



CHATHAM HOUSE

Chatham House, 10 St James's Square, London SW1Y 4LE

T: +44 (0)20 7957 5700 E: contact@chathamhouse.org

F: +44 (0)20 7957 5710 www.chathamhouse.org

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CENTRE ON GLOBAL HEALTH SECURITY WORKING GROUP PAPERS

The Grand Decade for Global Health: 1998–2008

Jon Lidén

April 2013

WORKING GROUP ON GOVERNANCE | PAPER 2





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Chatham House
10 St James's Square
London SW1Y 4LE
T: +44 (0) 20 7957 5700
F: + 44 (0) 20 7957 5710
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Charity Registration No. 208223

ISBN 978 1 86203 282 8

Cover image © WHO/Pierre Albouy

Printed and bound in Great Britain by Latimer Trend and Co Ltd



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ABOUT THE AUTHOR

Jon Lidén is a consulting research fellow at Chatham House. He was the communications director for the Global Fund to Fight AIDS, Tuberculosis and Malaria from 2003 to 2012 and a senior policy adviser to the director-general of the World Health Organization from 1998 to 2003. He worked as a journalist in Africa and Asia from 1986 to 1998.

PREFACE

This paper does not purport to be a comprehensive or even partial history of the evolution in global health between 1998 and 2008. It is rather an attempt to sketch a picture of the main features of the innovations in global health that took place during this period. In doing so, it exposes, I hope, some common threads in the thinking that drove the changes that took place, and provides a rough outline of the underlying forces, the external influences and individual actions that helped shape the outcomes.

Its purpose is simply to inform the thinking about future possibilities in global health financing, management and governance by providing a big-picture overview of the recent past.

I am grateful to the following people who gave of their time and shared their reflections: Christoph Benn, Gro Harlem Brundtland, Richard Burzynski, Andrew Cassels, Sir Richard Feachem, Tore Godal, Michel Kazatchkine, Julian Lob-Levyt, Jacques-François Martin, Sigrun Møgedal, David Nabarro, Robert Ridley, Bernhard Schwartlander and Sir Richard Sykes. Andrew Cassels and Sigrun Møgedal were also kind enough to share with me their archived documentation.

I am also grateful to David Heymann and Charles Clift for the opportunity to write this. The views expressed are of course entirely my own and not those of Chatham House.

J.L.

ABOUT THE SERIES

An earlier version of this paper was written as a background paper prepared for the first meeting of the Chatham House Working Group on 'Governance in Global Health' in October 2012. It is part of a Chatham House publication series related to the Centre on Global Health Security Working Groups, which are aimed at improving global health security. The first two Working Groups address issues of governance and financing.

EXECUTIVE SUMMARY

Throughout history, international cooperation to improve global health has generally advanced through brief periods of extraordinary innovation and excitement, followed by longer stretches of consolidation. The creation of the World Health Organization (WHO) after the Second World War was one such period; the uneven effort to eliminate malaria and the successful campaign to eradicate smallpox were examples of others over the subsequent decades.

A brief period spanning a few years on either side of the turn of the 20th century formed the latest and perhaps the most dramatic of these periods of innovation – in terms both of the breadth and scope of the change in the way the world does business to improve health, and of the progress that has been achieved in strengthening health outcomes on a global scale.

It was as if each one of the dozen or so new initiatives created during these years knocked down additional walls and allowed subsequent initiatives after an ever-increasing space in which to shape themselves. This boldness of ideas kept creating new initiatives until the financial crisis of 2008 firmly ended the appetite for new, resource-demanding experiments.

The innovations that took place in the period between 1998 and 2008 can be summarized as having six different, but closely linked elements:

- A shift from a system-focused approach toward health challenges to a problem-focused one;
- The establishment of multi-sector (public-private) operative partnerships;
- The inclusion of the private sector, private philanthropy and civil society as full, participating partners in strategy, coordination and governance of many areas of global health;
- A newfound focus on outcomes/results and an attempt to introduce objective evidence-based decision-making for the allocation of multilateral resources;
- The emergence of demand-driven funding; and
- A large-scale exploitation of market dynamics to stimulate investment in research and production capacity for medical products and to drive down prices.

The process began as multilateral organizations and national governments entered into open-ended discussions with civil society, private-sector philanthropic foundations and academics about finding solutions to some of the largest health problems facing the global community at that time without prescribing any preconceived answers.

Three separate and initially unrelated groups of actors together laid the groundwork for this extraordinary set of changes that took place during these years. Each of these groups tried to shape the outcomes to fit as closely as possible to their own agenda, and many were rather bemused by the outcomes, which in some cases were the rather hybrid result of many compromises.

The first of these three groups included the economists and global health experts that gathered around the new director-general of WHO, Gro Harlem Brundtland, and followed her call to 'place health at the centre of sustainable development'.

The second group comprised the political leaders meeting annually as the Group of 8 (G8). By 1999, the G8 had run into considerable trouble with what had amounted to a mainstay of the group's economic and foreign policies: the promotion of commercial and financial globalization as the key to creating global growth and prosperity. Searching for ways to help their leaders 'level the playing field of globalization', the political advisers to several of the G8 leaders found the views of the economists and health and development experts surrounding Brundtland particularly interesting.

The third group was essential in driving forward the process of innovation and increased investments in health. Without the moral voice and the protests of the AIDS activist movement,

it is unlikely that the decisions made by the political leaders and multilateral agencies would have been as bold as they were and the financial commitments as large as they became.

One additional factor is important if one is to understand the willingness to embark on new experiments during this period: the turn of the century. This is intangible and impossible to quantify, but many of the strategy documents and the rhetoric in the discussions about new initiatives at the time were infused by a sense that one was at the dawn of a new age.

The first phase of this process of innovation came as a small number of individuals, inspired by political and economic trends outside the health sector, came together to find solutions to the specific problem of how new investments could be secured for the development of new malaria drugs. The public-private partnership of the Medicines for Malaria Venture (MMV) became an important inspiration for further efforts to meet similar challenges, most importantly how to get existing but underused vaccines to children in the developing world. A wide collaboration of foundations, multilateral agencies and the private sector, energized by the unprecedented infusion of a \$750-million grant from the Bill & Melinda Gates Foundation, led to the creation of the Global Alliance for Vaccines and Immunization (GAVI), a more ambitious and larger public-private partnership than MMV.

By 2000, a combination of international realization of the possibility of investing in health as a way to reduce poverty, the mobilization around the Millennium Development Goals (MDGs), the fear of a rapidly spreading AIDS pandemic and the outrage over the lack of access to life-saving AIDS treatment, drove increasing efforts to channel large, additional investments into fighting the 'diseases of poverty'. In record time, these efforts had united around the creation of a new 'global health fund', and during the course of 2001, the Global Fund to Fight AIDS, Tuberculosis and Malaria was conceived, designed and provided with initial financing.

The period after the creation of the Global Fund was dominated by innovation aimed at financing the new, resource-demanding initiatives, and several new sources of funding for development were developed. UNITAID, funded partly through new taxes on air travel introduced by France and nearly two dozen other countries, has focused on influencing market conditions through purchase guarantees and price negotiations. The Affordable Medicines Facility for malaria has been integrated into the Global Fund structure, and is providing a subsidy for artemisinin-based combination therapies for malaria to enable them to drive out ineffective and substandard drugs of the market, initially in nine pilot countries.

The Global Fund has been a source of controversy throughout its history. The radical nature of its founding principles and the challenge these provided to existing practices in delivering development assistance and managing and planning health policies at a national level have driven a continuous debate about whether the Global Fund is too different to fit in with other sources of development funding. The considerable extra burden it placed on UN partners (for technical assistance) and donors (for funding and guidance) has also been a source of contention. However, the Global Fund has achieved results beyond what was anticipated and it continues to stir a passionate defence by its supporters.

The other initiatives that emerged between 1998 and 2008 quickly settled into the existing architecture. Roll Back Malaria (RBM), Stop-TB, MMV, GAVI, the Global Alliance for Improved Nutrition (GAIN), UNITAID, the Global TB Drug Facility, and several smaller partnerships have been accepted alongside the UN system, each as a useful 'house in the village'. The inclusion of the private sector, civil society and foundations in decision-making and oversight has been less problematic than many expected and has by now become routine.

The dozen or so institutions and initiatives that resulted from the wave of innovation around the turn of the century represented a large and important step forward in our collective effort to better and more efficiently solve the large health problems of our world. As today's leaders in global health face the challenges of a 'post-MDG world', they are better equipped to make progress than they were in the past.

1. INTRODUCTION

Throughout history, international cooperation to improve global health has generally advanced through brief periods of extraordinary innovation and excitement, followed by longer stretches of consolidation.¹ These stretches have, in turn, gradually slowed, leading to disillusionment and in many cases stagnation and regression before a new wave of innovation has revitalized the field.

A brief period spanning a few years on either side of the turn of the century formed the latest and perhaps the most dramatic of these periods of innovation – both in terms of the breadth and scope of the change in the way the world does business to improve health, and in the progress that has been achieved in strengthening health outcomes on a global scale.²

At times, it had been sudden advances in technology that triggered bursts of innovation and progress in global health efforts, such as the arrival of antibiotics and DDT. This time, however, the driver for change was not so much the emergence of new technologies as the moral and economic imperative to provide wider access to existing ones. In this sense, it resembled certain earlier periods of change that were driven primarily by shifting global political trends, such as the creation of the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) in the late 1940s, and the United Nations Development Programme (UNDP) and the regional development banks in the 1960s.

Sudden advances in technology had triggered bursts of innovation and progress in global health. This time the driver was the moral and economic imperative for wider access

The innovation that took place in the latest period of change was in the way the global health architecture was organized, governed and managed, i.e. the multilateral organizations, the financing institutions, the issue-specific partnerships and the task-specific initiatives that the world uses as its tools to fight pandemics and help countries build the foundations for basic, sustainable health services. (For simplicity's sake, this paper will refer to all the new creations during this period as simply 'initiatives' when referring to them collectively.)

What is striking is how progress was driven by a tearing down of structural walls, the breaking down of mental silos, a borrowing of ideas and practices from surprising quarters and the bridging of decade-long conflict lines.

Thus on different occasions during this period, civil society activists, management consultants and pharmaceutical company executives sat around the same table as UN officials, academics, health experts and government representatives. Out of this extraordinary jamboree came solutions to decade-old problems of how to finance and deliver health commodities and services. They drew on ideas from investment banking, private-sector management approaches, community-based mobilization, software development and scientific practices in project selection and review, to mention a few.

This new exchange of ideas did not happen all at once, although once started, it progressed with a surprising speed. The bulk of this innovation took place from the creation of the Roll

1 Manning, R. (2011), 'Origins and Diversity of Health Partnerships', in Low-Ber, D. (ed.), *Innovative Health Partnerships – The Diplomacy of Diversity*, World Scientific, December.

2 See for example Cohen, J. (2006), 'The New World of Global Health', *Science*, Vol. 31, No. 5758; and Low-Ber, D. (2012), 'Introduction and ... the Health Diplomacy of Diversity', in Low-Ber, D. (ed.), *Innovative Health Partnership: The Diplomacy of Diversity, Global Health Diplomacy Vol. 1* (Singapore: World Scientific Publishing Co. Pte Ltd).

Back Malaria Partnership in 1998 to the on-the-job design of the Global Fund to Fight AIDS, Tuberculosis and Malaria throughout 2002. It was as if each new initiative during these heady years knocked down additional walls and allowed subsequent initiatives after an ever-increasing space in which to shape themselves.

This boldness of ideas kept creating new initiatives until the financial crisis of 2008 firmly ended the appetite for new, resource-demanding experiments.

Given the interconnectedness of each of the new initiatives created over this ten-year period and the evolutionary thread that runs from the first through to the last of them, it is important to understand the sequence of events: how did these initiatives evolve? Why did they develop the way they did? What were the requisite factors for this evolution to take place? Since few – if any – of the actors and ideas were entirely new, why did this leap happen just when it did? Can it be recreated today?

This paper provides a chronological description of the creation and progression of the most impactful of these initiatives. The purpose here is not to provide an exhaustive history of the period, and any reader familiar with the material will notice that many events and institutions have been left out when these have not directly influenced the progress of the larger process of innovation. The aim is instead to expose some lines that run through the most crucial initiatives in order to better understand how each built on the other and how events and factors external to global health predisposed and often drove the course of events.

Many of the challenges that health ministers, health experts and aid agency and multilateral institution officials face today are products of the last decade's changes in the global health architecture: the dramatic but uneven progress seen in controlling major pandemics and reducing mortality has significantly increased ambition and expectations; the plethora of new initiatives has complicated coordination and decision-making; and unintended side effects or weaknesses of the new initiatives have led to new problems that need solutions.

The world is changing fast and it is already a very different place from what it was 15 years ago: brisk economic growth has been replaced with what seems to be a long-running global economic recession; nevertheless, the number of countries falling within the World Bank's category of 'poor' will have been reduced from 73 in 2000 to 20 by 2020.³

But while countries are getting richer, people, by and large, are not. Owing to an appalling and stubbornly growing imbalance in the distribution of national wealth in most countries, the proportion of poor people in the world will not have changed very much over the same period.⁴ Meanwhile, urbanization will drive most health challenges from the countryside into the cities,⁵ changing the nature of pandemics and demanding different ways of addressing them.

The world is also facing the challenge of dealing with the 'post-Millennium Development Goals' world. Over the past fifteen years, the MDGs have provided a focus, a direction and a unity of purpose to global poverty-reduction efforts. Even for the goals that have been met, a continued engagement and momentum need to be created.

All of these dynamics will demand new ways of organizing and prioritizing global health efforts and perhaps demand a wave of innovation similar to that around the turn of the century. Understanding what drove this last wave will assist in the task of identifying opportunities and seeking new solutions in today's world.

3 See Schwartlander, B., 'What will it take to turn the tide?' Speech at the 19th International AIDS Conference, Washington, DC, 21 July 2012.

4 Ibid.

5 Ibid.

2. THE CONTEXT

The innovations that took place in the period between 1998 and 2008 can be summarized into six different, but closely linked elements:

- A shift from a system-focused approach toward health challenges to a problem-focused one;
- The establishment of multi-sector (public-private), operative partnerships;
- The inclusion of the private sector, private philanthropy and civil society as full, participating partners in strategy, coordination and governance of many areas of global health;
- A newfound focus on outcomes/results and an attempt to introduce objective evidence-based decision-making for the allocation of multilateral resources;
- The emergence of demand-driven funding; and
- A large-scale exploitation of market dynamics to stimulate investment in research and production capacity and to drive down prices.

None of these elements was new *per se*. The debate about investing in health systems and primary health care versus predominantly focusing on efforts to control, eliminate or eradicate single diseases has been going on for decades, with the pendulum of priority swinging back and forth with some regularity. It was not unheard of to include the private sector in disease programmes prior to 2000; the Merck ivermectin donation programme against onchocerciasis, where the Carter Foundation plays a significant role as well, may be the best known of such collaborations from the past decades but it is far from the only one. Results-based financing also has been an integral feature of the polio-eradication programme (and many others) since its beginning. And so on.

What was new, however, was that multilateral organizations and national governments entered into open-ended discussions with civil society, private-sector philanthropic foundations and academics about finding solutions to some of the largest health problems facing the global community at that time without prescribing any preconceived answers.

This process was not planned or even deliberate: had someone in 1998 told World Health Organization Director-General Gro Harlem Brundtland or UK International Development Secretary Clare Short that within four years a new institution that would oversee billions of dollars in funds for AIDS, tuberculosis and malaria would be created, and that it would have a board where an HIV-positive former sex worker from India would have the same voting power as the representatives from the United States, the United Kingdom or the European Union, but that there would be no voting power for any UN agency, they would doubtless have been more than a little incredulous – and most likely concerned.

What was new was that multilateral organizations and governments entered into open-ended discussions with civil society, private-sector philanthropic foundations and academics

Any predictions that then President Bill Clinton would, during his retirement, play a role in negotiations with Indian generic pharmaceutical companies to bring down prices so that the drug costs of first-line AIDS treatment would go from \$15–20,000 to less than \$100 per patient per year – or that software magnate Bill Gates and his wife would have a driving role in almost every new international effort to control infectious diseases – would likewise have been dismissed as fanciful by most people involved in global health in 1998.

However, it is possible to identify three separate and initially unrelated groups of actors, each with its own agenda, who were brought together by circumstance between 1998 and 2001 and laid the groundwork for this extraordinary set of changes. Each of these groups tried to shape the outcomes to fit its own agenda as closely as possible, and many were rather bemused by the outcomes that in some cases – the Global Fund, in particular – were the rather hybrid result of many compromises.

The first of these was a group (known as the 'Brundtland Group') that saw health as an economic and development issue and argued for investing in it as key to fighting poverty and a central element of sustainable development. Gro Harlem Brundtland, the former prime minister of Norway, built her agenda as a director-general of the World Health Organization (WHO) from 1998 to 2003 to a large extent around arguments shaped by this group.⁶

Economists moved health in developing countries from what had been viewed by Western nations as a humanitarian issue to an economic one

Brundtland used as a starting point the economic arguments put forward in the World Bank's 1993 *World Development Report*.⁷ By devising the concept of 'disability-adjusted life years' (DALYs), that pivotal report enabled economists to begin calculating the economic costs of ill health. In doing so, they moved health in developing countries from what had been seen by Western countries predominantly as a humanitarian issue to an economic one. Preventing people from dying – or falling ill – from diseases such as malaria or tuberculosis was no longer only a question of charity and therefore a cost; it could be seen as a matter of reducing the economic cost of absenteeism and rehiring, of lost tourism and industrial potential. In other words, it could be seen as an investment.

The arguments made by the 'Brundtland Group' attracted the interest of a second group of actors: the political leaders meeting annually as the G8. By 1999, President Clinton, in particular, but also UK Prime Minister Tony Blair, had run into considerable trouble with what had amounted to a mainstay of both their economic and foreign policies: the promotion of commercial and financial globalization as the key to creating global growth and prosperity.⁸ Despite the rhetoric of liberal Western leaders, the 1990s was a decade of dramatic growth in inequality between north and south, with falling levels of overseas development assistance and stagnation or reverses in recent gains in basic indicators of human development, such as vaccination coverage, education spending etc.⁹

Increasingly loud and raucous protests by mostly Western youths at the meetings of the World Trade Organization (WTO), the World Bank and the International Monetary Fund (which culminated in violent protests at the WTO meeting in Seattle in December 1999) masked a much deeper vein of resentment among many political leaders and thinkers from the south. In short, through their blunt promotion of globalization, Western political leaders were actually widening the gap between the north and south that they purported to narrow. Painfully aware of this, the Blair government had made global poverty reduction one of its central goals.

6 See, for example, Brundtland, G.H. (1998), 'Speech to the Fifty-first World Health Assembly', Geneva, 13 May (as director-general elect of WHO).

7 World Bank (1993), *World Development Report: Investing in Health*, Washington, DC, June.

8 See, for example, Stiglitz, J. (2000), 'Two Principles for the Next Round or, How to Bring Developing Countries in from the Cold', *The World Economy*, Vol. 23, Issue 4 (April), pp. 437–54; and Feachem, R. (2001), 'Globalisation is Good for Your Health, Mostly', *British Medical Journal*, Vol. 323, p. 504.

9 Stiglitz (2000).

Desperately searching for ways to help the G8 leaders ‘level the playing field of globalization’,¹⁰ political advisers found the views of the economists and health and development experts surrounding Brundtland particularly interesting. For them, the appeal of investing in health was not only that it was a particularly good way of showing their leaders’ ‘softer and warmer’ side; if done in a ‘vertical’ way, by focusing on specific, tested interventions for a limited number of treatable or preventable diseases, it was also a very measurable kind of investment. This was particularly important for the British government, which was very much using arguments of ‘efficiency’, ‘accountability’ and ‘return on investment’ to justify its political and economic actions at home.

Later on, the involvement of private-sector actors and private-sector-inspired practices was very also much encouraged by especially the Clinton – and later the George W. Bush – administrations and the Blair government.

Into this mainly Anglo-American preoccupation with globalization¹¹ came the separate preoccupations of Japan and France, which both helped ‘condition’ the G8 for a larger investment in health.

Japan saw the fight against infectious diseases very much through a lens of ‘human security’, an issue the country had long promoted in diplomatic forums. It saw the recent discussion in WHO and elsewhere about health and development in the context of the human security concept of ‘freedom from want’ and therefore found it very appropriate to place health at the centre of the agenda for the G8 summit it hosted in Okinawa in 2000.¹²

France, for its part, had under President Jacques Chirac – at the strong urging of Health Minister Bernard Kouchner¹³ – been very sensitive to the inequality of access to health services and commodities. Already in Abidjan in 1997 Chirac had called for an international solidarity fund for AIDS drugs. As so often, France chose not wait for a multilateral process to develop, but went ahead with the launch of a small international treatment solidarity fund (*Le Fonds de Solidarité Thérapeutique Internationale*) in 1998, in collaboration with Luxembourg and South Korea.

So it was that WHO (supported by UNICEF and the World Bank) engaged in an increasingly concrete series of discussions with the G8 ‘sherpas’, political advisers, European Commission officials and relevant aid officials about a significant increase in investments to fight what became known as ‘diseases of poverty’, predominantly AIDS, tuberculosis and malaria. From 2000 onwards, it was clear that a significant increase in resources to fight these diseases would be made available. How much one could hope for was far from clear. When a suggestion to advocate for the need for \$1 billion each per year for AIDS, tuberculosis (TB) and malaria respectively came up in a strategy meeting at WHO in 2000, there were audible gasps in the room at the audacity of such an ambitious ask.¹⁴

However, a third group was essential in driving the process forward. Without the moral voice and the protests of the AIDS activist movement, it is unlikely that the decisions made by the political leaders and multilateral agencies would have been as bold as they were and the financial commitments as large as they became.

Rarely have so few achieved so much over such a short period of time. While the first stirrings of a global AIDS movement could be seen with the creation of the International Council of AIDS Service Organizations in 1991, the ambition of providing treatment to all who need it regardless of ability to pay for it was born at the International AIDS Conference in Vancouver in 1996 when it was becoming clear that lifelong treatment to keep people living with HIV healthy could be feasible.

10 Ibid.

11 Canada under Jean Chrétien, and to a lesser extent Spain under José Maria Aznar, were supportive but less active voices of globalization in the G8 context.

12 I am indebted to Andrew Cassels, Director of Strategy, Office of the Director-General, WHO, for this perspective on why Japan strongly promoted health issues on its 2000 G8 summit agenda.

13 Kouchner was health minister in 1997–99 but continued to exert strong influence on the thinking of Chirac until the end of the president’s second term. I am grateful to Michel Kazatchkine for his explanation of Chirac’s support for a global AIDS Fund.

14 Author’s recollection from an internal WHO meeting, spring 2000.

It took three more years for the movement to become united in the belief that treatment would indeed be feasible in even the poorest places on earth and that it was right to fight for universal access. Successful trials in Côte d'Ivoire, Rwanda, Haiti and South Africa strengthened this belief. There was also considerable work to do to get an unlikely coalition of traditional development NGOs, faith-based organizations, medical researchers and doctors, gay and lesbian activists and people representing drug-users and sex workers to trust one another and work in unison.

The gay-and-lesbian activists soon emerged as the leaders of the movement. Their lack of respect for (and fear of) authority, their relative lack of experience in the developing world, which made them less daunted by the challenge in front of them and unaware of the audacity of their demands, their experience in harnessing media for their cause and in using highly emotional publicity stunts to draw attention to it – but also their absolute commitment to equality, inclusiveness and respect – won them support and eventually admiration from everyone they encountered.

For decades, discussions had ebbed and flowed among human rights advocates and global health academics about whether access to basic health care could be counted among the universal human rights. Governments have understandably looked askance at such a view; if accepted, it would place some very expensive demands on public health facilities.

The AIDS activists had no interest in the theoretical aspects of this discussion. They simply took it for granted that when life-saving drugs exist, they must be available to all. By raising this demand for AIDS drugs – and gradually getting acceptance for it – they opened up a whole new way of looking at health care. If AIDS drugs, why not TB drugs, or safe childbirth or cancer treatment? Unwittingly, the activists opened up a new front for the provision of health services, one that is still far from fully explored and understood, and that will become increasingly important as more countries reach middle-income status and are expected to build self-sustaining national health services.

Without the moral voice and protests of the AIDS activist movement, it is unlikely that the decisions made would have been as bold and the financial commitments as large

For all their die-ins, their foghorns and their provocations, AIDS activists were the kind of protesters a political leader could learn to love. Unlike the often violent and sometimes nihilistic globalization protesters, the AIDS activists did not only know what they were against – they knew very well what they wanted. They rarely used violence, but rather relied on heart-wrenching emotion and moral outrage as their weapon. Their cause was one no astute politician could resist: saving innocent lives. And when all was said and done, their enemy was really not the political leaders or the system they represented, but first and foremost the pharmaceutical industry; a target few politicians had strong inclinations to defend publicly in the first place.

So, from 2000 onwards some highly unlikely partnerships developed: between the rock star Bono and the arch-conservative US Senator Jesse Helms; between Bob Geldof and Chancellor Angela Merkel of Germany, between the French Act-Up activist Khalil Elouardighi and President Chirac, and of course, between several of the activists and President Bush.

It was only with the work leading up to the creation of the Global Fund in 2001 that these three groups directly interacted for a defined, common purpose. Yet, between them, they provided the intellectual background, the political momentum, the promise of resources and the determination to break down the accepted limits of what is possible, which, taken together, propelled the innovations that changed global health architecture so dramatically.

However, one additional factor needs to be kept in mind when trying to understand the willingness to embark on new experiments during this period: the turn of the century. Intangible

and impossible to quantify, the sense that one was at the dawn of a new age, that one could close the door on what many saw as the ‘awful era’ of the 20th century¹⁵ and start afresh, infused many of the strategy documents and the rhetoric in the discussions about new initiatives at the time.

While no one would argue that the rulebooks should simply be thrown away, there were repeatedly references to ‘learning the lessons’ from the past and using knowledge, practices and experiences in new and different ways. The argument of ‘such a thing is just not done’ was simply met with ‘well, perhaps not in the past, but why not in the new century?’ The spirit that shaped the Millennium Summit with its ambitious development goals was also very much present in the rooms where new health initiatives were being discussed.

How important this spirit was in allowing unprecedented decisions to be taken or previously unacceptable risks to be accepted is hard to measure, but it is safe to assume that it made some difference in tipping the scale towards accepting risk or leaping into unknown territory, in particular for civil servants of the national ministries and multilateral organizations. It is important to keep this in mind when facing the need for similarly innovative and bold decisions today, well into the second decade of a century that seems to have shed its youthful optimism far too early.

15 Judt, T. (2009), *Reappraisals: Reflections on the Forgotten Twentieth Century* (London: Vintage Books) p. 4.

3. NEW LEADERSHIP AT WHO, NEW TYPE OF PARTNERSHIPS

The importance of change at the World Health Organization

By mid-2001, an inexorable momentum had built toward increased funding for the fight against AIDS, TB, malaria and vaccine-preventable diseases, under an assumption that the channelling of such additional resources had to go through new and different institutions.

That momentum had been building, however, since early 1998,¹⁶ when Gro Harlem Brundtland, as the freshly nominated director-general of the World Health Organization, travelled to more than a dozen countries, asking their health ministers ‘what are your largest challenges and how can WHO best assist you?’.

It is indicative of the scale of change that has taken place over the past 15 years that today the appointment of a new director-general of WHO would hardly have been such a pivotal event as it was perceived to be in 1998. At the time, the organization still was expected to be the dominant forum for setting global health policy and strategy. This was the case despite what had in one commentator’s words been a ‘decade of decline, weak leadership, (and) allegations of corruption at all levels’.¹⁷ It was, of course, because of this decline that the change of leadership was so eagerly anticipated. Since there was no alternative to WHO’s leadership, the organization’s rudderless drift had left global health policy directionless as well.

The establishment of UNAIDS outside WHO in 1996 was a clear declaration of mistrust in the organization’s ability to manage the global response to the AIDS pandemic

That WHO was in decline during the 1990s was a publicly acknowledged truism.¹⁸ The establishment of UNAIDS separately from WHO in 1996 was a clear – if unspoken – declaration of mistrust in the organization’s ability to manage the global response to this pandemic. Under Richard Feachem’s leadership, the World Bank’s Health, Population and Nutrition Division had taken a significantly larger role in global health issues and – as opposed to WHO – had the additional influence that its money could provide to get countries’ attention. However, while multilateral organizations have always been competitive in some respects, they were careful not to step across the boundaries set by their mandates, and while Feachem often prodded others to act, generated ideas and used the bank’s lending portfolio to the limited degree it was possible to address urgent needs, the bank did not fill the vacuum left by WHO’s weakness.

The promise of ‘Health for All’ made at the International Conference on Primary Health Care in Alma-Ata (Almaty) in 1978 was largely seen – fairly or not – as having been left to drift by former WHO director-general Hiroshi Nakajima’s aversion to all things political and his focus

16 Tracing the first occurrence of ideas that only over time manifest themselves in action is always difficult and risks leaving some people feeling ignored. One could also argue that the momentum for a step change in global health began building from the creation of UNAIDS in 1996 and the growing demand for global access to AIDS treatment at the IAS Vancouver conference that same year. However, for reasons explained in this paper, I will argue that Brundtland’s nomination in January 1998 is the best starting point for this review.

17 ‘The Brundtland era begins’, *The Lancet*, Vol. 351, No. 9100, 7 February 1998, p. 381.

18 See, for example, ‘WHO: Where There Is No Vision, the People Perish’, *The Lancet*, Vol. 350, 13 September 1997; and Reddy, S. (1998), ‘50 Years of the World Health Organization: Looking Back and Moving Forward’, *National Medical Journal of India*, May–June, Vol. 11, No. 3 (May–June), pp. 107–9.

on science rather than global policy.¹⁹ Yet WHO's reputation as a scientific leader was also increasingly battered.²⁰

The 1990s was turning out to be a depressing decade for global health outcomes. While WHO's TB Unit had done impressive work to develop the DOTS (directly observed treatment, short-course) strategy during the 1990s, the uptake was too slow to stem the explosive growth of the TB pandemic that followed the collapse of health services in the former Soviet Union and the dramatic increase in HIV/TB co-infections.

From her discussions as she travelled to campaign and prepare for her role at WHO, Brundtland saw the continuous spread of malaria as a dominant health threat for both Africa and parts of Asia.²¹ Vaccine coverage had stagnated and even started to backslide in the poorest countries around the world. In a wider perspective, the stubborn poverty rates in most countries outside East Asia, and the harsh consequences of a decade of donor-imposed 'structural adjustments' that had cut government spending and reduced investments in education and health threatened many of the hard-fought gains in life expectancy from the 1970s and early 1980s.

The contrast between the rhetoric deriving from the 'Health for All' movement and the anti-corporate health activists of the 1970s and 1980s (such as Baby Milk Action), on the one hand, and the economic realities in most developing countries in the years that would follow the declaration, on the other, was stark. 'Health for All' reflected the frustrations and aspirations of thousands of health workers in poor countries. Its sweeping vision for a different kind of world – one where health was recognized as a public good and a private right and governments made caring for their people's basic needs their main priority regardless of income – was inspiring. While it enthused the global health community, this language also turned out to be the declaration's greatest weakness. Its utopian references to the need for a 'New International Economic Order', and phrases such as 'the people have the right and duty to (...) participate individually and collectively in (...) their health care', actually made politicians, health officials and health workers ill-equipped to deal with the economic and social realities, which in many developing countries were very much rooted in an old – and in most cases exploitative, unequal and brutal – economic order.

While the 'Health for All' movement based its concepts, its planning and strategies on a public-sector-led, community-based approach dependent on a dramatic reorientation of world and national economic priorities, the world went largely in the opposite direction during the 1980s and 1990s.

A strong ideological drive to reduce the role of government, lower taxes, free trade, and let capital investments rather than development assistance provide the engine for growth in developing countries – driven predominantly by the United States and United Kingdom governments but quickly steering World Bank and IMF policies – forced many developing countries to reduce domestic health spending and saw bilateral aid for 'soft' areas dwindle during the 1980s. After the disintegration of the Soviet Union, Eastern European countries followed suit, experiencing shocking collapses of the kind of health systems the Alma-Ata declaration had set up as its model.

Distressed by these events but stuck in its old worldview, the primary health care movement had very little to offer in terms of new solutions for the very 'brave new world' the global health community was facing at the turn of the century.

It was into this reality that Brundtland stepped in 1997, once she had decided to run for the position of director-general.²² As a social-democratic prime minister in Norway, she had spent the past 20 years steering a course between the socialist ideals of her upbringing and the

19 Peabody, J. (1995), 'An Organizational Analysis of the World Health Organization: Narrowing the Gap Between Promise and Performance', *Social Science & Medicine*, Vol. 40, No. 6, pp. 731–42.

20 According to Nils Daulaire, the 'WHO used to be the place where good ideas went to die', quoted in McCarthy M. (2002), 'What's Going On at the World Health Organization?', *The Lancet*, Vol. 360, No. 9340, pp. 1108–11.

21 Brundtland, who repeatedly heard this comment as she consulted African ministers of health, attributed the emphasis on malaria over AIDS partly to the continued taboo regarding HIV and AIDS.

22 The following paragraphs have been informed by several conversations with Gro Harlem Brundtland, the latest on 26 August 2012.

Thatcherite international political and economic environment of the time while she was in office. This experience had made her an unsentimental pragmatist, whose only interest in any policy debate was in finding out ‘what works’.

Brundtland had had one previous international role as the chair of the World Commission on Environment and Development, now known as the ‘Brundtland Commission’, from 1983 to 1987. The commission’s work had almost singlehandedly turned the debate about environmental issues from local discussions of pollution and protection of untouched nature (mainly in rich countries) to a global challenge about ‘our common future’. In short, by politicizing environmental issues and making them a central element in global development, she elevated them to a level where global political action became possible for the first time.

As she prepared for her post as WHO director-general, she wanted to apply the same formula to health. She knew that only if health was seen as a global political and economic issue rather than a humanitarian and local concern would presidents or prime ministers, foreign ministers and finance ministers really get engaged.

Brundtland made no secret of this aim: it was stated in her first speech to the World Health Assembly in May 1998 and repeated regularly in her speeches throughout her time at WHO.²³ Having already stated her political plan, she ‘reverse engineered’ the process to provide scientific backing for it by setting up the Commission on Macroeconomics and Health (CMH) in 1999.

Brundtland and the people around her had already been strongly influenced by the thinking of the authors of the 1993 *World Development Report*, such as Dean Jameson and Chris Murray, as well as by the (then) head of Mexico’s National Institute of Public Health, Julio Frenk, the director of the Health Economics and Financing Programme at the London School of Hygiene & Tropical Medicine, Anne Mills; and (then) Harvard professor Jeffrey Sachs. These people would all become central in supporting her mission at WHO. Among them, Sachs was seen as the one academic who, better than any other, could operate on the complex border terrain between science and politics, and he was asked to chair the commission.

WHO Director-General Brundtland knew that only if health was seen as a global political and economic issue rather than a humanitarian and local concern would presidents or other political leaders really get engaged

Thanks to Brundtland’s international renown, the commission had an exceptionally high-calibre participation, from both the political and the academic fields.²⁴ Its final report, however, came rather late, in December 2001. By that time, most of the pivotal international events had taken place, including the Okinawa G8 summit, the UN Security Council’s discussion of AIDS as a global security threat, the UN Millennium Summit and the UN General Assembly’s Special Session on AIDS, as well as the creation of the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund.

Nevertheless, the commission had a significant influence on the thinking in all these forums and on the ideas for creating the new funds. This was mainly thanks to the considerable output of its several working groups along the way, but also through its interim commission meetings and its

²³ Brundtland (1998), ‘Speech to the Fifty-first World Health Assembly’, Geneva, 13 May.

²⁴ The 18 commissioners were Jeffrey Sachs, Isher Judge Ahluwalia, K.Y. Amoako, Eduardo Aninat, Daniel Cohen, Zephirin Diabre, Eduardo Doryan, Richard Feachem, Robert W. Fogel, Dean Jamison, Takatoshi Kato, Nora Lustig, Anne Mills, Thorvald Moe, Manmohan Singh, Supachai Panitchpakdi, Laura Tyson and Harold Varmus.

commissioners' public engagement on the issues of health and macroeconomics throughout its work from 1999 to the end of 2001. Sachs in particular was a vocal advocate, tirelessly hammering in the message of health's importance in poverty reduction and economic development in every forum he attended and every speech he made during this period and after.

By engaging Frenk, Murray and Derek Yach (whom she placed in charge of non-communicable diseases and her Tobacco-Free Initiative) and engaging a large number of other senior academics through the work of the CMH and other forums, Brundtland not only gained a large brains trust; she also involved most of the important thinkers in global health in 'her project', giving them a stake in her success.

Commission on Macroeconomics and Health Chair Jeffrey Sachs tirelessly hammered in the message of health's importance in poverty reduction and economic development

Two other allies were to become important for Brundtland: US First Lady Hillary Clinton and UK International Development Secretary Clare Short. The positive relationships between Brundtland and these two leading politicians²⁵ provided goodwill and support for her mission which trickled down through the state apparatus.

While it is hard to quantify, such tacit support and inherent trust are particularly important when one is trying to do something new and at times controversial. One of the intangible secrets behind Brundtland's successes in these early years must clearly be ascribed to the trust she enjoyed among political leaders, academics and senior civil servants in key countries.

A final significant adviser to Brundtland was Tore Godal, who had just stepped down after 12 years as the director of the Special Programme for Research and Training in Tropical Diseases, and who would be instrumental in setting up GAVI in 1999–2000.

Roll Back Malaria

The determination to create Roll Back Malaria (RBM) was announced in Brundtland's speech to the World Health Assembly in May 1998 and again in her inauguration speech in July 1998. The initiative was launched in New York in October that year.

It was created as what Tore Godal describes as being 'the last traditional partnership',²⁶ initially a simple interagency collaboration between UNDP, the World Bank, UNICEF and WHO. But it had larger ambitions. In an article outlining the campaign, David Nabarro (the UK Department for International Development's director of human development and chief health adviser, who would become the first project manager of the partnership) and Elizabeth Tayler outlined a number of elements that would become key features of most of the new partnerships that were to follow in the coming decade: a determination to partner with research-based pharmaceutical companies to develop new drugs and commodities; a realization that most diagnosis and treatment of malaria take place outside the public health sector; and the need to rely on civil society organizations as well as national health services to achieve results.²⁷

²⁵ As First Lady, Clinton could not be called a 'politician' in a strict sense of the word, but it has become evident that she played a more important role in influencing her husband and his administration's policy than any other First Lady since Eleanor Roosevelt.

²⁶ Discussion with the author, August 2012.

²⁷ Nabarro, D., Tayler, E.M. (1998), 'The 'Roll Back Malaria' Campaign', *Science*, Vol. 280, No. 5372, pp. 2067–8, 26 June.

It was no surprise that this willing embrace of actors outside the traditional nation-state/WHO axis came from someone who was the chief adviser in Short's department, perhaps reflecting its eagerness to use private-sector inspiration and collaboration as a driving force to renew dusty practices at home. If one believed it would work in the United Kingdom, why not believe it would work internationally as well?

The British government was instrumental in turning RBM so quickly from an idea to reality by inserting a line supporting it at the Birmingham G8 summit communiqué in 1998, only three days after Brundtland's announcement at the World Health Assembly, and by pledging £60 million 'to kick-start' the RBM process. The World Bank, for its part, was making available new loans for malaria control for the most affected countries.

All that helped, but a lot was missing. The idea of creating RBM was inspired by the success of the 1996 partnership of UNAIDS²⁸ but there were some significant differences. The fight against AIDS benefited from a movement that could come together around the promise of an effective treatment and a moderately effective prevention strategy based on condoms. And although the available funding for AIDS at the time was a small fraction of what it is today, it was still in a different league from what global malaria control could rely on.

In 1998, malaria had no effective or promising treatment technology and no effective prevention technology – and behind the declarations of African leaders there was no movement to drive things forward. Malaria had been neglected for decades.

Chloroquine, the first-line drug, had outlasted its usefulness by at least a decade. Some of the worst-affected malaria-endemic countries saw drug resistance rates of up to 70 per cent, and the second-line drugs were not doing all that much better. Insecticide-impregnated bed nets had to be re-impregnated every 6–12 months and often tore in the process. And even if such re-impregnation had been feasible on a large scale, with global malaria budgets ranging in the tens of millions of dollars at most, it was inconceivable to nourish ambitions about providing nets to all who needed them. Indoor residual spraying was still practised in some countries, but it had such a bad reputation at the time – given the reliance on DDT – that only those with a career death-wish would advocate its widespread use.

Malaria departments had been underfunded for so long that the only doctors left would be a few old holdouts from the malaria control activities of the 1960s and 1970s. Few of the young, smart doctors in Africa or elsewhere would choose a career in malaria. NGOs had little to work with to fight malaria. They had therefore been looking elsewhere, focusing on problems where they could expect to show their donors at least some progress. Unlike AIDS and TB, malaria was uniquely a tropical problem, so there were no vocal activists in wealthy countries engaging the public in this fight.

Undeterred by this, under David Nabarro's leadership RBM set out to create a belief that the fight against malaria could be turned around. Without any effective technology, the focus was on improving case detection and protecting pregnant mothers and infants by targeted use of information, improving drug supply and distribution and distributing bed nets to families with small children in particularly high-incidence areas.

Given the discrepancy between the high expectations that were being generated by Brundtland's and Nabarro's public statements on the one hand and the poor tools and few resources that were available on the other, it was inevitable that RBM quickly became a target for much criticism and frustration.

RBM was conceived as a traditional interagency partnership. But Brundtland had, as mentioned, been inspired by UNAIDS. One of the reasons for UNAIDS' early success was its embrace of a wide variety of civil society groups that saw it as their entry into a meaningful dialogue with the UN system. By inviting NGOs onto its Programme Coordination Board, UNAIDS had ensured that the NGOs and activists were on the inside of the house (for the most part) throwing stones out rather than standing outside throwing them at the organization.

28 Author's conversation with Gro Harlem Brundtland, August 2012.

RBM was very keen to replicate this engagement with civil society, but its problem was that there was no activist movement of the same intensity and engagement for malaria. And because it was exclusively an interagency partnership, RBM initially provided the NGOs and academics who did care about malaria with the comfortable position of criticizing from the outside, a position wonderfully free from responsibility.

This could possibly have been avoided had participation by civil society, private foundations and the private sector been built into the design from the conception, but this was too radical a step at the time. Two years later, when the STOP-TB Partnership was revamped, the inclusion of non-UN partners had already become a given, but for RBM this process took some time. It was only when the two new technologies of artemisinin-based combination therapy (ACT) and long-lasting pre-impregnated bed nets came on the market, and when the Global Fund dramatically changed the magnitude of available funding, that the NGO movement against malaria really took off.

While RBM aimed to jump-start a movement to fight malaria and did its utmost to create a belief that the fight could be won, its early documentation and strategies more than anything highlighted how underequipped the world was for this fight.

Roll Back Malaria was the last ‘traditional partnership’. Because it was exclusively an interagency partnership, it initially provided NGOs and academics with the comfortable position of criticizing from the outside

By the late 1990s the global health community was almost in despair over the sorry state of research and development for tropical diseases drugs.²⁹ Only 13 new drugs had been developed for such diseases between 1975 and 1996 (out of more than 1,200 new drugs globally) and all but four of these were more or less accidental by-products of other research. By 1995 the 15 largest pharmaceutical companies had virtually closed down their research efforts for any drugs for tropical diseases.³⁰ Hoffmann LaRoche was the last one in the business, and in 1997 it signalled that it too would pull out within a year.

The pharmaceutical companies maintained that the tropical diseases represented particularly intractable scientific challenges and drugs were therefore particularly costly to develop.³¹ However, a more significant underlying reason seemed to be insufficient profitability. As a result, no significant new molecule for malaria had been commercialized since chloroquine appeared in 1945.

Most of the public health community concerned with pharmaceuticals understandably reacted to this abandonment by the research-based pharmaceutical companies with moral indignation and righteous anger. They compared the billion-dollar profit figures of the major companies with the needs of the developing world and built a moral argument around the unfairness of the situation.

29 See, for example, Trouiller, P. (1996), ‘Recherche et développement pharmaceutiques en matière de maladies transmissibles dans la zone intertropicale’, *Santé*, Vol. 6, No. 5, pp. 299–307; and Pécou, B. et al. (1999), ‘Access to Essential Drugs in Poor Countries: A Lost Battle?’, *JAMA*, Vol. 281, No. 4, 27 January, pp. 361–7.

30 Trouiller (1996), ‘Recherche et développement pharmaceutiques’; Ridley, R., Gutteridge, W. and Currat, L. (1999), ‘A Case Study of the Establishment of a Public Sector/Private Sector Partnership’, paper presented to the Global Forum for Health Research, Geneva, 8 June; Ridley, R. and Gutteridge, W. (1999), ‘Medicines for Malaria Venture’ paper presented to the Médecins sans Frontières Symposium: Drugs for Communicable Diseases – Stimulating Development and Availability, Paris, 15 October; and author’s conversation with Robert Ridley, September 2012.

31 Sir Richard Sykes, in a conversation with the author, insisted that it was more the scientific and technical difficulties than the market failure that caused so little research into tropical diseases such as malaria and TB.

But since companies would not listen to the argument that ‘you ought to use part of your profits to finance research in tropical diseases and sell the products cheaply’, the firm belief of most WHO experts and their associates among the NGOs and academia was that only when the public sector intervened forcefully to override market dynamics would the status quo be broken.³²

This thinking ran largely counter to where global market trends were heading, and for many outside the global health community (and many inside it), WHO was seen as marginalizing itself, banging its head against an ideological wall.

The increasingly rancorous exchanges between activists, academics and some senior staff at WHO’s Action Programme on Essential Drugs, on the one hand, and representatives for the pharmaceutical industry, on the other, had by 1997 practically ended all constructive communication.

Medicines for Malaria Venture

Meanwhile, a few blocks away from WHO’s headquarters, another interagency partnership was taking a different approach to the problem of finding new drugs and vaccines for tropical diseases. In the early 1970s, WHO had joined forces with UNDP and the World Bank (UNICEF would join after some years) to create the Special Programme for Research and Training in Tropical Diseases (TDR).

A distinctly old-fashioned affair of clinical researchers in white coats, TDR organized and coordinated research into mainly neglected tropical diseases. Despite waning interest among the pharmaceutical companies to see commercial opportunities in these areas, TDR did important work that helped create the control programmes for onchocerciasis, leprosy and African trypanosomiasis (sleeping sickness).

During the 1990s TDR organized trials of the two technologies that ended up revolutionizing malaria control. The first came from a small trial of insecticide-impregnated bed nets in Gambia in 1992, which had shown remarkable results. These were soon confirmed by a much larger TDR-organized study in four African countries: use of the nets had reduced overall mortality among children by 20 per cent.

The second was a collaboration that sprung out of some remarkable results Chinese researchers presented in 1989 around the use of artemisinin derivatives to cure malaria. During the 1990s TDR would focus on creating products that could facilitate community treatment using these products and on developing combination therapies, which would slow development of resistance. Out of the several different development paths, two secured sufficient pharmaceutical company interest to get through to approved, market-ready products: an injectable treatment, Artemotil, and blister-packed tablets, Coartem.

Even before Coartem had become market-ready, TDR began worrying about the next generation of malaria drugs. The private-sector collaborations on artemisinin-based drugs made it clear that private companies would not carry the full risks of transforming public-sector basic research on promising drug candidates into approved and market-ready products on their own.

Tore Godal (who headed TDR at the time) and his colleagues had noticed, however, that there were many individuals in the pharmaceutical companies – all the way up to the highest corporate levels – who understood the importance of developing these drugs and who were personally keen to see them come to market. Godal engaged two of them: Winston Gutteridge, from Glaxo Wellcome, and Robert Ridley, who had led the malaria research programme at Hoffmann La Roche. These two argued that the trick to finding a solution to this dilemma would be to ‘think

32 Bennet, S., Quick, J.D. and Velasquez, G. (1997), ‘Public–private Roles in the Pharmaceutical Sector’, Health Economics and Drugs DAP series No. 5, WHO. While this paper primarily discusses supply and pricing of existing drugs, it reflects the outlook of the authors on the wider issue of the role of the private sector in the pharmaceutical sector.

like a corporation' and find ways to reduce the risk in developing the drugs. If they could do this, the 'pro-malaria' corporate leaders would perhaps win the board discussions and invest.

In November 1997, the Wellcome Trust and WHO invited the heads of the largest pharmaceutical corporations to a meeting to discuss the challenge. Gutteridge, with the support of Trevor Jones of the Association of the British Pharmaceutical Industry, Richard Sykes of GlaxoSmithKline and Harvey Bale, the newly appointed head of the International Federation of Pharmaceutical Manufacturers & Associations, proposed a model that would basically pool research resources from the pharmaceutical companies into one joint research facility. This, however, did not fly with the majority of the industry CEOs, who foresaw large capital outlays and no exit strategy.

Discussions in a working group that also included Richard Feachem of the World Bank, Tore Godal of TDR, Tim Evans of the Rockefeller Foundation and Louis Currat of the Swiss Development Corporation generated a second idea of a publicly backed venture-capital investor. This investor would assess candidates for likelihood of success and pick the most promising.

The private sector was worried that, if such an investor sat under WHO, political interference would distort the selection process and make it hard to cut funding for unsuccessful trials. The organization's leadership was initially worried it would lose control by establishing an independent entity. Yet WHO under Nakajima worried that by supporting and participating in this entity it could be seen to be breaking down the wall between its normative role and its role as a sponsor of independent research on the one hand and the private sector's commercial interests on the other.

TDR, which was technically part of WHO but felt largely unconstrained by the larger, structural concerns of its leadership, was less worried. Building on his experiences in developing the artemisinin-based malaria drugs with the private sector, Godal took the view that whatever was needed to get results should be done. He believed that as long as the principles were clear and the structure thought through, it should be possible to defend the initiative against criticism, and that it was always better to defend action than inaction. Nakajima, clearly, did not share that view.

When Brundtland took over at WHO in 1998 – and Godal moved from TDR to become one of her advisers – she saw the idea of such a public–private venture-capital initiative as exactly the kind of new partnership that could break the constraints WHO laboured under. Brundtland had realized that, in several areas, the organization no longer had the accepted authority to go it alone, or else political and economic developments made it impossible to dictate solutions, or it would run into crippling rivalries with other multilateral organizations, as was happening with UNICEF around vaccine delivery and development. She saw partnerships – shaped and adapted according to the specific circumstances – as the only way for WHO to move forward. As long as it initiated such partnerships and managed to provide knowledge and leadership of a high calibre, Brundtland believed that such partnerships would strengthen rather than undermine WHO's position in global health.

She gave the green light to complete the arrangements for what became known as the Medicines for Malaria Venture (MMV), and by letting Godal and his TDR colleagues organize the work she kept it outside the remit of WHO's Legal Office, which would have found much to worry about in the novel and private-sector-designed venture. Richard Feachem promised some seed capital from the World Bank; Tim Evans did the same on Rockefeller's behalf, and David Nabarro stepped in with support from RBM. By the launch date, MMV would have \$4 million in initial capital, which soon would be boosted by \$25 million over five years by the Bill & Melinda Gates Foundation. By November 1999, Brundtland could launch the venture at a ceremony in Geneva.

MMV took on a structure that would become familiar over the next few years. It had a board that represented the main 'stakeholders' (in this case, the multilateral organizations, the pharmaceutical companies, the research institutions and the funders), a small management group and an independent scientific committee that was charged with selecting fundable projects based on proposals/applications. This selection committee model was something everybody was familiar with and for the most part trusted, and it blunted the fear that the funding might be biased in one direction or the other.

To some extent, MMV had used elements that Seth Berkley had pioneered when he designed the International AIDS Vaccine Initiative (IAVI) in 1996. But IAVI was like an NGO with no significant involvement of multilateral organizations in its governance. The challenge of MMV was to involve multilateral organizations in leading roles while avoiding the legal pitfalls of UN organizations being directly linked in a venture with private-sector companies. Louis Currat proposed to create MMV as an independent, autonomous Swiss foundation, and in doing so managed to establish the necessary firewall between WHO and the new venture.

Brundtland saw the idea of a public–private venture-capital initiative such as the Medicines for Malaria Venture as exactly the kind of new partnership that could break the constraints WHO laboured under

The fact that no WHO budget money was at risk, that the project selection followed a familiar scientific practice and that there was an arm's length relationship between WHO and the new foundation that had eloped with the private-sector companies helped blunt the criticism against starting up such a venture. Few, if anyone, in late 1999 (except perhaps Tom Topping, WHO's sharp and risk-averse legal counsel) realized that MMV had opened the door to a new type of institution, which would eventually fundamentally change the whole architecture of global health.³³

GAVI

While Godal, during his last years at TDR, was concerned about the lack of new medicines in the research pipeline to treat malaria, elsewhere he and others were equally worried about the decline in immunization rates and the lack of commercial investments in research for future vaccines against malaria, TB and to some extent AIDS. There was widespread frustration over what many saw as both UNICEF lethargy in the immunization programme for the six basic vaccines for children, and WHO's perceived stagnation in driving forward vaccine research and wider use of existing, expensive vaccines.

To prod the others into action and to generate discussion about how stagnation in vaccine delivery and development could be ended, Richard Feachem convened international organizations, foundations, NGOs and pharmaceutical companies to a 'Vaccine Summit' at the World Bank in Washington in March 1998. World Bank President Jim Wolfensohn opened the summit, and Brundtland attended (though she had not yet been appointed to her new position), as did the CEOs of the main pharmaceutical companies.

While the ambition of the meeting was to push the pharmaceutical companies to invest more in research for new vaccines – particularly for an AIDS vaccine – the debate at the summit quickly turned to the several existing vaccines that were underused. 'Why', asked Jacques-François

³³ A little-known initiative, but one of the most successful to be created on the back of the new enthusiasm for public–private partnerships, was the Health InterNetwork Access to Research Initiative. Several of the editors of the leading medical journals were highly enthusiastic about the new spirit of collaboration WHO had initiated through MMV and GAVI. In 2001, a WHO librarian, Barbara Aronson, exploited this enthusiasm by convincing them come together and offer their publications for free online to research institutions and hospitals in the poorest countries. What started out as a portal with publications from six publishing houses in January 2002 is now an online platform for more than 8,500 journals from 150 publishers. It benefits more than 5,000 medical institutions in 106 countries, where researchers would otherwise not have access to such a wide range of medical literature. See <http://www.who.int/hinari/en/> and Aronson, B. (2002), 'WHO's Health InterNetwork Access to Research Initiative', in *Health Information and Libraries Journal*, Vol. 19, pp. 164–5.

Martin, who represented the International Federation of Pharmaceutical Manufacturers & Associations during the meeting, 'would you expect us to invest hundreds of millions of dollars in a new AIDS vaccine when there isn't anyone even buying existing vaccines for use in developing countries?'³⁴

The first task force that was created following the summit laid out a detailed argument explaining why private-sector investments in an AIDS vaccine was not a realistic hope without guarantees that there would be a future market for such a vaccine beyond the OECD countries. The task force argued that in addition to providing some future purchase guarantees, the best way to stimulate private-sector interest in vaccine research would be to bolster the use of existing vaccines – both the basic childhood vaccines and the more recent vaccines such as for Hepatitis B, yellow fever and haemophilous influenza-type B (Hib), which were hardly used in developing countries at all.³⁵

In short, the conclusion from the summit was that the best way both to reverse the slide in immunization rates in many poor countries and to spur interest in developing new vaccines would be to create a momentum for making use of the new, largely unused vaccines that were either too expensive or simply not a priority for countries struggling to manage immunization against the basic childhood infections.

Brundtland was concerned, however, that the collaboration between UNICEF and WHO in the 'Children's Vaccine Initiative' (CVI) over the past decade had been plagued by rivalries and that WHO's role in this partnership had been weak. In the end, the turf battles had undermined the initiative's appeal with donors and by 1998 it was near failure.³⁶ She therefore encouraged thinking about an alternative model for structuring such a new initiative.

The Rockefeller Foundation, which was one of the original partners in CVI, helped drive this process forward. It led a second task force that was trying to come up with good ideas for improving the uptake of underused vaccines in the poorest countries.

Jacques-François Martin, who sat on the IAVI board as well as advising the fledgling new Children's Vaccine Program at the international NGO PATH founded by the Gates Foundation, was engaged in this task force. Several of the task force members envisaged a new alliance of partners, which he believed would have a better fundraising appeal and more trust *vis-à-vis* the vaccine-producing companies than a traditional UNICEF/WHO/World Bank alliance.

The task force that emerged from the 1998 Vaccine Summit argued that in addition to future purchase guarantees, the best way to stimulate private-sector interest in vaccine research would be to bolster the use of existing vaccines

One of Brundtland's reasons for having supported a new partnership outside the existing CVI was to neutralize the rivalries that dominated the relationship between UNICEF and WHO. Yet, she saw that they both needed to be strongly involved and she was initially sceptical when Martin first proposed an alliance fully outside their control, something the World Bank supported. However, this reluctance paled in comparison with the unwillingness shown by UNICEF, whose legal department – to everybody's irritation – provided reasons throughout the process why a new alliance could not work.

³⁴ Conversations with Tore Godal and Jacques-François Martin, August and September 2012.

³⁵ 'Accelerating an AIDS Vaccine for Developing Countries: Recommendations for the World Bank', The AIDS Vaccine Task Force, World Bank, January 2000.

³⁶ Muraskin, W., (1998), *The Politics of International Health: The Children's Vaccine Initiative and the Struggle to Develop Vaccines for the Third World* (New York: State University of New York Press).

Nevertheless, at a second summit at the Rockefeller Foundation's centre in Bellagio, Italy, in March 1999, the idea of a global vaccine alliance was put forward, but its structure and financing were still open questions.

Tore Godal retired from WHO in May 1999 and was immediately asked by Tim Evans of the Rockefeller Foundation to participate in the task force, ensuring close communication with – and a high level of engagement by – Brundtland in the workings of the group.

WHO's vaccine department had in late 1997 approached Bill Gates Senior, who ran the forerunner of what would in 2000 become the Bill & Melinda Gates Foundation, to seek support for its work. This had not been successful. Gates Senior's focus at the time was on family planning activities. Besides, he did not think that Gates' charitable contributions should go towards financing ongoing UN-led programmes, believing this to be the responsibility of UN agencies and their donor governments. The Gates family wanted to focus its health funding on research into new technologies and seed funding for innovative initiatives that otherwise would not have made it off the ground.³⁷

Vaccines were nevertheless something that interested Bill and Melinda Gates. Bill Gates recognized some similarities between vaccines and software: for one, they both demanded huge effort to develop but were then fairly cheap to produce and distribute. Melinda Gates, having a three-year old daughter and being pregnant at the time, was very receptive on the injustice of life-saving vaccines being unavailable to millions of newborns.

These considerations had led the couple in late 1998 to allocate \$100 million to create the Children's Vaccine Program. Through their work on family planning, they had established good relationships with PATH, and had decided to place the new programme under its management. Mark Kane, a former staff member at WHO and US Centers for Disease Control and Prevention who had long been working to expand the use of the Hepatitis B vaccine in developing countries, had recently moved to Seattle, where he worked at PATH. He was asked to lead the programme. Kane also had another role: thanks to his previous engagement to promote the use of the Hepatitis B vaccine, he was one of the members of the Rockefeller-organized task force.

Melinda Gates had already begun hosting what over time became a well-known feature of high-level global health policy discussions: the private dinners at the Gates' Seattle home. At the time, these dinners were most often a tool for the couple to educate themselves in health matters. At one such dinner, in late 1998, they signalled their interest in investing considerably more money into vaccines if they could just find an effective way to do so.³⁸ Jacques-François Martin and Mark Kane were among the guests.

The Gates family was understandably preoccupied with achieving impact. It considered the large, UN-led health efforts to be largely adrift and feared investing in existing efforts that would not be able to achieve tangible, measurable results. It also feared that, given its enormous economic clout, an investment by the Gates Foundation would simply replace public-sector funding and 'let governments off the hook'. However, Martin and Kane described to them the current discussions between Rockefeller, WHO, UNICEF and the World Bank on how to bring underused vaccines to the poorest countries, and how to set up an alliance outside the remit of the UN. The Gates were sufficiently intrigued to eventually invite the working group to organize a 'proto-board' meeting of the main partners in Seattle.

Several people had been cynical about the attempt to create yet another partnership with no new money behind it. With the possibility of significant financial support from the Gates Foundation in the air, the idea of a new alliance modelled on IAVI and MMV rather than on a UN partnership like CVI took on a momentum of its own. Whatever sum the Gates Foundation might provide, it was likely to be more than anyone had first imagined the alliance could hope for. Partnerships in the 1990s, it should be remembered, often operated with pots of money counted in the single

37 See Muraskin, W. (2005), *Crusade to Immunize the World's Children* (Los Angeles, CA: Global Bio Business Books, USC).

38 'An architect of global health retires', *Seattle Post-Intelligencer*, 30 December 2005.

millions or at most lower tens of millions of dollars. These small budgets were in themselves a major impediment to success. The prospect of the Gates Foundation coming on the scene meant ambitions could be raised to a whole new level. The working group was asked to send in an application of no more than five pages for funding of a maximum of \$750 million.

The 'proto-board' meeting took place in July 1999 and set up the main objectives, governance and management structure for the new alliance. By this time, Brundtland was convinced that such an alliance would only work if it was independent of both WHO and UNICEF, but she ensured strong WHO involvement by making certain that she chaired the board of GAVI. At the first board meeting in October 1999, she called the alliance 'The merger of our comparative advantages'.³⁹

UNICEF chief Carol Bellamy accepted this as long as the organization would have the chairmanship during the following two-year period. UNICEF also offered to host GAVI at its offices in Geneva. That was initially a rather small concession since everybody agreed, on Bill Gates Sr's insistence, that GAVI should be 'nimble', i.e. have a very small secretariat and predominantly rely on the services of the existing organizations. No parallel structures or capacity should be built up.

One large design hurdle needed to be overcome in order to secure the Gates contribution: to ensure that the contribution would be tax-exempt, the new alliance could not receive it directly. Instead a Global Fund for Children's Vaccines had to be set up as a tax-exempt US institution – a 501(c)(3) – with its own funding and decision-making power. Jacques-François Martin became the head of this fund, while Tore Godal was asked to lead the GAVI Secretariat.

On 23 November, Bill Gates signed the grant agreement with the Vaccine Fund, guaranteeing funding of \$750 million over five years. Two months later, GAVI was launched with much fanfare at the World Economic Forum's meeting in Davos. Gates' record contribution ensured that GAVI got unprecedented media attention, far beyond what any single health initiative had attracted in the past. In 2005, Bill Gates was quoted as saying the contribution to GAVI was the 'best investment we've ever made'⁴⁰ and, as of 2013, his investment in GAVI totals \$2.5 billion.

By 2005, Bill Gates was quoted as saying his contribution to GAVI was the 'best investment we've ever made.'

Looking back, that original investment decision was taken on little more than faith, trust and gut feeling. In January 2000, GAVI did not look innovative as much as simply unfinished. The major policies and practices that came to define its success over the following years were worked out in the course of the first year. Apart from the personal involvement of Bellamy and Brundtland, the acceptance of the vaccine industry's legitimate seat at the table, and the momentum Gates' money provided – and the challenge it provided – there was little in GAVI's initial structure that set it apart from the failed Children's Vaccine Initiative from a decade earlier.

As Godal and his handful of colleagues at GAVI got to work in late 1999, there was no agreement as to whether it should allocate its funding to a few pilot countries or go wide from the start, whether it should finance health systems or focus on vaccine cold-chains, and how it should measure results. These questions were solved during the first half of 2000 after lengthy and often tough debates. Godal prevailed in his argument that with \$750 million in the bank, there was no need to waste time with a pilot phase. He argued that the focus should be on the 77 countries the World Bank classified as low-income. The money should be allocated through an application process, with country applications being assessed solely on a technical basis

39 Brundtland, G.H. (1999), 'Speech to the opening of GAVI's first Board Meeting', New York City, 28 October.

40 See Check, E. (2005), 'Global Vaccine Project Gets a Shot in the Arm', *Nature*, Vol. 433, No. 7024, 27 January, p. 345.

by an independent panel of experts. A special committee separate from the board of directors, in which the pharmaceutical industry would have no seat, should decide on procurement of vaccines.

The impasse over whether funding should go to governments with certain criteria for their spending or should be earmarked to simply buy cold-chains and other commodities was solved by the bold proposal by a young WHO expert, John Lloyd, that governments should simply be paid \$20 per child vaccinated and countries should be allowed to work out their own needs.

Technical support was formalized through agreements with donors. This, together with the fact that despite intense conflicts all key stakeholders had participated in the design and creation of GAVI from the start, helped it get the support it needed to see successful grants early on

The reason such a radical and simple solution could gain traction was the enormous pressure to get going quickly, and the intangible sense that the principals behind the venture expected new and creative solutions. Godal's daily interaction with Brundtland – and Brundtland's experience as a political leader rather than a health expert – helped to keep the decision-making fast. Brundtland, like Gates, was willing to take risks in return for possibly rapid and instantly visible results on the ground. The Gates Foundation saw every option through a private-sector lens, most often favouring exactly the kind of practices that would alarm the conservative WHO and UNICEF lawyers.

Godal was very concerned about mushrooming expectations in view of the unprecedented amount of funding he was managing.⁴¹ He therefore carefully designed the grant policies in such a way that GAVI should be able to approve all technically sound applications over the first five-year period within the funds already pledged. This, he believed, was crucial to the credibility of GAVI and essential for governments' planning process.

Finally, to keep GAVI true to its promise of being small and 'nimble', technical support from partners (predominantly WHO and UNICEF) was formalized through agreements with donors to provide additional, earmarked funding to these agencies to carry out specific tasks in relation to the GAVI grants. This, together with the fact that despite the intense conflicts between the different partners, all key stakeholders had been participating in the design and creation of GAVI from the start, helped it get the necessary support to become operative quickly and see successful grants early on.

In this way a number of features that would later inspire the workings of the Global Fund emerged. But the Global Fund made some twists to several of these policies and structures, which would have dramatic and unforeseen consequences over the years.

⁴¹ By the end of 2000, GAVI's resources had been increased to well over \$1 billion by Norwegian, UK and Dutch pledges.

4. THE AGE OF GRAND AMBITIONS: THE GLOBAL FUND

Bill and Melinda Gates may have signed their \$750 million cheque in November 1999 against little more than a hope and a prayer,⁴² but the mood was fundamentally different from what it had been only two years earlier. The self-propelling effect of this money was dramatic. The fact that resources for health could get close to the ‘b-word’ – billion – in one simple stroke energized the global health community beyond anything ever seen before. It liberated the minds of those striving for global action and enabled them to think really big for the first time. This would have tremendous consequences for the discussions that were to progress toward creating the Global Fund two years later.⁴³

There was also a sense that, finally, health was placed in a larger context and people of influence and power outside the field began to accept and sympathize with the argument that health investments were a foundation for all other development efforts. Brundtland’s single-minded advocacy effort can take a large part of the credit for this, but by no means all.

By 2000, several centres of ambitious ideas had emerged in different quarters:

- in London in the Prime Minister’s Office and DFID, as well as the academic centres that provided the intellectual nourishment for the department’s thinking;
- in Brussels, where Lieve Franssen, the head of the Health, AIDS and Population Sector under European Development Commissioner Poul Nielson, worked to find new pricing models to make more drugs affordable to the poor in developing countries;
- in Canada, where the Canadian International Development Agency’s director for Global Initiatives, Ernest Loevinsohn (in partnership with Tim Evans at the Rockefeller Foundation), had begun stirring up the global TB NGOs for renewed action;
- in the offices of Médecins Sans Frontières (MSF) in Paris and Geneva, in Partners In Health’s headquarters in Cambridge, Massachusetts and in the National Agency for Research on AIDS (ANRS) in Paris, where successful AIDS treatment trials stirred debate about the feasibility of rolling out such treatment on a global scale;
- in Tokyo, where Prime Minister Yoshirō Mori wanted an agenda for Japan’s G8 presidency that could live up to the symbolic importance of the first summit in the new century and that could blunt the growing perception of the G8 as a heartless group of rich countries which used the promises of wealth and development for all through globalization as a smokescreen for continued hegemony;
- in the London offices of rock star Bono’s advocacy organization DATA, where in heated discussions health began to take over from debt relief as Africa’s largest opportunity for growth and poverty reduction; and
- in AIDS activist organizations from San Francisco to Cape Town, where people were busy building a unified front and finding a common voice in their demand for access to AIDS treatment for all, regardless of income.

By June 2001, all these efforts would meet in one united push to create and finance the Global Fund. But the foundations of that joint effort had been two years in the making and were anything but united.

42 Bill Gates has said to several people that his ‘hand shook’ when he signed the \$750 million grant agreement for the Vaccine Fund.

43 The following section draws heavily on internal documentation related to the G8 and Global Fund preparatory processes and to conversations with several of the key actors. I am indebted to Andrew Cassels for access to his archive and his insightful observations and comments. I also draw on a large number of conversations with dozens of people involved with the Global Fund in one capacity or the other over the years.

Again, the first and most systematic steps were taken at WHO, or rather by a small group of former DFID officials and consultants, such as David Nabarro, Andrew Cassels and later Malayah Harper, who had moved to the organization's leadership and were working with their successors in London, with the blessing of Short and Brundtland.

In January 1999, at a meeting organized by the King's Fund in London, where both Short and the Nobel-Prize-winning economist Amartya Sen were present, Brundtland set out her most detailed description yet of the link between health and poverty and pledged to dedicate WHO's efforts and resources to promote health as a central tool to reduce poverty. The meeting took place against a background of stagnation in several indicators for human development and a backward slide in international commitments to development assistance. Brundtland was stark in her warning: 'We risk going down in history as the generation that allowed the hard-won health achievements of the century to be lost.'⁴⁴

In the United Kingdom, the Blair government had issued a White Paper on 'eliminating world poverty' in 1997, and the King's Fund seminar had been a careful collaboration between DFID's health advisory group and WHO to formulate the latter's strategy for promoting a poverty agenda.

While support for health commodities was not new, most national donor agencies were reluctant to commit to such support for TB, malaria, and certainly for AIDS treatment, fearing an expensive commitment with no exit in sight

Malaria, of course, was central to this agenda. So were maternal and child health. In addition, TB was forcing its way onto the agenda. In late 1998, US First Lady Hillary Clinton had organized a meeting in the White House with Brundtland to focus on the rapidly spreading TB pandemic. A year later, the philanthropist George Soros had organized a second meeting in New York. While Soros and his Open Society Institute were concerned about the galloping infection rates in the countries of the former Soviet Union as a result of the collapse of the old communist health systems there, others were warning of the impending catastrophe of HIV/TB co-infection in southern Africa.

There was a growing sense at WHO that at least some basic interventions and technologies were available to tackle these problems on a global scale. Some national success stories, such as Vietnam's 90 per cent reduction in malaria deaths and Peru's arrest of the rise in TB infections over the past decade, suggested that if the lessons from these were applied on a global scale, dramatic progress should be possible.

Yet most disease control programmes were small and national in scale at most – often even focused on a single province or state. Each organization involved in such work jealously guarded the control over its own programme and there was only limited sharing of information.

While support for the supply of health commodities (e.g. vaccines, medicines and diagnostics) with development aid was not new, most national donor agencies were reluctant to commit to similar support for TB or malaria, and certainly for AIDS treatment, fearing an expensive commitment with no exit in sight. Instead, aid was channelled toward building infrastructure and training staff. But with pharmacy shelves empty and minimal salaries for health staff, such 'health system strengthening' efforts had little effect on health outcomes. Such aid, it was felt, was like tinkering with a car's engine while there was no fuel available to get it running.

⁴⁴ See WHO (1999), 'Public Health for a New Era', London, 14 January, http://www.who.int/director-general/speeches/1999/english/19990114_london.html.

Brundtland saw that this deadlock needed to be broken. In a speech celebrating the success of the onchocerciasis control programme in October 1999, she said:

As our world becomes more global, more intertwined and more complex, the clear-cut limits of responsibility between government, the private sector, the international organizations and civil society are blurring. The world is becoming a stakeholder society where all of us have a responsibility for reducing poverty and improving health.

...

We are increasingly moving from our traditional approach, which too often has favoured our own small-scale projects, to one which gives more emphasis to strategic alliances in which we influence both the thinking and spending of other international actors and where what we do fits into a broader picture. It is a question of effective division of labour.⁴⁵

Such multi-stakeholder engagement was already beginning to stir. Nabarro had reached out to NGOs and national governments to work together under the RBM umbrella, but more progress had appeared in another alliance: the Stop-TB Partnership. Created in November 1998, it had rapidly grown in size and ambition. The fight against TB, unlike malaria, could rely on some very well-established NGOs, which drove their own agenda – with the support of the Rockefeller Foundation and the Canadian International Development Agency's director for global initiatives, Ernest Loevinsohn.

In March 2000, a large ministerial TB conference formalized a global plan and called for the establishment of a TB Drug Purchasing Facility, a precursor to the Global Fund, although it was solely focused on procurement and delivery of TB drugs. It was up and running within a year with some initial funding from several donor countries.

In the Stop-TB Partnership, WHO at first took a back seat, until in November 2000 Brundtland replaced the head of the Stop-TB department at WHO, Arata Kochi, with J.W. Lee. Under Lee's leadership, and later through the long-running leadership of Mario Raviglione, cooperation improved to the point where the Stop-TB Partnership has probably become the most effective multi-stakeholder alliance in global health.

In March 2000, Brundtland's Chief of Staff, Jonas Gahr Støre, suddenly left to take up a senior post in a new Norwegian government, and Brundtland asked David Nabarro to replace him. Nabarro, working closely with Andrew Cassels, another former DFID employee who had worked on WHO's new strategy document, determinedly set about creating a global movement for increased funding for TB, AIDS and malaria programmes. Together with their former colleagues at DFID (where Julian Lob-Levyt had taken over the post of health adviser after Nabarro's departure), they set out to achieve political agreement among the G8 for an increase in the resources to fight the three main 'diseases of poverty'.⁴⁶ An intensive consultation process was established between the G8 sherpas, Nabarro and Cassels in preparation for the G8 summit in Okinawa that June. They also aimed to get developing-country buy-in for such an increase and a focus on these three diseases. On the sidelines of an African malaria summit in Abuja in April 2000, the concept of a 'global fund' for the three diseases was mentioned for the first time by Jeffrey Sachs in a discussion with Brundtland, Nabarro and President Olusegun Obasanjo of Nigeria.

Sachs, who was in Abuja to present his findings on the dramatic economic toll of malaria in Africa, argued that investing in fighting malaria, AIDS and TB was like a nuclear reaction. Large amounts of money could be invested without much result, but if investments could be increased to a critical mass, there could be rapid and dramatic improvements. He argued that such an amount meant at least billions of dollars per year over a period of a decade or more, but

45 See WHO (1999), *Speech at Onchocerciasis Roundtable, Geneva, 6 October*, http://www.who.int/director-general/speeches/1999/english/19991006_oncho_roundtable.html.

46 These three diseases were lumped together not only because they hit the poor the hardest, but also because they had the greatest detrimental effect on individual and national earning power.

that it would be a hugely cost-effective investment – both by reducing infections and therefore treatment needs down the road, and because these lower infection rates would improve productivity and lead to economic growth.

Sachs said that neither the bilateral donors nor the World Bank would be fast or flexible enough to channel the large amounts of money that were needed quickly, and that a new, specially designed global fund would be necessary to take on this role.

WHO was ambivalent about such an idea; it was concerned about adding to an already complex global architecture, while at the same time seeing the positive momentum created only months earlier by the establishment of GAVI.

In the end, the G8 communiqué from Okinawa set specific targets for control of AIDS, TB and malaria (foreshadowing the MDG targets that would be agreed some months later); committed members to doing something to improve access to medicines and reduce prices; and referred to a vague commitment to ‘support innovative partnerships’. Most significantly, the communiqué promised to convene a specific health conference in December to maintain the momentum towards a new level of health investments. Japan backed up its commitment with a pledge of \$3 billion for bilateral investments in health over three years.

Health investments had become the human face of globalization that the G8 leaders had so desperately needed, and the United Kingdom, Canada, the United States, Italy and to some extent Japan enthusiastically embraced the initially vague but increasingly coherent strategies for building a new push to invest in fighting diseases of poverty.

Meanwhile Peter Piot, the executive director of UNAIDS, was struggling with the ever louder outcry from activists over the high prices of AIDS drugs. Although activists had pointed out as early as 1996 the perversity that 95 per cent of all those who needed AIDS treatment could not afford it, the successful treatment trials by Médecins Sans Frontières, Partners in Health and the French National Agency for Research on AIDS (ANRS) and its counterpart in Cote d’Ivoire had during 1999 unified the NGOs and AIDS activists around the view that rolling out AIDS treatment on a global scale would be possible.

WHO was ambivalent about the idea of the Global Fund, worrying about adding to an already complex global architecture while appreciating the positive momentum created by GAVI

The northern development NGOs still had some trepidation about the risk that AIDS treatment would overwhelm the capacity of both NGOs and national health systems and suck funding, staff and attention away from other health and poverty issues. And many of the southern NGOs and faith-based charities raised their eyebrows about their newest allies; in-your-face gay and lesbian rights groups from the north. Nevertheless, by the end of 1999 they had united and threatened UNAIDS and anyone else representing ‘the establishment’ that they would not tolerate anything less than a breakthrough in the access question by the time of the 2000 Durban International AIDS Society conference. Given the further provocation caused by South African President Thabo Mbeki’s denial of the causes of AIDS and his refusal to allow treatment through the public health service, the Durban conference promised to be an explosive event.

During the first half of 2000, the World Bank and WHO negotiated with the CEOs of several of the largest pharmaceutical companies about a trial programme to reduce prices for the most important antiretroviral drugs. The programme would begin in five high-burden countries, mainly in southern Africa.

The companies’ concern was not the price *per se*: there was no market anyway for these expensive drugs in the developing world, so it would not hurt them to sell the drugs ‘at cost’ to

some countries.⁴⁷ Their concern was the re-import of cheap drugs to other markets or, more likely, demand from patients in developed countries for the same prices as in developing countries. However, over time this turned into a non-issue for antiretroviral drugs.

The companies were ready to go ahead with this programme but wanted endorsement from the UN agencies. WHO was willing to provide it, but Peter Piot at UNAIDS was concerned about the reaction of the activists and was sitting on the fence. In the end, the 'Five-Country Initiative' went ahead, but given the nervousness both of the companies and of some UN partners, it seemed like a hesitant trial rather than a major breakthrough, and the activists dismissed it as an industry publicity stunt.

Even at low prices, government donors were reluctant to take on open-ended commitments to pay for drugs for any specific disease

Boehringer-Ingelheim separately announced that it would donate its antiretroviral drug, Nevirapine, for any national programme to prevent transmission of HIV from mothers to children.

While the prices of drugs were crucial to deciding how many people could get access to AIDS treatment, this was largely academic for the vast majority of patients who could not afford to pay anything at all. If there were to be any hope that ordinary people in the developing world would gain access, someone else would have to pay.

Even at low prices, government donors were reluctant to take on open-ended commitments to pay for drugs for any specific disease. Even by early 2000, achieving such commitments for AIDS treatment on a global scale seemed utterly unrealistic.

As early as 1997, President Chirac, influenced by Health Minister Bernard Kouchner, had called in Abidjan for a global AIDS treatment fund. Following this, *Le Fonds de Solidarité Thérapeutique International* did come into existence in 1998. This was a precedent of sorts, but it consisted of a few million French francs and could basically only provide funding for trials and pilots.

Bill Gates had entered into an agreement with Merck & Co to pay for a national treatment programme in Botswana, but he was reluctant to give the impression that his billions now would finance a global drug programme. For several years, he actually did not believe that AIDS treatment was a cost-effective intervention and argued against commitments to make such treatment universally accessible. (His stand has shifted over time, as evidence of the ability of people on AIDS treatment to lead productive lives and of 'treatment as prevention' has accumulated.)

Going into the Durban AIDS conference, Piot was agonizingly caught on the one hand between the activists who demanded money on the table immediately to finance drugs, and on the other the key donor countries, which did not want to see expensive, open-ended and unfulfillable commitments made on their behalf. Reflecting this dilemma, UNAIDS dedicated only five out of 135 pages in its 2000 *World AIDS Report* to treatment, and much of those simply to describing the obstacles to widening access.⁴⁸

Brundtland and Piot were caught between the interest of the pharmaceutical industry in protecting patents to secure incentives for the development and production of drugs, and the immediate need for emergency action to make AIDS drugs affordable; and neither had much

⁴⁷ 'At cost' is in itself a highly controversial and in the end nearly meaningless concept, since it is practically impossible for any outsider to judge what a company includes in such a price. The pure production costs? Production plus the investment in production facilities? Any share of research development?

⁴⁸ UNAIDS (2000), 'Report on the Global HIV/AIDS Epidemic', Geneva, June, http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2000/2000_gr_en.pdf.

to offer in terms of new sources of financing for a global roll-out of AIDS treatment. Brundtland – who had endorsed the Five-Country Initiative – was booed by the activists in Durban, while Piot narrowly escaped that fate.

Despite a slew of meetings over the next two years, in the end neither the UN system nor national governments contributed much to the lowering of drug prices and diagnostics for AIDS treatment. Not much, that is, if one discounts the multi-billion-dollar markets that were created by the establishment of the Global Fund and UNITAID, and by the US President's Emergency Plan for AIDS Relief (PEPFAR).

For in the end, the drug price problem was not to be solved by multilateral, negotiated or coordinated action, but instead by a combination of market opportunities (which enabled generics companies to invest in production capacity), competition, public relations considerations in the face of activist pressure (which made the research-based pharmaceutical companies back off from their hard-line stance on prices), and occasional midwifery (such as the Clinton Health Access Initiative's price deals).

Sensing that momentum had begun to build among leading governments to invest in health 'for global prosperity', UNICEF, WHO, UNAIDS and the World Bank got to work to make sure the generalized commitments of the G8 communiqué could be turned into specific action by the December Okinawa follow-up conference.

David Nabarro and David Heymann, who was executive director for the Infectious Diseases Cluster at WHO, were concerned to ensure that the G8 countries' commitment became something more than marginal bilateral increases and 'double-counting' of existing initiatives. They saw the need to build a broad alliance to drive the momentum forward, especially in ensuring that new and truly additional resources would be committed. Heymann had engaged Kraig Klaudt, an effective TB advocate, to help him with his communications work, and Klaudt came up with the idea for a broad advocacy campaign that should argue for at least \$3 billion per year for a concerted effort to fight AIDS, TB and malaria. This campaign, which soon became known as the 'Massive Effort', was launched in October 2000. But rather than becoming a unifying force, it immediately demonstrated how difficult it was going to be to create a joint alliance for such a broad, global push.

UNAIDS was unhappy that AIDS was lumped together with TB and malaria as a 'disease of poverty' and wary of WHO's prominence in advocacy for AIDS issues, which it saw as its own domain. UNICEF and the World Bank were expecting a more traditional, operational collaboration and were concerned about the advocacy nature of the campaign. While many NGOs were pleasantly surprised that the conservative WHO now touted slogans and used activist language in its press releases, MSF in particular was suspicious of the campaign and worried it would draw attention away from what it saw as the most important task of the time: the fight against pharmaceutical companies over patent rights and price reductions.

Soon enough, WHO itself realized that its mandate and responsibilities were incompatible with running an advocacy campaign for more funding, and the Massive Effort was spun off as an NGO. Klaudt and his allies continued their advocacy and were to provide valuable communications support for the Global Fund once it was up and running, but WHO's foray into activism became little more than a brief and ill-advised expression of the excitement and impatience that now drove the main actors forward.

Nevertheless, real progress was being made in closed meetings between the UN agencies and the World Bank, and in meetings between these and some of the G8 nations' health advisers, especially those of the United Kingdom, Canada and Italy, in preparation for the December 2000 Okinawa conference.

In fact, several G8 countries, the European Commission and some EU members such as Sweden and the Netherlands had recognized that an unprecedented will to tackle the challenges of infectious diseases was sweeping the capitals of industrialized and developing countries alike. President Obasanjo of Nigeria had brought a strong African voice to the call for a new offensive in health. The G8 targets agreed that September for reduction in AIDS, TB and malaria deaths, as well as the Millennium Development Declaration, were inspirational

and blew a wind of urgency that reached even into the prime ministers' and presidents' offices around the globe. Document after internal document in London, Ottawa, Rome, Brussels and elsewhere started with the sentence 'health is essential for development' in one form or the other. The European Commission laid out a strategy for fighting AIDS, TB and malaria and promised additional money to back it.

In November, Nabarro informed Brundtland that some of the G8 nations would want to announce new funding commitments at the Okinawa meeting but that they were suggesting such new funding should be channelled through a 'new and more streamlined mechanism that enables funds to reach countries and communities who need them' in order to 'increase the impact of existing policies and programmes'.⁴⁹ Such a mechanism was to be hosted and managed by a 'UN system agency' or it could be a joint venture with several agencies. It should also engage the private sector.

The main aim of announcing such a mechanism in Okinawa in December seems to have been so that the G8 could be seen to 'do something' concrete and that Japan could take the credit for it during its presidency. A 'longer-term' solution was to be discussed at the G8 summit in Genoa the following year. There was only one problem with this: Japan was not one of the countries behind the idea and its firm opposition meant that no announcement was made at the Okinawa meeting.

For some UN agencies, in particular UNDP and UNICEF, as well as for the World Bank, this donor-country enthusiasm for a new mechanism was at first disheartening. Not only did it signal a lack of confidence in existing multilateral channels for aid; it would probably mean that a new, big and shiny competitor for multilateral funding in other fields would soon appear on the scene.

For UNAIDS and WHO – which were not in the business of distributing large amounts of development funding anyway – this was exciting news. Both organizations set to work to facilitate and coordinate the many discussions that were now taking place around the globe.

For some UN agencies, in particular UNDP and UNICEF, as well as for the World Bank, this donor-country enthusiasm for a new mechanism was at first disheartening. Not only did it signal a lack of confidence in existing multilateral channels for aid; it would probably mean that a new, big and shiny competitor for multilateral funding in other fields would soon appear on the scene

The months from January to July 2001 were possibly the most intense period of political thinking, planning and consultations on global health ever seen. In addition to the United Kingdom, Italy, Canada, Sweden and the European Commission were hosting meetings to thrash out what a new fund could look like. The transition from the Clinton to the Bush administration meant that the United States, preoccupied with establishing the new presidency, did not participate actively in these discussions.

While some disagreements were still apparent by the time UN Secretary-General Kofi Annan publicly called for the creation of such a fund in late April (UNAIDS was still holding out in that month for an AIDS-only fund; Italy and WHO wanted it to be a broad health fund stretching beyond AIDS, TB and malaria; the United Kingdom wanted predominantly a commodity fund), what is striking is how quickly the main outlines of the new fund were agreed, given what a radical departure it represented from the past.

⁴⁹ Internal briefing document from Nabarro to Brundtland, November 2000.

Inspired by Annan's UN Global Compact, created the previous year – and by GAVI – there was general agreement on (and high expectations for) private-sector involvement in the new fund, both from corporations and foundations. It was agreed that a significant part of the fund's resources should go toward buying commodities. It was also agreed that the fund should have a governance structure that included civil society as well as the private sector, and that developing countries should be heavily represented, in contrast to other multilateral funding mechanisms, where donor countries dominated. It should be 'light' with a small secretariat, and it should rely on the services of UN agencies and other partners to execute its mission.

One agreement among these parties was surprising: the new fund should only spend a minimal amount on financing AIDS treatment. In the position papers of all the major initial parties, it was stressed that the fund should focus on paying for prevention activities, non-health HIV-related activities and palliative care for AIDS patients, but antiretroviral treatment should be limited to a minimum.

This was less strange at the time than it may seem in retrospect. While several initiatives were chipping away at antiretroviral drugs prices, treatments still cost well over \$1,000 per patient per year, even in Brazil, where the government had produced several of the drugs and negotiated good deals on imported ones.

There was also a much wider scepticism in governments and in multilateral agencies than they wanted to admit in meetings with AIDS activists about the feasibility of rolling out AIDS treatment in the poorest countries. It was one thing that the Harvard-based Partners In Health could successfully administer treatment to some hundreds of patients under strict surveillance in Haiti. It was another thing altogether to open the door to nationwide treatment programmes in countries that could not even manage to distribute rehydration salts to clinics to treat children for diarrhoea.

These officials were worried that AIDS treatment would suck money away from other programmes, and that ill-conceived and rushed treatment programmes would create a galloping drug resistance problem. However, after USAID Administrator Andrew Natsios had voiced these concerns in a particularly inept way, nobody else was willing to speak publicly about this issue.⁵⁰

In fact, the documentation around the planning of the new fund reveals that, while concern over the AIDS pandemic was a major driver to create a fund, the activists' demands for a an 'AIDS treatment fund' did not rank high among the concerns that drove the discussions during the first half of the year. It was only at the UN General Assembly Special Session (UNGASS) on AIDS that activists forcefully voiced their treatment demands in the context of the new fund, and even then the other parties (governments and multilateral organizations) held back.⁵¹

The activists had first been alerted to the plan of an UNGASS dedicated to the AIDS pandemic at the UNAIDS Programme Coordinating Board in December 2000. The possibility that donors were willing to finance a new health fund (which activists immediately took to mean an AIDS fund) became clear as the NGOs prepared for the UNGASS through the International Council of AIDS Service Organizations (ICASO), which had coordinated a global response since 1991.

Richard Burzynski, who headed ICASO at the time and had the unenviable task of negotiating a unified position, from the NGOs to the UN, about the new fund, saw it as the treatment fund the activists had waited for since 1996. Activists who for years had scraped together unused antiretroviral drugs from patients in the West and sent them to patients in developing countries to save at least a handful of lives were in no mood to hear about a fund for prevention and care. It even took some convincing for them to accept that the fund should also focus on malaria and TB.

50 On 7 June 2001, Natsios told the *Boston Globe* that many Africans 'don't know what Western time is. You have to take these [AIDS] drugs a certain number of hours a day, or they don't work. Many people in Africa have never seen a clock or a watch their entire lives. They know morning, they know noon, they know evening, they know the darkness at night.' See *Boston Globe*, 7 June, p. A8.

51 See Hale, P. et al. (2001), 'Success Hinges on Support for Treatment', *Nature*, Vol. 412, No. 6844, 19 July, p. 272.

Back in April, the discussions about a new fund had reached an impasse and almost failed as nobody could agree on a 'convener', someone who could turn the informal discussions into proper negotiations among formal parties. Unfortunately, the relationship between Brundtland and Piot had grown tense over their disagreements about the Five-Country Initiative and now on whether the new fund should focus solely on AIDS or on malaria and TB as well. Unhappy about this lack of unity, the EU, the United Kingdom and others were unwilling to let WHO or UNAIDS take the lead. The non-G8 countries did not want the new fund to be solely a G8 initiative (knowing full well that they would still be asked to contribute significantly to it), so Italy (which held the G8 presidency) could not take the lead.

However, Brundtland, concerned that the new fund could end up being set up outside the UN system altogether, sensed that she had Kofi Annan's support for her main ideas, and in early April she proposed (through Nabarro) that the UN secretary-general call for the new fund and take the role as a convener for the process.

This proposal got the support of most of the countries involved in the process. It also secured buy-in from several African leaders, and later ensured the trust of the NGOs and activists. Only one party did not like the central role of the secretary-general: the United States.

The Bush administration (having been preoccupied with the fight over the hung election in what would have otherwise been a planning and transition period) had come late to the discussion, and its starting point was very different from those of the other countries inside and outside the G8. It had little time for the poverty-reduction thinking of the United Kingdom or the solidarity concept of France, and tended to regard the UN and its many agencies as a slow bureaucracy that was at best indifferent and at worst hostile to US interests (these positions would evolve significantly over time, but they were fairly strong as the Bush staffers faced off against the UN in 2001).

Bush's interest in global AIDS (and, more specifically, AIDS in Africa) stemmed from a religious concept of compassion and charity. Bush had noted US Senator Jesse Helms' recent 'conversion' to the cause of helping the 'innocent victims' of the AIDS pandemic, i.e. the women infected by their husbands, their children and the orphans. It fitted well with Bush's position as a 'compassionate conservative' during the election campaign (and it would soon serve well as the soft-power side of a foreign policy that after 9/11 increasingly relied on military force to further US interests).

The White House seized the opportunity for a good PR event; Bush trumped the international efforts that had gone on for months by announcing the support for a new fund and pledging \$200 million for it at a ceremony in the Rose Garden at the White House during a visit by President Obasanjo in May.

The US proposal for the fund was not very divergent from what the other countries and agencies had negotiated among themselves, but there were differences in emphasis that were to prove challenging as the details were hammered out. Among them were an envisaged larger role for the private sector in the fund (the United States originally expected that the private sector would match the government contribution dollar for dollar), the insistence that the fund should respect and promote intellectual property rights (although it could purchase generics where these were in undisputed use) and an emphasis of this as a G8 initiative rather than a UN one.

The first meeting by all interested parties was hosted in Geneva by WHO in early June, and a second meeting took place in Brussels after the UNGASS in July. By then, there was agreement on organizing a Transitional Working Group (TWG) that would be led by Chrispus Kiyonga, Uganda's minister of health, and meet in Brussels during the last months of 2001 with the aim of having the fund up and running by year-end.

While the creation of MMV and GAVI could be hammered out in the relative simplicity of small working groups consisting of mainly private-sector and UN agency representatives (and working for a year or more), the negotiations over the new fund's shape and principles were an altogether larger, more public, political and therefore also considerably messier affair. Given the many camps with an important stake in the new fund (the TWG consisted of nearly 40 people, each of whom had to consult with often global constituencies or government departments), it is impressive that the work could be completed between September and December 2001.

It was only by October that the new fund finally got its name, the Global Fund to Fight AIDS, Tuberculosis and Malaria, settling the tug of war about what it should finance.⁵²

The funding principles borrowed heavily from GAVI, and the French AIDS Treatment Solidarity Fund, with applications being evaluated by a technical review panel that would recommend fundable programmes to the board. However, given that the fund would finance a number of interventions (some of them not even health-related) for each of three diseases, and that it was aiming to fund the public, the private and the NGO sector, the review process was necessarily going to be considerably more complex.

The board composition reflected mostly a US position, with two seats each for the private sector and civil society, and with the UN organizations initially sidelined by being given just two non-voting seats.

While the United States had no interest in a formal UN involvement but insisted that the World Bank would handle the fiduciary arrangements, the Europeans demanded some formal tie to the UN. This conflict was resolved when the Swiss government offered the new fund status as a Swiss foundation (as it had with MMV and GAVI), and WHO offered to provide administrative services (for a fee and for a limited time period) that would enable staff and actions of the new fund to enjoy UN immunities and privileges. (Brundtland, against the urging of some of her staff, did not fight for the fund to become a part of WHO, something the Americans would never have accepted.)

The WHO administrative agreement would also ensure UN-style accounting and oversight, which was a condition required by most European donor countries to trust this new fund with billions of dollars.

With the Gates Foundation's pledge of \$100 million and the Credit Suisse banking group's donation of \$1 million up front, there was a strong expectation that the Global Fund would become the second (after GAVI) and largest global effort to be jointly financed between the private and public sectors.

By mid-December, the TWG dissolved itself and delivered the structure it had agreed on to the Global Fund's board. The board, holding its first meeting in late January 2002, inaugurated the fund almost exactly six months after its creation was announced at the Genoa G8 summit.

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Never before had a major global financial institution been created with such speed, nor had an institution managing billions of dollars for development from (mainly) public donors ever been created outside a treaty arrangement and (mainly) outside the UN system. No such institution had ever been governed by a board that had equal representation from donors and implementers of the funding, and never before had civil society and private-sector entities had voting power on such a board.

The dissolution of the TWG was, however, also the end of the harmony and goodwill – and relative unity – that had enabled such a quick design period. When everybody finally stepped back and took a look at the new fund they had created, almost nobody was happy.

⁵² The name, while descriptive and accurate, has been a continuous branding challenge with its cumbersome length and its financial-sector connotations. 'The Global Fund does good work but you sure as hell are no poets,' was Bono's comment (to the author) on the name.

The price of the speed with which the Global Fund had been created was that consultations had been narrow and short. The enthusiasm for innovation and bold new thinking among those individuals engaged in the process was in many instances not shared by their superiors, peers or wider constituencies.

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Adding to this was the fact that, while the TWG had been at work in Brussels, the world had fundamentally changed. Until 10 September 2001, the overarching and dominating focus for all the G8 leaders for the coming decade was to ensure steady, predictable, global economic growth and better share the world's growing prosperity by finally eliminating extreme poverty. By 12 September, fighting terrorism had taken over as the predominant focus of these leaders, and as this fight evolved, the unity among the leaders would crack and splinter.

Before the TWG could announce the design of the new fund, a war was raging in Afghanistan, and during the first year of the fund's existence, the unity from Genoa had been replaced by an increasingly polarized and bitter dispute over Iraq, the UN's role in world affairs and the wisdom of dividing the world into 'enemies and allies'.

Against this new background, the first, constituting board meeting of the Global Fund did not go well.

Factions disappointed with initial result

France (and several other European countries) was dismayed at what it saw as a fund created in an 'Anglo-American' image and did not know what to make of the strange board onto which it had been thrust. It immediately voiced its displeasure during the first board meeting in January 2002 by characteristically demanding that the fund should operate in fully bilingual (French and English) fashion. Many others around the board table thought that acceding to this demand would put an end to 'the light touch' and the minimal secretariat function the fund was meant to have, and it promptly threw the board into its first crisis. Only after the Chinese board member insisted that the fund should operate either in English only or in all six UN languages did the French give up.

The UN organizations were deeply disappointed that rather than enhancing a UN-led global effort to fight the three diseases, the new fund appeared to become an independent competitor in terms of funding and authority. Knowing well the power of money, they saw the Global Fund as a real threat to the UN system's leading role in the global health effort – rather the opposite of what they had hoped when they started the process.

As the fund got up and running, it also became clear that countries would need substantial amounts of technical assistance, and in particular WHO's country offices bristled at having their priorities changed for them by the force of Global Fund financing. WHO, and to a lesser

extent UNAIDS, began to complain of the large ‘unfunded mandate’ that was imposed on them. Funding for technical assistance was very much built into the Global Fund model, but many countries did not think it was right that they now should start paying for assistance from UN agencies, even with Global Fund grant money, since they had never paid for in the past. It also became apparent that WHO’s ability to provide high-quality technical advice varied widely from country to country, and in many instances, WHO lost out in such a ‘market situation’ to NGOs and academic institutions, which delivered better value for money.

Ironically, it was UNDP, which agreed to become a Principal Recipient ‘of last resort’ for Global Fund grants, which found the fund to be a financial windfall. Soon, the Global Fund had become a major source of finance for more than 20 of UNDP’s country offices.

The World Bank felt bruised throughout the process, having served very much as the ‘negative example’: the process-heavy, top-down, dictatorial and slow funder the Global Fund had been created to bypass. Knowing a thing or two about managing funds and administering aid flows, it scoffed at the idea that 10–15 people with no experience over in Geneva would be able to manage the billions of dollars that the fund confidently asserted would flow through it over the coming years. It approached its trustee role as something it would do at the minimal expense of intellectual and staff resources.

The developing-country governments felt rather bemused by all this activity supposedly on their behalf but into which they had had minimal input. Most implementing health ministers were sceptical of the prominent role civil society had been given in running national health planning by sitting on the country coordinating mechanisms (CCMs). They saw national planning and resource allocation as the exclusive domain of their own ministries. For many health ministers, the CCMs would become a major source of friction.

The Gates Foundation was rather appalled at the political nature of this new institution. It had been led to believe the Global Fund would be similar to GAVI but it looked nothing like it. Hearts were sinking among delegates from the private sector and private foundations during that first board meeting when they saw the worst of UN-style bickering (about official languages) hijack several hours of the agenda. The Gates Foundation had taken a backseat role in the design of the new fund, feeling that this new institution was altogether too large, too complicated and too political to be one of its core investments. It was also wary of any hopes or expectations that it should somehow be a majority funder for the Global Fund as it was in GAVI. Bill and Melinda Gates saw themselves as funders of innovation and entrepreneurs for new solutions in health, not as the world’s back-stop for broken national promises of increases in foreign aid.

Only the United States and the NGOs were reasonably pleased with the new creation. For the Americans, it was because it looked not too different from the original idea that Ken Brill, the US Ambassador to the UN, Bill Steiger, the Department of Health and Human Services’ international affairs adviser, and others had presented to Kofi Annan in early May 2001. But the Global Fund had already become peripheral to American interests. In line with the Bush administration’s rapidly escalating distrust of multilateral institutions and approaches, Washington was already drawing up the plans for a US-only initiative to fight AIDS (and later also malaria), of a size and a scope that, in its view, would render the Global Fund secondary and relatively unimportant.

The NGOs were therefore the sole genuine supporters of the new fund, because they were for the first time sharing the driver’s seat of an organization that would be able to channel the long-awaited billions of dollars to the people they cared about.

Conceived by a hundred fathers, the Global Fund was thus largely orphaned at birth. That was a shame for many reasons, not the least because its design was barely half-finished. There were no policies and hardly any guidance for how grants should be disbursed, managed and reported. There was no oversight mechanism to control facts and figures. There were no policies for what to do when a grant came up for evaluation of results after two years, or for the procedure for cutting funding if results were lacking or unacceptable. There were no policies on procurement. And there was little idea what CCMs should actually look like and how they should work in practice. To make it all worse, there was only a handful of staff and – looking to GAVI as a gauge – an expectation that the secretariat should never grow beyond 20–30 people.

And yet there was a ferocious pressure to get going. The only way this orphan could prove it was worth keeping alive was to deliver on its mission. By February, the first call for applications had been issued. And instead of a few dozen envelopes arriving in response to the call, the small Global Fund secretariat had to clear out a whole office to stack the hundreds of applications – many several folders thick – it received in response. In April, the first \$550 million were awarded for 'Round 1', and by December, the first three grant agreements had been signed and disbursements had been readied for Haiti, Ghana and Tanzania.

As with GAVI, many of the policies that made the Global Fund such an innovative institution were actually developed as the organization tried to cope with the practical challenges of managing grants.

By far the most important and revolutionary of these policies came as an unintended by-product of the rounds-based grant system. What few had really contemplated during the rushed days of the TWG was that there is a difference between using calls for proposals to solicit research proposals and using it to finance every credible intervention for preventing and treating the three largest pandemics of the world. What the Global Fund basically said to about 145 eligible countries was 'let us know what it will take to deal with these pandemics and we will see if we can finance it'.

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This demand-driven funding model did two major things to the world of global health and development assistance: it shifted the attention from the relatively abstract and theoretical 'needs' figures regularly issued by UNAIDS and WHO to a measure of a much more concrete 'fundable demand'; and it created a moral and feasible case for raising the necessary funding. It is easy for any donor government to scoff at someone who says '\$40 billion is needed annually to deal with the global AIDS epidemic'. It is considerably more difficult to wave away someone who tells you 'we have a billion dollars' worth of programmes ready to go, vetted by health experts and found to be sound. They will save X hundred thousand lives, so please come up with the money.' Not that the technocrats in many of these governments did not still try to dismiss such appeals, but every time they did, the NGOs (and the Global Fund secretariat) rather unsubtly reminded everybody that lives would be lost as a consequence of any withholding of funding.

The way in which the Global Fund's rounds of applications provided the world with a measure of realistic fundable demand, broken down to the extent that one was able to count the bed nets that would be delivered and the number of AIDS, TB and malaria treatments administered – and thereby attached a moral imperative to funding this demand – was probably the single most significant reason behind the dramatic rise in spending on the pandemics over the past decade.

The funding model: Global Fund vs PEPFAR

While the funding principles of the US President's Emergency Plan for AIDS Relief were very different, the public and very heated debate over Global Fund financing and the unspoken but very real competition about which of the two funding streams could ensure more lives saved through treatment also influenced the ambition level and funding for PEPFAR.

On two occasions the power of the Global Fund's model became particularly apparent for all to see: at its board meeting in Arusha in November 2004 the representative of the communities

of people living with HIV, TB or malaria, in one withering speech, managed to turn around a firm position taken by the US delegation, supported by a number of other board members, to postpone the launch of the fifth round of financing by holding the members personally responsible for the thousands of people who would die because of such a delay. As a result of the decision to fund a new round of financing after all, the need for an additional \$730 million was presented to the donors. And at the board meeting in New Delhi in November 2008, the board decided to approve a near tripling in the amount for new grants (previous rounds had cost around \$1 billion per year; Round 8 would cost nearly \$3 billion, all in) after ferocious, all-night lobbying by the implementer bloc of the board, supported by the private-sector and foundation members.

This funding model also provided an answer of sorts to the perennial question of ‘absorptive capacity’. As long as there was very little money to go around, many – donors in particular – were fond of speculating on the extent to which countries with weak health systems really were able to make use of new resources rapidly in an effective way. ‘Not that much’ was a favoured response by the many who saw the Global Fund’s approach as an invitation to waste.

The Global Fund answered that question by disbursing money when the implementing countries were ready and when they could prove results for what they had already received. Clearly, some countries were overwhelmed by the amount of money they received and struggled greatly to make efficient use of it. Malawi stands out in that category. And there have been egregious examples of waste in some cases, such as \$10,000-per-month administrative salaries and fleets of expensive vehicles being financed by Global Fund grants. There have also been cases of misuse of funds (although at a scale nowhere near what media attention led one to believe). However, for every case of waste, there is at least one of success, where countries have been able to scale up health services dramatically, in many instances also producing benefits far beyond the three pandemics. Ethiopia, Rwanda, Tanzania and Lesotho are only some of the most outstanding. Other success stories are subtler in that they have taken place in countries with small and more localized pandemics, but where Global Fund financing has protected and strengthened vulnerable groups and limited the spread of concentrated epidemics.

If one is to compare the investment made through the Global Fund to the cost of health services in industrialized countries (not to mention the scale of waste and inefficiency in them),⁵³ the \$17.2 billion the Global Fund has disbursed to date is not an overwhelming sum, given that it has been spread over ten years and 145 countries.

Local Fund Agents (LFAs) were an improvised response to the question of how the Global Fund – with its one office in Geneva – would oversee the grant management and verify results reporting from its eventually 145 implementer countries. This invention was as problematic as it was ingenious. Provided by the consultancy firm McKinsey in the spring of 2002, it is the single most ‘private-sector-inspired’ feature of any of the public-private partnerships at the time. The idea was that instead of establishing country offices itself or relying on the World Bank or other agencies to act on its behalf, the Global Fund would tender out contracts for such oversight commercially.

Although several board members and other stakeholders have complained over the years about the costs of such an arrangement (the LFA budget for 2012 was approximately \$84 million), it most probably compares favourably with the cost of setting up 145 country offices.

However, the arrangement soon revealed its weaknesses. The accounting firms that won most of the contracts (UNIDO and the Swiss Tropical Institute also won some tenders) were not well equipped to do much of the health-data verification, and – more worryingly – in some cases refrained from providing critical reports to the Global Fund secretariat to protect its business relationships with the government.

⁵³ In a recent report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (National Academy of Sciences, September 2012), the Institute of Medicine calculates that waste in the US health system was \$750 billion in 2009.

Over the years, many of the initial problems have been overcome, and had donors continued to adhere to the original vision of the fund as a ‘light-touch’ financing institution, the LFA system might have become an elegant way of balancing cost and oversight.

However, from 2005 onwards, the United States, followed by other donor countries, began to require an increasing level of control and accountability for Global Fund grant spending, soon demanding to know practically how every single dollar had been spent. While the political expediency of such demands is easy to comprehend, it ran counter to the original vision of the fund as having a ‘light touch’ and has led to near-paralysis in the management of grants over the past two years.

The Global Fund was designed for an extremely radical idea: that funding in should equal results out (in terms of health outcomes) and that what happened in the middle was pretty much the countries’ own business. That idea presupposes a number of conditions: that there is a ball-park, accepted agreement on unit costs for delivery of different services (so one can roughly calculate what a reasonable price is for, say, procurement and distribution of 10 million bed nets); that there are functioning systems for measuring results and health outcomes in every country; and that countries by and large are honest – or at least that they will police and punish any dishonesty among those involved in the grants.

Of course, none of this is fully the case, even in the best-functioning country. And so the Global Fund’s overarching dilemma has been to harmonize the idealism of its model with the realities on the ground.

A third, controversial innovation was the Global Fund’s decision in 2005 to measure results in terms of lives saved and attempt to produce as exact a calculation of that measure as possible, based on assumptions about the consequences of the interventions it financed.⁵⁴ The methodology was peer-reviewed and repeatedly revised on the basis of input from WHO and others, but concerns have persisted about the built-in assumptions and the right counterfactuals for comparison.

However, the concept has had a significant importance in terms of advocacy since it is easier for a lay audience to understand than DALYs and is very evocative in showing a concrete return on investment. It has therefore been picked up over the years in one form or another by several other agencies and institutions.

The Global Fund’s overarching dilemma has been to harmonize the idealism of its model with the realities on the ground

Possibly the Global Fund’s largest missed opportunity has been its inability to harness its enormous purchasing power to influence markets. From the start, the fund was seen as a supporter of countries’ own efforts to build capacity and strengthen their institutions. Each grant recipient therefore manages its own procurements and in doing so should over time strengthen its national procurement systems. The capacity-building argument was strongly defended by the majority of the implementer board representatives and won out in most board discussions during the fund’s first years. The priority given to country-controlled procurement helped build procurement capacity in many countries (although it is an open question how sustainable such capacity was and how widely it reached into a country’s overall health procurement system), but it came at a cost of fragmenting procurement into hundreds of small orders.

⁵⁴ For the sake of full disclosure, the author conceived of the concept of ‘lives saved’ in collaboration with Bernhard Schwartlander in our positions as the Global Fund’s director of communications and director for evidence, strategy and policy, respectively.

Had a solution been found early on to coordinate and pool procurements, the Global Fund could have played a substantial role in driving down prices, providing market guarantees and therefore influencing production and development of new drugs and commodities. Instead, it has had to concede that role to UNITAID, which in large part found its niche by exploiting the Global Fund's 'failure' in this area.⁵⁵

The issues of technical assistance have been left unresolved at a structural level and in practice have fostered a number of ad hoc solutions that have worked more or less satisfactorily, depending on the area of work, country and point in time. With the traditional UN partners initially unwilling to take on what they considered a large 'unfunded mandate', a burgeoning market of consultants from the private sector, NGOs and academic institutions filled the vacuum created by the UN agencies' early reticence. Interestingly, the RBM and Stop-TB partnerships have been highly effective in coordinating and facilitating technical assistance for Global Fund implementers; much more so than WHO on its own. In fact, the Global Fund's financing provided a renewed focus and impetus for collaboration within these partnerships, in particular for RBM, and they have become invaluable parts of the sub-architecture in global health that has grown up to ensure effective use of Global Fund resources.

Through its size, the breadth of its mandate, the radicalism of its founding principles, and the 'build-the-road-as-you-go' approach to its own design, the Global Fund has been a continuous battleground and a laboratory for how to modernize development assistance in the 21st century

While the Global Fund – as opposed to GAVI – did not include separate funding channels for WHO, UNAIDS, UNICEF and other UN agencies for a formalized provision of technical assistance, a growing number of donors have over time earmarked money for this, either as a part of what they provide for the Global Fund or in addition. Moreover, the increasingly close collaboration between PEPFAR and Global Fund programmes on the ground has meant that PEPFAR has taken on a large role in providing technical assistance that also benefits Global Fund programme outcomes.

Through its size, the breadth of its mandate, the radicalism of its founding principles, and the 'build-the-road-as-you-go' approach to its own design, the Global Fund has been a continuous battleground and a laboratory for how to modernize development assistance in the 21st century. It has constantly tried to balance the sometimes incompatible ideals of country ownership and efficiency, control and independence with varying degrees of success. However, a small number of individuals during the first decade of its existence played crucial roles in bridging the gaps and finding workable compromises. The Norwegian and Swedish AIDS ambassadors Sigrun Møgedal and Lennart Hjelmaker, the Foundation representative Todd Summers and the NGO representative Asia Russell stand out as individuals who, through their commitment to the Global Fund's success and their ability to find common ground, enabled the Global Fund to survive its many bitter conflicts. The existence of such individual intervention should not be underestimated when the necessary factors of success are evaluated.

⁵⁵ During the course of 2004, Novartis was practically begging the Global Fund to come up with a system for procurement of ACTs that could allow for a more solid indication of future demand. Executive director Richard Feachem, unable to get the board to agree on any such system, had to decline.

5. FINDING THE MONEY: INNOVATIVE FINANCING, UNITAID AND AMFm

With the creation of the Global Fund, most people in global health seem to have thought there had been enough innovation for a while. In fact, some felt the proliferation had gone a bit too far and that the global health architecture was getting too complicated. The first redundancy became clear when the Global TB Drug Facility found itself overlapping greatly with the TB grants of the Global Fund, and as a result found it hard to raise money. It is considerably harder to close an institution than to create one, however, and the TB Drug Facility has over time developed a very useful role as a technical partner and procurement agent, rather than as a financing institution.

While innovation *in* health slowed down by 2002, innovations *for* health continued to flourish. The focus shifted from creating new health partnerships towards novel ways of raising money for the existing ones, as well as for the significant commitments the world's countries had made through the Millennium Declaration, and that the G8 had made in several of its summit declarations.

With the exception of private foundations, the private sector turned out to provide nowhere near the amount of money the creators of the Global Fund had expected. By 2012, total direct corporate donations to the Global Fund stood at \$45.5 million out of a total of \$24.3 billion. Of this, \$38 million came from a single donor.

Governments that had enthusiastically embraced the new public-private partnerships with an expectation that they would ease the pressure on public-sector development assistance felt let down.

The new institutions felt the pressure. By 2004, they were busily exploring ways of extracting large sums from new sources. A number of ideas were tested: private-sector transaction fees (e.g. a small, voluntary sum added to phone, hotel or credit card bills) were a favourite, but it was notoriously difficult to get private companies to agree to them.⁵⁶ Private bond-issuing arrangements were explored, as were lottery returns.

The new institutions did not have the staff to seek contributions from individual citizens, nor did they want to compete with the NGOs and UNICEF, organizations on which they were very dependent as partners and which relied heavily on individual contributions for their livelihood.

With the exception of private foundations, the private sector turned out to provide nowhere near the amount of money the creators of the Global Fund had expected

In 2007 the Global Fund came up with a novel way of brokering debt forgiveness and splitting the benefit between its programmes and the indebted countries' own coffers. If a creditor country forgave debt for, say, \$100 million, \$50 million would go to the debtor country as a saving, and \$50 million would be paid by the debtor country against its receipt of a Global Fund grant. This arrangement, which became known as 'Debt2Health', worked well, but only for the limited number of countries that had the suitable type of debt (serviced, government-to-government debt) and a willing creditor country (Germany has been the leading actor in this programme).

⁵⁶ The battle stood often between 'opt-in' and 'opt-out' schemes. In an opt-in scheme, customers would have to tick a box to participate; in the opt-out, they would have to tick the box only if they did not want to participate. The difference was generally 1–5 per cent versus 80–90 per cent compliance, but few corporations have so far been willing to risk their customer goodwill by agreeing to a major opt-out scheme.

The rock star Bono, working with his friend Bobby Shriver, came up with a transaction-fee-based scheme that relied on an ingenious combination of marketing, corporate social responsibility and rock-star cool. Called 'Product Red', this was based on the assumption that if customers were given the choice between two products of equal value at the same price, they would choose the one that in addition would do good. A number of companies signed on (probably as much for the chance to use Bono and a large stable of celebrities in their advertising as for altruistic reasons), and the scheme has raised nearly \$200 million for the Global Fund since its launch in 2006, more than any other consumer-based charitable donation scheme.

It has become clear that the private sector cannot provide an alternative – or even a considerable complement – to public-sector funding

However, it has become clear that the private sector cannot provide an alternative – or even a considerable complement – to public-sector funding. The United Kingdom and France, in particular, have therefore sought other ways to finance the greater demand for funding in global health, beyond their increases in development assistance.

GAVI was the focus of two of the most significant of these innovations: the International Financing Facility for Immunization (IFFIm) and the Advance Market Commitment (AMC) for Vaccines. Both were promoted by the staff of Gordon Brown while he was the UK's Chancellor of the Exchequer.

IFFIm was originally a pilot for a much larger idea of front-loading tens of billions of dollars through the bond markets to finance the Millennium Development Goals. While the larger scheme has been shelved, the more manageable idea of raising funds through a bond issue, which would be guaranteed by national governments, has so far raised \$2 billion in cash for GAVI. Nine governments have now joined the original IFFIm partners, France and the United Kingdom.

The Advanced Market Commitment is exactly what the name indicates; an arrangement where donors commit funds to buy a vaccine once it has been developed. In exchange, the vaccine manufacturers agree to develop and provide the vaccine at an affordable price. The idea of such a commitment has been around for a long time, but it was only with GAVI that a sufficiently solid and trustworthy framework was put in place to allow both donor countries and manufacturers to commit.

So far, the AMC has been used to bring to market pneumococcal vaccines against pneumonia, speeding up the distribution of such a vaccine to the poorest countries by at least a decade.

While Brown in the United Kingdom was working on bond issues and advance market commitments, in France President Chirac was exploring the possibility of using global transaction taxes for development purposes.⁵⁷

⁵⁷ While the analysis of Chirac's motivation for the tax is mainly based on the author's presence at a conversation between then Global Fund executive director Richard Feachem and President Chirac at the Elysée Palace in June 2003, the subsequent paragraphs are based predominantly on Philippe Douste-Blazy's account of the origins of UNITAID in Douste-Blazy, P. and Altman, D. (2010), *Power in Numbers: UNITAID, Innovative Financing, and the Quest for Massive Good* (New York: PublicAffairs Books).

UNITAID

The idea of UNITAID was born at the discussion of options for a French push in March 2004 to help achieve the MDGs. President Chirac wanted to show that France – and he himself in his final term – could make a major contribution. At a time dominated by his battle with President Bush over Iraq, Chirac wanted to challenge the US vision of the world as fundamentally a place of conflict between good and evil. His own view of the world, which he very much wanted to promote to counter US assertions that he was ‘on the wrong side of history’, was of a place where solidarity and joint development were the solutions to move towards a stable and secure future.

Chirac had engaged a group, led by the French governor on the board of the European Bank for Reconstruction and Development, to find an innovative way to finance such an initiative, and its proposal was to introduce an international transaction tax. Since it seemed too difficult to get agreement at the time on a tax on financial transactions – the Tobin tax⁵⁸ – Chirac’s advisers proposed air travel as another global activity that could fairly easily be taxed.

Chirac asked Philippe Douste-Blazy, who was the minister of health at the time, to explore how such a tax could work and what it could best be used for. The idea gained little support outside France, however, and nothing happened until Douste-Blazy, a year later, had been appointed foreign minister and was again asked by Chirac to build international support for the idea.

Given his own background as a doctor and a health minister, and Chirac’s strong support for the fight against AIDS, Douste-Blazy believed any new air ticket levy should be used in support of the health-related MDGs. In 2005 Clinton urged him to use the tax revenue to influence the market for medical drugs by providing purchase guarantees, buy large volumes and thus encourage new products and lower prices.

France, as always working ‘bilaterally’ with a number of countries at the same time, like a hub building spokes in every direction, eventually managed to build a coalition with Brazil, Chile, Norway and the United Kingdom behind the initiative that by September 2006 was launched as UNITAID. As of today, 29 countries (and the Bill & Melinda Gates Foundation) are contributors to the initiative, although not all of them contribute in the form of an air tax. Efforts to expand the tax to a voluntary contribution on airline ticket purchases in countries not covered by the tax have been unsuccessful.

One could argue (and many have) that there was no need to set up a new organizational structure to channel the revenue from an airline tax. The Global Fund could certainly absorb this new funding in its entirety, and if that were not desirable, GAVI, the Global TB Drug Facility, UNICEF and others would be willing recipients of additional funding streams.

This was never really an option, however. France was not going to put in motion this major initiative without having a brand to show for it and a way to specify a return on its investments, and nor would any of the other countries that joined it. Moreover, by having focused on drug procurement, UNITAID could claim a niche that the Global Fund was not filling, and all the other organizations would be too narrowly focused or too widely spread to claim ownership of it.

So far UNITAID has used its money in a way that has managed to reduce some prices and encouraged investment in production facilities for new formulations of existing drugs in a way none of the other existing institutions would have managed. It has also, however, duplicated (or complemented, depending on one’s perspective) existing efforts for delivery of prevention of mother-to-child transmission of HIV and in supply chain management.

58 Named after James Tobin, the Nobel laureate economist who first proposed the tax. While Tobin originally saw it as a way of preventing speculative financial transactions and creating more stability in the financial system, its potential for huge revenue streams has led humanitarian and development groups to promote the tax as a ‘holy grail’ for development spending. See <http://www.ceedweb.org/iirp/factsheet.htm>.

In terms of administration and governance, it has taken a 'step back' from the Global Fund model in the sense that it has been hosted at WHO and therefore has a stronger anchor in the UN system than the Global Fund and GAVI, although it still functions under its own governance. It has a board that is heavily weighted toward the donor governments with only one seat representing implementers from Asia and one from Africa. It does, all the same, have two NGO seats, one for development NGOs and one for communities living with the diseases. And one seat for the foundations, as well as one for WHO. Douste-Blazy serves as the chair and 13th board member. In a sense, it can be seen as an example of a 'normalized' institution in a 'post-innovation world'. It has taken the importance of a multi-stakeholder involvement as a given, but it has sought a governance and management model that is seeking to establish a functional equilibrium between UN and non-UN influences.

Affordable Medicines Facility for malaria

The Affordable Medicines Facility for malaria (AMFm) is also a tool to influence markets, but its approach and design are as different from UNITAID as can be. While UNITAID grew out of an innovative idea for financing that sought a purpose, AMFm was the response to a specific and narrow – but crucial – problem that had emerged and needed to be addressed.

As the Global Fund in 2004 (and later the US President's Malaria Initiative and others) began to finance a global switch of malaria treatment from chloroquine-based products to ACTs through the public sector, a new dilemma appeared: since most malaria treatments were bought over the counter in private pharmacies or stalls, it would not be possible to phase out the old drugs as long as the new ones were vastly more expensive. The difference between the (in principle) free ACTs in the public sector and the very expensive ones sold through the private sector also created other typical 'arbitrage problems': an incentive to steal drugs from public facilities and sell them on the market, and the danger of counterfeits. It also encouraged the use of monotherapy artemisinin drugs and the under-dosing of the expensive drugs; both of which would hasten drug resistance against artemisinin.

'Saving Lives, Buying Time', a study led by Nobel-prize laureate in economics Kenneth Arrow and published in 2004 by the Institutes of Medicine of the US National Academy of Sciences, laid out this problem in considerable depth and detail and concluded that a global subsidy for ACTs was needed to get prices low enough to compete with and drive out the use of chloroquine wherever it was no longer an effective drug (which is, with a few exceptions, everywhere).⁵⁹

The Gates Foundation, being very concerned about drug resistance for the last effective malaria drug available, pushed to find a workable way of following up on the Arrow report. In 2006, RBM set down a working group chaired by the World Bank and financed by the Gates Foundation to find a way to make such a subsidy work effectively.

While the idea met strong ideological and practical resistance in the US President's Malaria Initiative, it was strongly supported by the United Kingdom, Canada, the Netherlands, the Gates Foundation and several others. By 2007, RBM had agreed on a business plan and a structure for AMFm, which would not create a new institution but instead integrate its activity into the Global Fund grant process. A small management team would also work inside the Global Fund's structure. After lengthy board discussions, the Global Fund agreed to this arrangement in 2008, but – given the US concerns – it was agreed that AMFm would have a pilot phase limited to nine countries and lasting until 2013. Any continuation and widening of the subsidy would happen only after a thorough, independent evaluation of the pilot phase. The majority (\$180 million) of the \$332 million for AMFm has been directed from UNITAID income, while the United Kingdom, Canada and the Gates Foundation have supplied the rest.

So the last of the great innovations was an initiative as large and ambitious as any that had preceded it, but that was seeking to exploit synergies in the existing global health architecture

⁵⁹ Arrow, K. et al. (2004), *Saving Lives, Buying Time: Economics of Malaria Drugs in an Age of Resistance*, National Academy of Sciences (Washington DC: National Academies Press).

rather than adding to it. In that sense, it represents perhaps yet another step in the evolution of health partnerships. The relatively smooth collaboration that has characterized AMFm – between RBM with the World Bank’s leadership, the Gates Foundation and its intellectual and financial inputs, the UK and Canadian governments, UNITAID and its decision to channel a significant share of its income to it, and the Global Fund as a host – on the whole seems to indicate a maturing of the new ‘multi-stakeholder’ way of working together. The US government’s resistance notwithstanding, AMFm seems to have been able to come to the completion of its pilot phase to a large extent because the stakeholders were by now familiar with ways of working together, shared some mutual trust, and were more focused on achieving results than on taking credit and promoting their own brands.

AMFm, the last of the great innovations, sought to exploit synergies in the existing global health architecture rather than adding to it. In that sense, it represents yet another step in the evolution of health partnerships

It is tempting to see AMFm as the last big experiment of the very exciting decade that began in 1998. By the time of its public launch in April 2009, the global financial crisis had already turned everybody’s attention to safeguarding whatever progress had been made and new, bold and innovative initiatives were no longer a priority.

The independent evaluation of Phase 1 of AMFm is now completed. It will be interesting to see if this last and in many ways most elegant of the innovations from 1998 to 2008 will be able to move to a second phase.

6. DISCUSSION AND SUMMARY

What lessons can be drawn from these years of innovation? What, if anything, of the events between 1998 and 2008 is replicable today or in the future? How much of this progress was driven by deliberate action from leaders within the field of health, and how much was simply a by-product of wider global trends?

One of the important triggers of the wave of innovations in health from 1998 onwards was WHO's willingness to move from a rigid systems-based approach to the big unsolved issues of global health to a pragmatic problems-based approach.

This 'systems thinking' gave the organization a defeatist view of any attempt to solve the large problems: 'What's the point? Unless X and Y changes outside the field of health, what we do will make little difference', is how a lot of contributions from WHO during the 1990s could be summed up. It also gave rise to a number of taboos: 'involving the pharmaceutical industry leads to conflict of interest'; 'focusing on one disease will draw resources away from the overall health system'; 'WHO must never cede control to others'.

This last taboo is the natural reaction of a bureaucracy that feels increasingly threatened by outside criticism, and that is exactly what WHO experienced during the mid- to late 1990s. While at that time no other organization could replace it, the World Bank, in particular, made impatient and unflattering comments and took provocative initiatives to prod and shame WHO into action. Its response was to defend its turf and reject the new ideas.

What the World Bank/TDR first introduced in 1997–98 (and then Brundtland endorsed for the whole of WHO when she arrived) was a complete break with the systems-based view. By asking initially: 'How do we practically deal with the concrete problem of lack of research into new malaria medicines?' and then reaching out to (or, rather, accepting the overtures from) individuals working in the private sector, Feachem and Godal broke a deadlock. The same happened with the under-use of existing vaccines, which led to the creation of GAVI.

The tension between a systems approach and disease-focus has persisted and is as acute today as 14 years ago, but a large amount of field experience now informs the debate and makes it more operational and less theological than in 1998 and the years that followed.

What gave the initial shift in thinking momentum and force was a wider political environment that supported such thinking.

What Richard Feachem, Tore Godal and Brundtland did was little more than apply to global health what had become mainstream ideas about public–private collaboration, rooted in a centrist, 'post-Thatcherite' ideology that private enterprise was superior to the public sector in efficiency and problem-solving and could be harnessed for the common good. While that view of the private sector has diminished significantly over the past five years, the concept of public–private partnerships has become considerably less charged than it was in 1998, and few initiatives today would not involve at least an extensive dialogue with relevant private entities. In that sense, the involvement of the private sector in global health strategy and policy-making has become an irreversible development.

While the dialogue and the new, practical solutions they produced can seem simple and obvious in retrospect, it is important not to underestimate the courage, creativity and willingness to take risks that the leading individuals displayed at the time. There was nothing inevitable or even obvious about the successes they achieved, and these initial discussions were undertaken in a climate of intense negative pressure from colleagues, and at times superiors, in their respective institutions.

One lesson that stands out when looking back, especially at the 1997–99 period, is the negative effects of angst, defensiveness and turf wars, and the extent to which these very common collective sentiments of any institution can hamper innovation and change.

Yet one can argue that the nay-sayers were correct: the ultimate result of the wave of innovation around the turn of the century was a significant loss of control and authority for WHO and to some extent also the other UN agencies. However, the world in which

WHO would retain a monolithic authority demonstrably no longer exists, and like Mikhail Gorbachev's Soviet Union a decade earlier, WHO was basically simply trying to manage a process of inevitable change.

The second shift was the transformation of civil society as a purveyor of outside pressure into an inside stakeholder with shared responsibility for decision-making on global health issues.

The transformation has been extraordinary. To read Philippe Douste-Blazy's heartfelt eulogy to the hardline AIDS activist Khalil Elouardighi, crediting him with some of the most important guidance and vision in the creation and governance of UNITAID, is truly remarkable.⁶⁰ NGOs have now not only reached a position where they shape decisions on funding and policies from the inside of most institutions; they also have a power that in many instances overrides that of the multilateral organizations within the field of AIDS, TB and malaria, although significantly less so in areas such as maternal and child health.⁶¹

While few would deny that the inclusion of civil society in global health policies, strategies and the governance of new funding has been hugely positive overall, a perpetual question of legitimacy and accountability hovers over their presence

While few would deny that the inclusion of civil society in global health policies, strategies and the governance of new funding has been hugely positive overall, a perpetual question of legitimacy and accountability hovers over their presence. While several civil society constituencies have attempted to install transparent nomination and selection procedures for board seats and other representation on international institutions, practice shows that a very small number of individuals wield a significant amount of power within the field of AIDS, TB and malaria in particular. Fortunately, these individuals have for the most part shown an extraordinary integrity, engagement and intelligence in carrying out their responsibilities. But an unresolved issue hangs over many of the new institutions and to some extent weakens their weight and authority: on whose behalf do the civil society representatives formally speak?

The same question of balance between power and accountability shows up in a different guise with the private foundations – primarily the Bill & Melinda Gates Foundation, since no other has the same amount of money to put behind its word.

Since its humble beginnings in Bill Gates Sr's basement in 1998, the Gates Foundation has developed into the single largest centre of gravity in global health expertise and priority-setting outside WHO, and the coexistence of these two organizations is often awkward and tinged with rivalry and limited mutual respect.

This shift toward civil society/foundation power has particular consequences for WHO, UNICEF and UNDP. Despite making several overtures towards bringing civil society and foundations into consultation and strategy, these member-state-driven organizations have not yet found any feasible way to reflect the extent of civil society power in their formal decision-making process. This is significantly weakening their authority. UNAIDS is somewhat better off with its civil society members on its Programme Coordinating Board; and in the fields of TB and malaria,

60 Douste-Blazy and Altman (2010), *Power in Numbers*, pp. 37–8. Elouardighi started his career in ACT-UP Paris as an uncompromising activist, doing stunts to heckle President Chirac. He now also plays a major role in shaping NGO thinking on the Global Fund and a number of other organizations without having lost any of his activist fervour.

61 See, for example, how MSF in July 2012 successfully demanded an end to UNAIDS' efforts to create standards for price negotiations between the pharmaceutical industry and developing countries, arguing that such work would undermine the UNITAID-led Patent Pool initiative.

WHO has at least a forum for interaction in the Stop-TB Alliance and the RBM partnerships, although even here there are significant tensions between WHO as a host and the diverse membership of these two umbrella organizations.

The third shift that happened during this period was that the global health community no longer acted in isolation from – or indeed in opposition to – the global economic and political trends. Instead, it aligned with these trends and even became a major force in shaping them, until the attacks on the United States on 11 September 2001 abruptly changed the world's priorities.

The drive to see health as a central force for sustainable development and health investments as a particularly effective way to reduce poverty was perfectly designed to mitigate the global concerns about the destabilizing effects of globalization as a result of growing inequality in the world.

Equally importantly, while the severe human consequences of the recent economic crises in Asia and Latin America and the economic stagnation in large parts of Africa at the time had rattled the rich countries' leaders, the West was experiencing robust growth, so there was in fact substantial extra money in the West to do something about these concerns. Not only did the West have a particularly soft heart at that particular moment, it also had a full wallet. In addition, it was the holiday season – the one New Year in a millennium, when it seemed right to make ambitious resolutions to match the occasion.

The next leap forward in global health will be quite some while away if it is to be dependent on such a landmark date or on a time when the West is again flush with money.

The real lesson to be taken from the events that led to the funding of the tremendous push in global health over the past decade, therefore, is how a few central actors in the global health community managed to anticipate these global trends and to construct a message and produce the evidence to back that message in a way that ensured maximum support from a nearly united global leadership. After all, the Millennium Development Goals cover a wide number of areas, and yet it was predominantly in health that the major investments and major results were seen.

The global health community no longer acted in isolation from or in opposition to the global economic and political trends, but aligned with these and became a major force in shaping them, until the September 11 attacks abruptly changed the world's priorities

Interestingly, the idea of investing in health as a global priority settled in as a deep, personal conviction with most of the 'millennium generation' of leaders – and to some extent it has been transferred to the next one. The Global Fund, PEPFAR and other major health investments would not have seen such a rise had not Blair, Clinton, Bush, Chirac, Mori (during and after their terms in office) and later Angela Merkel and Barack Obama all overridden the trends, fashions and political squabbles of their respective relevant ministries and insisted on continued growth in global health investments. Only because of this deep conviction (obviously made possible thanks to the rapid and spectacular returns in terms of lives saved) have health investments survived the downturn of the last five years.⁶² It was those organizations that understood this dynamic and constantly engaged with the political leaders that succeeded in attracting the most resources.

⁶² In December 2011, Tony Blair said about the Global Fund: 'It was the only time I can remember as a political leader where you set something up that was supposed to have a dramatic impact and it actually had a dramatic impact.' Global Fund, 'The Global Fund: 10 Years of Impact', http://www.theglobalfund.org/en/mediacenter/videos/The_Global_Fund_10_Years_of_Impact/.

With one exception, the institutions that saw the light of day between 1998 and 2008 quickly settled into the existing architecture. RBM, Stop-TB, MMV, GAVI, GAIN, UNITAID, the Global TB Drug Facility and several smaller partnerships have been accepted alongside the UN system, each as a useful 'house in the village'. The inclusion of the private sector and civil society in decision-making and oversight has been fairly unproblematic and has by now become routine. Had these been the only outcomes of the wave of innovation during that period, there would most likely not have been such a sense of change and upheaval in the global health architecture.

The Global Fund is a different story and must be discussed separately from the other initiatives. It has generated more controversy, more volatility, more engagement and support and more frustration and concern throughout the past decade than any other international institution in development, let alone in health.

That, one can argue, has simply come with the combination of the huge resources it has managed (\$33 billion in pledges, of which \$22 billion are committed to current grants), and which it has channelled to dozens of different interventions for three separate diseases to 145 countries. No one would claim such a task would be easy.

Nevertheless, the upheavals and polarization around the Global Fund are rooted in much deeper and morally fertile soil. The creators of the Global Fund – both those sitting in Brussels in 2001 and several of the leaders of the fund's secretariat and on its board – were on a quest far larger than creating an efficient type of health partnership: they aspired to nothing less than to change the way development assistance was delivered and health was managed in the developing world. The Global Fund, stripped down to its most basic principles, represents a radical rethinking of how development assistance is done.

The fraught board meetings, the vicious criticism, the passionate defence, the dramatic battles about new funding most often fought out in a language laden with morality and personal responsibility for lives lost, the jealousy and head-shaking: underneath the petty (or crucial) topics of disagreement rages a fundamentally *philosophical* battle between those who believe the fund can change – and is changing – development and health planning for the better, and those who believe it complicates and muddies an already acceptable way of doing business.

One need look no further than to the candle that is lit at the start of every board meeting to commemorate all those who have died from AIDS, TB and malaria since the last meeting to see that what is going on here is about much more than efficient money management.

In the ideal Global Fund world, all sectors of society in a country with a large (or concentrated) epidemic of AIDS, TB or malaria would come together and agree upon a national strategy to combat each of the diseases, determine the cost of the strategy, agree on the funding shortfall and ask the Global Fund to cover it. Its donors would see the accumulation of such requests as a realistic, efficient expression of demand and somehow come up with the money needed to finance the total amount. Funding would be spent efficiently with clear, agreed targets in mind, and continued funding would depend on the extent to which countries achieved those targets.

Results would focus on outcomes, and so partners, such as WHO, UNAIDS, bilateral donors, academic institutions and NGOs would invest heavily in improving health data collection and analysis. The way the 'Global Fundschnicks' see it, the fund is no competitor to the UN agencies; it is the genie that could make these agencies' dreams (in terms of health outcomes) come true. So it should be in the UN agencies' self-interest to assist the countries in the best possible way to achieve success.

Of course in practice, nothing works as smoothly as that. And it is over the imperfections in the execution of the Global Fund's model that the large battles emerge; between the 'idealists' who believe that the vision can succeed if action is just bold and radical enough and the 'traditionalists' who believe success is only possible when the Global Fund reduces the risk, plays safer and becomes 'more like the others'.

Each side has its passionate followers, and given that the board's powers have been balanced almost to the point of paralysis, the battles are long, bitter and often dirty (with the removal

of two successive executive directors and the blatantly political use of the findings of the organization's inspector general being only the most patent examples).

Over the past two years, the traditionalists have gained significant victories and it remains to be seen if the Global Fund will continue to represent any alternative to 'business as usual' for much longer.

However, in the debate over the costs and benefits of the innovations of the past 14 years, it is important to understand this ferocious fight in and about the Global Fund, and to see that it is an exception to the rule. Bringing civil society, UN and non-UN multilateral organizations, the private sector, foundations and national governments from the north and the south together does not necessarily mean conflict and deadlock. GAVI is but the most obvious example of that.

The dozen or so institutions and initiatives that resulted from the wave of innovation around the turn of the century represent a large and important step forward in collective efforts to achieve more effective and efficient solutions to the world's large health problems. As today's leaders in global health face the challenges of a post-MDG world, they are better equipped to make progress than they have ever been in the past.



Chatham House, 10 St James's Square, London SW1Y 4LE
T: +44 (0)20 7957 5700 E: contact@chathamhouse.org
F: +44 (0)20 7957 5710 www.chathamhouse.org
Charity Registration Number: 208223