's Health Sector Strategic Plan. Most of the resources are used to finance primary health care (PHC) services. In a move to ensure that the money gets to where it is needed most, the HBF changed its modus operandi in 2017. Since then, instead of channelling funds through local government authorities, the resources are transferred directly into the accounts of over 5,000 PHC facilities across the country. While the HBF is designed to pool both domestic and foreign funds, contributions have only come from external sources until now, making it a 'donor pooled fund'. The main funders supporting the HBF comprise five bilateral and three multilateral partners: Canada, Denmark, Ireland, Korea and Switzerland, as well as UNFPA, UNICEF and the World Bank. Their contributions in fiscal year 2020/21 amounted to $54 million.

The HBF presents a major opportunity for development partners to align themselves to country systems, reducing inefficiencies and massively reducing the government's administrative burden by channelling funds through one common mechanism.

Huzeifa Bodal, who leads BACKUP's team in Tanzania, wanted to help the Global Fund get involved:

> *A Global Fund investment in the basket fund, a mechanism existing for over 20 years, although not without its problems, would be a big sign of alignment because then you are working through a mechanism that is set up by Tanzania, that is cross-cutting and for health system strengthening. This would be a very big deal.*
>
> [Huzeifa Bodal, BACKUP Health Initiative, Tanzania]

In 2020 and 2021, BACKUP Health commissioned a series of three consultancies to help the Global Fund explore the advantages and the technicalities of making an HBF contribution. BACKUP's analytical reports assessed the opportunities and risks of engagement from programmatic and fiduciary perspectives. Also taking into account the results of previous assessments, the expert advisers concluded that, 'overall, fiduciary risk can be regarded low in the HBF model' (Thiede, 2021). A scenario analysis was done to gauge the level of impact that Global Fund investments of different sizes would have. Bodal recalls from certain conversations that 'the Fund was considering putting $1 million into the basket to try it out in a pilot. In terms of Global Fund investment in Tanzania, this is really not very significant. In the current funding period (2020-2022), the Fund invests $675 million in the three diseases and Covid. The $1 million would be a minor, calculated risk that they would be taking.'

Given that the World Bank, a major multilateral financial institution, is already an HBF partner, the expectation was that the Global Fund would eventually be able to follow suit. After all, the Fund's Sustainability, Transition and Co-Financing Policy (2017-2022) seems to be in full harmony with such a move, with its core pillars built around supporting countries to develop robust national health financing strategies and to strengthen alignment between the Global Fund grants and country systems (The Global Fund, 2016c).

The money for the HBF could come from the Global Fund's RSSH budget. But the BACKUP consultants also cautioned that the Fund's portfolio managers would need to be willing to navigate an – initially probably complex – internal approval process because the Global Fund's policies do not explicitly foresee an investment in pooled funding mechanisms –thus there is no default model and approval process to follow. However, the Global Fund's grant budgeting guidelines would be applicable in principle, and an investment in the HBF appears to have been in line with the relevant criteria.

The BACKUP-hired experts spoke with the Fund's staff about the options for engaging in the basket fund. They noticed that 'the Global Fund experts refer less to documented evidence (which is hardly available to prove concrete experiences) than to anecdotal knowledge when it comes to assessing the strengths and weaknesses of an engagement within pooling arrangements' (Thiede, 2021). One of the few – if not the only – documented examples where the Global Fund experimented with operating through a common fund stems from Mozambique. It is noteworthy that here, in 2004, the Fund was the first to make the leap into the pool, with the World Bank later following its precedent. The Global Fund's experience with using the common fund model in Mozambique was overwhelmingly positive (Dickinson et al., 2007). The hope was that, nearly 20 years later, the Fund would dare to make a similar investment in Tanzania.

Following the BACKUP-supported consultancies and a flurry of activity in 2021, communication from the Fund ceased. After months of uncertainty, the BACKUP team in Tanzania learned in late March 2022 that the Global Fund had some reservations and appeared to let go of pursuing alignment through the basket fund. However, the nature of the issue was not entirely clear, or what specifically could have been an obstacle for the Global Fund but not a constraint for the World Bank.

BACKUP's Huzeifa Bodal is not ready to give up:

> *We have developed strong and trustful working relationships with the Government and with the development partner side. BACKUP has already put in a lot of work to pave the way. I hope we can continue supporting this process that helps to foster and develop the right framework conditions and eventually convince the Fund to decide in favour of alignment and system strengthening.*
>
> [Huzeifa Bodal, BACKUP Health Initiative, Tanzania]

However, a look at the broader trends of how the Global Fund does business somewhat dampens potential optimism for alignment and greater focus on strengthening systems rather than disease-specific investments. In 2021, the Fund's Technical Review Panel concluded that three-year funding cycles are too short to accommodate impactful RSSH interventions, which require longer-term commitments and investments; the lack of country-level presence limits the degree of influence of the Global Fund but also the support it can provide for RSSH; key in-country stakeholders whose support for RSSH would be crucial have not been sufficiently involved; and overall stakeholder engagement beyond ministries of health has been limited, as has community engagement (The Global Fund, 2021c).

> *The focus of Global Fund contributions [has been] on 'supporting' rather than 'strengthening' health systems, namely focusing on short-term support (such as salaries and equipment) rather than longer-term changes in policies and regulations, organizational structures and behaviors which could sustain changes. This limits the potential of Global Fund investments to contribute to lasting benefits beyond the period of investments and does not help to build resilience and sustainability.*
>
> [Global Fund Technical Review Panel (The Global Fund, 2021c)]

The disruptions wrought by the COVID-19 pandemic have provided a powerful reminder of the critical importance of getting alignment right, requiring programmatic integration of disease-specific interventions in national health systems as well as coordination of numerous actors relevant to health policy, financing and service provision.

For BACKUP Health and the P4H advisers who recently came under its roof, it is important to consider where their efforts to strengthen GHI coordination and alignment are likely to be impactful. Examples like Tanzania are promising signs that inroads can be made at country level. However, a sustainable solution – making alignment the norm rather than the exception – is likely to require structural changes at a central, policy level of the Global Fund. This is what we will turn to in the closing reflections below.

Where next for BACKUP Health?

Over the past 20 years, the BACKUP Health initiative has financed hundreds of measures to support partner countries to access and implement Global Fund investments, helping to make them more effective. BACKUP has also shown innovation and persistence in working towards more inclusive, participatory, accountable and aligned Global Fund processes and practices. Its trust among partners, paired with its resolve to learn and adapt, have allowed the initiative to remain relevant. In 2021, BACKUP Health created a new workstream on COVID-19 to mitigate the risks that the global pandemic poses to Global Fund programmes and national health systems. [11]

All of BACKUP's partners – grantees, funders and Global Fund Secretariat staff – have unanimously praised the initiative for its commitment and results-orientation as well as its personable and cordial approach to technical cooperation. The UK's FCDO, Expertise France and SDC have all opted to provide TA through the BACKUP model – a resounding endorsement. A recent Global Fund audit report on capacity building and technical assistance acknowledged BACKUP's modus operandi as good practice, underscoring its 'fully transparent approach with the Global Fund, from the initiation of in-country technical assistance to assessing impact and reporting results. This approach has allowed Global Fund Country Teams to assess, with countries, their needs and remaining gaps after GIZ support, reprogramming where necessary' (The Global Fund, 2020).

The preceding discussion has shown that BACKUP's efforts have gone well beyond 'only' helping partners access and implement grants, much as the discourse

→ *The BACKUP Health team in 2022 brings together staff of 22 different nationalities.*

[11] In 2021, the German government channelled an additional €10 million through BACKUP to support vaccine production in African countries. It is debatable whether this is still aligned with the core of BACKUP's mission and mandate.

around the Global Fund has changed. The Fund was conceived in response to what Kofi Annan called a 'worldwide revolt of public opinion'. The primary concern was making money available to counter blatant health inequities. Resources started flowing and impressive results were achieved. Now, with progress stalling and the world falling behind on its ambitions in global health, most visibly expressed through the SDGs, the attention has shifted. The debate is now much more about ownership, accountability, alignment and ensuring that health financing strengthens systems.

The impact of the COVID-19 pandemic has underscored the importance of coordinated action and strong health systems. The alignment of GHIs with countries' needs and priorities is more relevant than ever, as is their focus on systemic investments rather than narrow, disease-specific interventions. Yet, major trends in global health governance appear to run in the opposite direction: towards narrower mandates and problem-focused vertical initiatives, away from broader systemic goals; towards more discretionary funding and away from core or longer-term funding (Clinton & Sridhar, 2017).

The pioneering efforts of BACKUP Health and its partners have demonstrated how alignment, accountability and participation can work in the day-to-day practice of the Global Fund. However, these successful country-level examples – though numerous – are unlikely to precipitate a transformational change in the workings of the Global Fund. In the same vein, the Global Fund and other GHIs cannot change their procedures on a case-by-case or country-by-country basis: e.g., how recipients apply for funding, report on results or organise their accountability functions. A strategic shift requires farsighted Board-level decisions, allowing the Fund to harmonise its procedures with Gavi and GFF and, ideally, to fully align and integrate into existing national systems and priorities.

This may be too much to ask. So where to start, and what role can BACKUP Health play? Helping the Global Fund participate in existing pooled funding mechanisms, which have been set up in many countries, would be a consequential starting point. Likewise, fully localising accountability mechanisms should be feasible. The initiatives supported by BACKUP have demonstrated how this can be done bottom-up as well as from the highest levels, but such initiatives should not be dependent on external support. The Global Fund has the resources to make this happen from within the countries.

Ultimately, the question of alignment and ownership comes down to the parallel structure of CCMs and the administrative procedures of the funding model to which the recipient countries must adhere. Transitioning these constructs to a modus operandi that is more country-owned and -led might mean a drastic restructuring for the Global Fund. But this might be called for to preserve the chance of achieving the SDGs in 2030, and to respond to the ever louder calls for greater health equity – not only in access to treatment and care, but in governance arrangements.

The 'political origins of health inequity' have long been acknowledged, aptly summarised in the report of the *Lancet–University of Oslo Commission on Global Governance for Health* (Ottersen et al., 2014). Ensuring the health and well-being of citizens is primarily the task of governance systems and capacity within countries. However, health inequities within and between countries are influenced by agencies, processes and agendas beyond national borders (Brown et al., 2013). The norms, policies and practices that arise from transnational interaction must be understood as political determinants of health that cause and maintain health inequities. GHIs, including the Global Fund, are influential actors in global governance processes. They constitute platforms via which financial, intellectual, normative, and political resources are distributed. Their effect on health cannot be understood without taking into account the power asymmetry between them as global actors and their recipient countries (Ottersen et al., 2014; Labonté, 2010; Labonté & Ruckert, 2019).

Engaging in this power play goes beyond the ambit of BACKUP Health as a provider of technical assistance. But BACKUP has shown that it can make valuable contributions, pioneering innovative solutions and demonstrating how the Fund's ambitions – whether on participation or accountability – can be put into practice. Moreover, the initiative should continue sharing its experiences and insights, like the ones reviewed in this paper, to inform the strategic and political discourse around the Global Fund and health governance at a higher level. To this end, BACKUP has taken steps during its most recent project phase to be in a stronger position for providing inputs and support to the Global Fund – via closer contacts with the BMZ unit representing Germany on the Global Fund board, with the GIZ Sector Project Global Health serving as a practical interface between BACKUP, BMZ and the Global Fund.

BACKUP Health is likewise well positioned to leverage its local-to-global insights, particularly regarding support to health systems strengthening, to explore and operationalise synergies between the Global Fund's new strategy 2023-2028 and the German government's recent Global Health Strategy that puts strong emphasis on holistic approaches and systems strengthening (Federal Ministry of Health Germany, 2020).

There are only eight years left to achieve the SDGs. At the same time, the disenchantment with global health governance is manifest, which is understandable given the recent examples: On the one hand, the Access to COVID-19 Tools Accelerator (ACT-A) and the COVID-19 Vaccines Global Access (COVAX) initiative are seen by many as illustrations of how rich countries first serve themselves, buying up all the tests or becoming rivals in a vaccine-buying race before releasing the little that is left for poorer nations (*The Lancet*, 2021; Mueller & Robbins, 2021). On the other hand, many countries from the lower-middle- and middle-income groups do not appear to be willing to contribute. The ACT-A consolidated financing framework has calculated what would be countries' 'fair share' contributions, based on a formula linked to gross domestic product (GDP) per capita. The figures show that, while rich Germany has paid more than its 'fair share' – 132% or $2.65 billion in the 2020/2021 funding period – China has paid 3% of its fair share and countries like Poland, Turkey or Thailand (the latter's fair share is calculated at $190 million) have paid nothing.

In this ever more complex and contentious context, the reflections gathered in this study suggest that BACKUP Health would do well to prioritise where to focus its energy and resources. At the country level, the initiative has supported an extraordinarily diverse range of activities, owing to its mostly demand-driven approach: funding request preparation, civil society participation, community engagement, accountability, organisational capacity development, grant implementation management, to name just a few. Prioritisation criteria could be based on which TA investments (a) offer the greatest leverage, whether in terms of funding volume or policy change, or (b) lend themselves to replication and scale-up, offering a favourable sustainability outlook.

The dedication, commitment and successes of the past 20 years have earned BACKUP Health the trust of its funders and partners and given it considerable latitude over what it wants to take on next. What is it going to be, BACKUP?

Acknowledgements

The German Federal Ministry for Economic Cooperation and Development (BMZ) would like to thank the many individuals and organisations who have contributed to this study, particularly the key informants: current and former staff of BACKUP Health, implementing partners, funders and the staff of the Global Fund Secretariat who took time out of their busy schedules to be interviewed.

Special thanks are due to Kim Blumnau and Jean-Olivier Schmidt of the GIZ BACKUP Health team at the GIZ head office for facilitating and supporting the case study process and for their comments on draft versions. We further thank GIZ's Gesa Walcher, Christina Heese and Therese Tasche for reviewing the draft report, Mary White-Kaba for her inputs to a later version, and Katrin Hartmann for her early involvement in the study process.

This case study was researched and written by Clemens Gros. As Managing Editor of the German Health Practice Collection, Anna von Roenne guided the production of this case study from its inception to its publication. Her inputs and editorial support are gratefully acknowledged.

List of key informants who generously contributed their insights to this study:

Michael Adelhardt, GIZ
Téwendé Belemgnygre, CICDoc
Huzeifa Bodal, GIZ
Ivana Božičević, Centre for HIV Strategic Information
Michael Byrne, Global Fund
Alois Dörlemann, Health Focus
Judith Fischer, GIZ
Éric Fleutelot, Expertise France
Alexander Freese, BMZ
Ida Hakizinka, Aidspan
Onesmus Mlewa Kalama, EANNASO
Andreas Kalk, GIZ
Kristina Knispel, GIZ
Carla Koch, SDC
Rolf Korte, formerly GIZ
Sibu Malambo, ZYP
Cornelius Oepen, formerly GIZ
Igor Oliynyk, Global Fund
Klaus Peter Schnellbach, GIZ
Sandy Pillay, ECF
Sarah Respaut, Expertise France
George Shakarishvili, Global Fund
Peter Weis, formerly GIZ
Athanase Zagaré, CICDoc

References

Adams S (2012). *Reinforcing civil society contributions to health: A publication in the German Health Practice Collection*. Bonn and Eschborn.

AAFROSAI-E (2021). Partnership with Aidspan to improve accountability of Health Donor Funds through SAI audits [web site]. https://afrosai-e.org.za/2021/03/11/%ef%bb%bfpartnership-with-aidspan-to-improve-accountability-of-health-donor-funds-through-sai-audits/, accessed 21 December 2021).

Amendah DD, Ithibu A (2018). *Involvement of Supreme Audit Institutions (SAIs) in Global Fund Grants Oversight: Insights from Cameroon, Kenya, Malawi, Rwanda and Zambia. An Aidspan Report*. Nairobi.

Annan K (2000). *`We the Peoples' : the role of the United Nations, 21st century / Kofi A. Annan, Secretary-General of the United Nations*. New York (https://digitallibrary.un.org/record/413745).

Annan K (2001). *Secretary-General proposes global fund for fight against HIV/AIDS and other infectious diseases at African leaders summit. Press Release SG/SM/7779/Rev.1*. New York. (https://www.un.org/press/en/2001/SGSM7779R1.doc.htm).

Boothroyd J (2011). *Regions of Expertise. How Knowledge Hubs are boosting HIV prevention, treatment and care across whole regions*. German Health Practice Collection. Bonn and Eschborn: BMZ. (https://health.bmz.de/studies/regions-of-expertise/)

Božičević I et al. (2009). *Radiating knowledge: How a core of experts based in Croatia is boosting HIV surveillance across Eastern Europe, Central Asia and beyond*. Eschborn.

Brown C et al. (2013). *Governance for health equity: taking forward the equity values and goals of Health 2020 in the WHO European Region*. Copenhagen.

Brugha R et al. (2004). The Global Fund: managing great expectations. *The Lancet*, 364(9428):95–100. (https://linkinghub.elsevier.com/retrieve/pii/S0140673604165951).

Clinton C, Sridhar D (2017). Who pays for cooperation in global health? A comparative analysis of WHO, the World Bank, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance. *The Lancet*, 390(10091):324–332. (https://linkinghub.elsevier.com/retrieve/pii/S0140673616324023).

Desai M et al. (2010). Critical interactions between Global Fund-supported programmes and health systems: a case study in Indonesia. *Health Policy and Planning*, 25(Suppl. 1):i43–i47. (https://academic.oup.com/heapol/article-lookup/doi/10.1093/heapol/czq057).

Dickinson C et al. (2007). *The Global Fund operating in a SWAp through a common fund: issues and lessons from Mozambique*. London (https://www.mottmac.com/download/file/6123?cultureId=127).

Dye C et al. (1999). Global Burden of Tuberculosis. *JAMA*, 282(7):677. (http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.282.7.677).

EANNASO (2015). Assessing the inclusion of civil society priorities in Global Fund concept notes: A Desk Review of Concept Notes Submitted by Kenya, Malawi, Swaziland, Tanzania, Uganda, Zambia, Zanzibar and Zimbabwe. Arusha (https://icaso.org/wp-content/uploads/2015/09/EANNASO2015AssessingInclusion..pdf).

EANNASO (2020a). *CCM-Plus engagement project: A report on CCM and Civil Society/Community Groups Engagement Score Card and Lessons Learnt*. Arusha.

EANNASO (2020b). *Community based monitoring: A Technical Guide for HIV, Tuberculosis and Malaria Programming*. Arusha.

EANNASO (2020c). *Guidelines for effective civil society and community representation in national decision-making processes and platforms*. Arusha.

Faculty of Harvard University (2001). Consensus Statement on Antiretroviral Treatment for AIDS in Poor Countries. *Topics in HIV Medicine,* 9(2). (https://120qrk11gh163n79gg1cg656-wpengine.netdna-ssl.com/wp-content/uploads/2001/06/9-2-14.pdf, accessed 28 March 2022).

Farmer P et al. (2001). Community-based approaches to HIV treatment in resource-poor settings. *The Lancet*, 358(9279):404–409. (https://linkinghub.elsevier.com/retrieve/pii/S0140673601055507).

Feachem R (2001). HAART - the need for strategically focused investments. *Bulletin of the World Health Organization*, 79(12):1152–1153.

Federal Ministry of Health Germany (2020). *Global Health Strategy of the German Federal Government*. Berlin (https://www.bundesgesundheitsministerium.de/service/publikationen/details/global-health-strategy-of-the-german-federal-government.html).

Freedberg KA et al. (2001). The Cost Effectiveness of Combination Antiretroviral Therapy for HIV Disease. *New England Journal of Medicine*, 344(11):824–831. (http://www.nejm.org/doi/abs/10.1056/NEJM200103153441108).

G8 (2000). *G8 Communiqué Okinawa 2000*. Okinawa (https://www.mofa.go.jp/policy/economy/summit/2000/documents/communique.html).

Gilks C, AbouZahr C, Türmen T (2001). HAART in Haiti - evidence needed. *Bulletin of the World Health Organization*, 79(12):1154–1155.

GIZ (2015a). *Projektevaluierung Kurzbericht: Deutsche BACKUP Initiative (unpublished).* Eschborn.

GIZ (2015b). *Projektevaluierungsbericht: Deutsche BACKUP Initiative, 10/2012 bis 09/2015 (unpublished).* Eschborn.

GIZ (2018). *BACKUP Health: Support for partners in their work with the Global Fund (fact sheet).* Eschborn.

GIZ (2020). *Central project evaluation – executive summary: GIZ BACKUP Health, October 2015 to September 2020 (unpublished).* Eschborn.

GIZ (2021a). *Progress report on a sector project: BACKUP Health, 04/2020 to 08/2021*. Eschborn.

GIZ (2021b). *BACKUP Health: Advising partners in the implementation of global health financing (fact sheet).* Eschborn.

GTZ (2007). *Accelerating action: A technical support guide to develop capacity and to benefit from global health financing.* Eschborn (http://dx.doi.org/10.4126/38m-003596528).

Hadden J, Tarrow S (2007). *The Global Justice Movement in the United States since Seattle*. In: della Porta D et al., eds. Global Justice Movement: Cross-national and Transnational Perspectives. Routledge,2007:210–231.

Kalk A et al. (2009). Health systems strengthening through insurance subsidies: the GFATM experience in Rwanda. *Tropical Medicine & International Health*. (https://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.2009.02424.x).

Kapp C (2002). Global fund on AIDS, tuberculosis, and malaria holds first board meeting. *The Lancet,* 359(9304):414. (https://doi.org/10.1016/S0140-6736(02)07634-1).

Khan MS et al. (2018). How do external donors influence national health policy processes? Experiences of domestic policy actors in Cambodia and Pakistan. *Health Policy and Planning,* 33(2):215–223. (https://academic.oup.com/heapol/article/33/2/215/4718134).

Kidder T (2003). *Mountains Beyond Mountains.* New York, Random House.

Labonté R (2010). Health Systems Governance for Health Equity: Critical Reflections. (http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0124-00642010000700005&lng=en&nrm=iso&tlng=en).

Labonté R, Ruckert A (2019). *Health Equity in a Globalizing Era.* Oxford University Press (https://oxford.universitypressscholarship.com/view/10.1093/oso/9780198835356.001.0001/oso-9780198835356).

Laison IS, Sy OA, Dieng A (2017). *Appui au renforcement de capacités de l'ICN-Guinée: Rapport de la mission d'appui technique et de conseil, pour le compte de la GIZ/BACKUP Santé. Internal progress report.*

Mayaud P, Hawkes S, Mabey D (1998). Advances in control of sexually transmitted diseases in developing countries. *The Lancet*, 351:S29–S32. (https://linkinghub.elsevier.com/retrieve/pii/S0140673698900095).

McDonough A, Rodríguez DC (2020). How donors support civil society as government accountability advocates: a review of strategies and implications for transition of donor funding in global health. *Globalization and Health,* 16(1):110. (https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00628-6).

Ministry of Health Rwanda (2021). *Health Sector Annual Performance Report 2020-2021.* Kigali, Republic of Rwanda. (https://www.moh.gov.rw/fileadmin/user_upload/Moh/Publications/Reports/Health_Sector_Annual_Performance_Report_2020-2021.pdf).

Mounier-Jack S et al. (2010). Critical interactions between Global Fund-supported programmes and health systems: a case study in Lao People's Democratic Republic. *Health Policy and Planning*, 25(Suppl. 1):i37–i42. (https://academic.oup.com/heapol/article-lookup/doi/10.1093/heapol/czq056).

Mueller B, Robbins R (2021). Where a Vast Global Vaccination Program Went Wrong. *The New York Times* (New York), 2 August 2021. (https://www.nytimes.com/2021/08/02/world/europe/covax-covid-vaccine-problems-africa.html).

Muniu S (2021). Aidspan and partners enhance the capacity of three Supreme Audit Institutions to audit Global Fund grants [web site]. (https://www.aidspan.org/en/c/article/5675, accessed 21 December 2021). (https://www.aidspan.org/en/c/article/5675, accessed 21 December 2021).

Oberth G et al. (2016). *Donor Agendas, Community Priorities and the Democracy of International HIV/AIDS Funding.* Cape Town (CSSR Working Paper).

Ottersen OP et al. (2014). The political origins of health inequity: prospects for change. *The Lancet*, 383(9917):630–667. (https://linkinghub.elsevier.com/retrieve/pii/S0140673613624071).

della Porta D (2005). *The Social Bases of the Global Justice Movement.* (https://www.files.ethz.ch/isn/91585/21.pdf).

Powers T (2020). *Sustaining Life.* University of Pennsylvania Press. (https://www.degruyter.com/document/doi/10.9783/9780812296853/html).

Reich MR, Bery P (2005). Expanding global access to ARVs: the challenges of prices and patents. In: Mayer KH, Pizer HF, eds. *The AIDS pandemic: Impact on science and society.* New York, Academic Press,2005:324–350. (https://cdn1.sph.harvard.edu/wp-content/uploads/sites/480/2013/01/Reich_Bery_AIDS_drugs.pdf).

Spicer N et al. (2020). 'It's far too complicated': why fragmentation persists in global health. *Globalization and Health*, 16(1):60. (https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00592-1).

The Global Fund/World Bank Group (2020). *Accelerator Discussion Paper 1: Sustainable Financing. Global Action Plan for Healthy Lives and Well-being for All. With contributions from Gavi, Global Financing Facility (GFF), WHO.* (https://www.who.int/docs/default-source/global-action-plan/accelerator-paper-1.pdf?sfvrsn=1e84ed11_2).

The Global Fund (2001). *The Framework Document*. Geneva.

The Global Fund (2005). Rwanda Signs Sixth Grant With The Global Fund [web site]. (https://www.theglobalfund.org/en/news/2005-11-28-rwanda-signs-sixth-grant-with-the-global-fund/, accessed 30 March 2022).

The Global Fund (2009). *Review of Principal Recipient audit arrangements*. Geneva.

The Global Fund (2013). *The Global Fund's New Funding Model: Global Fund Fourth Replenishment Update on Results and Impact*. Geneva (https://www.theglobalfund.org/media/1467/replenishment_2013newfundingmodel_report_en.pdf).

The Global Fund (2016a). *Audit Report: The Global Fund Country Coordinating Mechanism*. Geneva.

The Global Fund (2016b). *Country Coordinating Mechanism Funding Policy*. Geneva.

The Global Fund (2016c). *The Global Fund Sustainability, Transition and Co-financing Policy*. Geneva. (https://www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf).

The Global Fund (2019a). *Evolving CCMs to Deliver on the Global Fund Strategy: 42nd Board Meeting*, Board Information. Geneva.

The Global Fund (2019b). Guidelines for Annual Audit of Global Fund Grants. Geneva.

The Global Fund (2020). *Audit of Global Fund Capacity Building and Technical Assistance*. Geneva. (https://www.theglobalfund.org/media/9504/oig_gf-oig-20-009_report_en.pdf).

The Global Fund (2021a). Global Fund Overview [web site].

The Global Fund (2021b). *Results Report 2021*. Geneva (https://www.theglobalfund.org/en/results/).
.
The Global Fund (2021c). *Advisory Paper on Resilient and Sustainable Systems for Health, Technical Review Panel*. Geneva.

The Lancet (2006). Richard Feachem's legacy to the Global Fund. *The Lancet*, 367(9515):960. (https://linkinghub.elsevier.com/retrieve/pii/S0140673606684006).

The Lancet (2021). The ACT Accelerator: heading in the right direction? *The Lancet*, 397(10283):1419. (https://linkinghub.elsevier.com/retrieve/pii/S0140673621008357).

Thiede M (2021). *Business process analysis - in support of the successful further development of the Health Basket Fund in the collaboration of the government of Tanzania and development partners. Unpublished*. Berlin.

U.S. Department of Health and Human Services (2022). History : A Timeline of HIV and AIDS [web site]. (https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline, accessed 28 March 2022).

UNAIDS/WHO (1998). *AIDS epidemic update: December 1998*. Geneva.

UNAIDS/WHO (2000). *AIDS epidemic update: December 2000*. Geneva.

WHO (2020). World malaria report 2020: 20 years of global progress and challenges. Geneva.

WHO (2021a). *State of inequality: HIV, tuberculosis and malaria*. Geneva. (https://www.who.int/data/health-equity/report_2021_hiv_tb_malaria).

WHO (2021b). *Stronger collaboration for an equitable and resilient recovery towards the health-related Sustainable Development Goals: 2021 progress report on the Global Action Plan for Healthy Lives and Well-being for All*. Geneva.

York N, Hofer S, Watkins J (2020). *Joint Evaluability Assessment of the Global Action Plan for Healthy Lives and Well-being for All*. Sheffield. (https://cdn.who.int/media/docs/default-source/global-action-plan/joint-evaluability-assessment-of-the-sdg3-global-action-plan---report.pdf?sfvrsn=27b74ac4_4).

PUBLISHED BY THE
Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH

Registered offices
Bonn and Eschborn, Germany

Sector Programme Global Health
Friedrich-Ebert-Allee 36
53113 Bonn, Germany
Phone +49 228 44 60 – 0

German Health Practice Collection
ghpc@giz.de
www.health.bmz.de/studies/

AS AT
September 2022

DESIGN
Karsten van der Oord

PHOTO CREDITS
Cover © Aidspan, p. 7 © GIZ/BACKUP Health, p.10 © GIZ/Dirk Ostermeier, p.16 GIZ/BACKUP Health, p.17 © Speranta Terrei, p. 20 © IPPF, p.23 © World Vision, p.24 © GIZ/BACKUP Health, p.27 © GIZ/Huzeifa Bodal, p.29 © GIZ/BACKUP Health, p.31 © GIZ/BACKUP Health

TEXT
Clemens Gros

ON BEHALF OF
German Federal Ministry for Economic Cooperation and Development (BMZ)