How did “Health Systems Strengthening” become a component of the Global Fund’s public politics in 2007?

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Abstract

The phenomena of recent decades, globalization and neoliberalism, have given rise to new international health organizations, like the Global Fund to Fight AIDS, Tuberculosis and Malaria. A young organization, the Global Fund is currently in the process of institutionalization. The process, according to Selznick, which involves the definition of a distinctive identity and the taking on of ways of acting and believing that are deemed important. In order to investigate how this distinctive identity is created, the purpose of this work is to explore how a singular program of action and approach to health financing was added to that identity: the Global Fund’s health systems strengthening policy of 2007. Relying on John Kingdon’s theory of public politics and policy windows, the hypothesis of a window of opportunity created by multiple converging factors is tested as the explanation for this key policy development in 2007. Indeed, the analysis came to the conclusion that the 2007 policy cannot be explained by one singular influence but rather by a moment ripe for change, born out of the confluence of participants, problems, policies and politics surrounding the Global Fund’s health systems debate.
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I. An Introduction to the Institutionalization of the Global Fund to Fight AIDS, Tuberculosis and Malaria

Phenomena of recent decades have given rise to new international health organizations, like the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund (GF) is a new type of international organization, a unique global public private partnership, which is dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, Tuberculosis and Malaria. Their approach to financing international health is innovative in two distinct ways. First, “this partnership between governments, civil society, the private sector and affected communities represents a new approach” to solving health financing issues (GF, 2010 About). Second, the way that the Global Fund finances AIDS, Tuberculosis and Malaria is original in the sense that it incorporates not only targeted financing for the three diseases but has come to include financing health systems strengthening components as well. This specificity has come to be in recent years due to a change in the Global Fund’s perspective and their guidelines for financing in 2007. In that year, the Global Fund’s guidelines for grants went from being primarily specific to AIDS, Tuberculosis and Malaria, to including the possibility of financing integrated and cross-cutting health systems strengthening. This is the equivalent of a significant change from a vertical to diagonal approach to financing global health.

Health systems strengthening (HSS) includes the various forms of financing that target the overall improvement of the health system as a whole, including (but not limited to) the funding of infrastructure and health professionals’ salaries. This form of financing may be linked to targeted diseases but its effects are meant to extend beyond. The inclusion of HSS components in the Global Fund’s guidelines for grants is significant because these guidelines are instruments of public action for the Fund. The evolution of the Fund’s overall perspective is reflected in the modifications of their instruments, namely these guidelines for grant proposals that are set out by the Board.

Instruments of public action are both technical and social tools, which organize the relations between the public actor (Global Fund) and its beneficiaries, in function of its underlying representations and significations (Lascoumes and Le Galès 269). They are carriers of values, nourished by interpretations and precise conceptions of the envisaged mode of regulation (Lascoumes and Le Galès 269). Instruments like the Global Fund’s guidelines comprise a specific representation of the problem that they address (Lascoumes and Le Galès 274). Therefore, the alterations in the instruments of an organization can be seen as a mirror of more profound transformations in the underlying cognitive framework and world vision of
that organization (Lascoumes and Le Galès 274). For the purposes relevant here, this would mean that the fluctuations seen in the Global Fund’s guidelines for approval of financing may be a reflection of larger changes in the Fund’s perception of global health issues and their solutions, and thus of the Fund’s role in their worldwide resolution. These changes in the Global Fund’s actions and instruments can be expected as they are a young international organization still transforming and molding their identity.

A. The Topic at Hand

In its infancy, the Global Fund is in the process of institutionalization. It is via this process that an organization transforms into an institution by embracing a certain identity. Acquiring this “distinctive identity,” involves the “taking on of values, ways of acting and believing that are deemed important” (Selznick 21). In this way, instruments, which are carriers of values and specific ways of acting to resolve a problem, reveal the developing identity of the institution in the making. New organizations, like the Global Fund, go through this transformation over time as they adapt to the environment that surrounds them and undergo the influence of the people and groups that they embody (Selznick 16). In this way, the final product is a reflection of the organization’s history. Following this logic, one question that could be posed is: how did certain types of action and a certain identity of the Global Fund come to be assembled and evolve?

However, because this question is too vast to be investigated in its entirety within the confines of this composition, the scope must be narrowed. Rather, this paper will focus on one area of the Global Fund’s actions that has evolved and that may have a potential long-term impact on the identity of the Fund: health systems strengthening (HSS). The restriction to this topic is more feasible, but to further limit the subject, special emphasis will be given to the changes in HSS financing opportunities, which took place in the year 2007. The question to answer then becomes: How did HSS become a component of the Global Fund’s public politics in 2007?

Before going any further, it is necessary to clarify the meaning of this question. First, what are public politics? A public politic is a program of action specific to one or multiple public authorities (Hassenteufel 7). Public politics, plural, is the entire collection of these actions. Generally, the study of public politics is focused on the action of the state, however, in what concerns the Global Fund, their actions are international public politics. The latter are the collection of programs for action carried out by public authorities, with a goal of
producing effects that go beyond state boundaries (Petiteville and Smith in Hassenteufel 18). More specifically, the Global Fund’s actions fall into the sub-category of multilateral, international public politics, which are elaborated by international actors and are not just the foreign affairs of a state (Petiteville and Smith in Hassenteufel 18). In today’s world, the effects of globalization have made it so that nearly all public politics, and the problems they address, go beyond the nation-state. With these definitions in mind, the question asked here should be understood as: how did HSS become a part of the Global Fund’s programs of action in 2007, or how did HSS become part of the Global Fund’s instruments for public action in 2007?

To respond to this question, the how is to be answered by research largely designed around John Kingdon’s theory of ‘policy windows.’ Kingdon’s theory is based on the notion that ideas and actions become issues and are adopted at given moments because ‘their time has come’. This is to say that a ‘window of opportunity’ opens as the convergence of various factors takes place, including but not limited to: personnel changes, policy feedback, and changes in the problem itself. Kingdon’s theory seems more than appropriate for the study of the Global Fund’s HSS changes in 2007, as multiple events of importance did take place leading up to the alteration, including but not limited to: the election of a new Executive Director of the Global Fund, the publishing of evaluation studies’ results, and the replenishment of major monetary donations to the Global Fund. With that said, the hypothesis is that it is expected to find that HSS became an issue and changes were adopted in 2007 due to the opening of a ‘policy window,’ and that between the various converging factors that led to this ‘window of opportunity,’ the changes in the personnel of the key organs of the Global Fund are given the most importance.

In order to confirm or disprove this hypothesis, the first method of research will be an analysis of the official Global Fund documents. This first phase of inquiry will help place key actors and draw assumptions on influencing factors, from the rhetoric they’ve preached while with the Global Fund and their respective constituencies. In a second phase of research, interviews with officials will help to confirm these assumptions drawn from documentation and fill the gaps in the available, official information. By way of such investigations, the objective will be to place and prove the convergence of factors that made up a moment of opportunity for HSS financing to be added to the Global Fund’s guidelines. Subsequently, the method of research will be explained in greater detail.

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1 This idea will be addressed later on in the section explaining the history of the Global Fund and the globalization of health.
B. The Justification and Interest of the Research on HSS Financing

What is the point in studying the adoption of one specific form of public action by the Global Fund? What significance could the work here have? In reality, such a narrow subject of research could reveal a lot about the Global Fund’s development as a young institution. Questioning how a certain type of public action emerges and evolves, provides insight regarding the development of a specific identity during the process of institutionalization.

The 2007 HSS alterations could result in the long-term revision of the Global Fund’s self-defined purpose and distinctive identity within the global community of health actors. As abovementioned, the evolution of the Fund’s approach to health financing is reflected in the modifications of their instruments or guidelines for grants. These instruments hold specific representations of the problem and their solution, making the adding of HSS components the reflection of a change in what the Global Fund deems to be the best way of acting. Later on, we shall elaborate on the significance of this new form of public action by explaining the different approaches to health financing and their correlating forms of acceptable action. With this is mind, questioning how a certain type of public action emerges and evolves, provides insight regarding the development of a specific identity during the process of institutionalization.

Besides the potential meaning behind the results, the interest of this research is multifold. First, since the Global Fund was only created in the year 2002, very little research actually exists on the organization itself. A look into how the organization has evolved in seeing the solutions to global health could be seen as an original contribution to the field of political science due to its youth as a subject. Moreover, the process of institutionalization and the pre-decisional processes that lead to singular changes in policy, are infrequently examined dimensions in political science. Since the Global Fund is still a relatively young institution, which is forming its identity and role, an examination of its recent alterations in actions, and the latter’s underlying representations, provides a unique opportunity to explore these processes. This possibility is exceptional because it’s of the moment, which allows for new documents surfacing regularly and the opportunity to interview officials of the Global Fund about the progress that is taking place now\(^2\), reducing the negative effects that memory loss may have on an analysis.

\(^2\) This process of institutionalization, identity and role development, is still in the making today. Regarding HSS financing, the Global Fund is still steadily discussing the best route, and lately has been discussing the division of work in HSS amongst its partner organizations. The HSS guideline changes in 2007 offer an opportunity to restrict the research, but this singular moment is definitely part of the Global Fund’s ongoing process of institutionalization.
C. The Blueprint of this Document

The remainder of this inquiry is to be presented in six chapters. First, in order to have a better appreciation for the Global Fund’s youth and organizational bodies, a chapter will be dedicated to giving a brief history of the institution and an explanation of the interaction between the different organs of the Fund during the approval process. This is an important step in order to have a minimal appreciation of the functions of each body. Second, the significance of the 2007 HSS policy changes will be revealed, by explaining the context of the international health debate and clarifying the different approaches to health financing. Third, the most important aspects of the theories of institutionalization and ‘policy windows’ will be clarified, as they serve as the backbone of the research to be seen here. Fourth, prior to seeing the results of the analysis, a more in depth account of the method of research will be elucidated, along with the problems encountered. Fifth, the results of the assumptions drawn from documentation and the analysis of the interviews will be presented, as well as an ultimate affirmation or nullification of the original hypothesis, and finally, in a concluding chapter, a summary of the work will be provided.
II. The Global Fund, a New International Organization and a Developing Institution

International organizations have never been as central to world politics as they are today. Post 1945, the number of international organizations increased drastically as various states and actors set out to “solve problems’ that require collaborative action for a solution” (Haas 1-2). Their place in world politics has continued to grow and today, international organizations are at work on “every imaginable global issue;” investigate almost any issue and you will find “international organizations involved, probably in a leading role” (Barnett and Finnemore 1). The issue of global health is not an exception.

Worldwide pandemics affect every country on earth in some way, and they present the imminent risk of spreading their physical burden to additional states. Not to mention, global killers wreak havoc on the potential of social and economic development of impoverished countries, which in the age of globalization means that there are effects felt by everyone. Naturally, global health has been recognized as a communal problem for these reasons, and a multitude of international organizations have been born in order to deal with these troubles. Solutions to worldwide health issues only seem possible if the various states and actors collaborate to find an answer.

The need for such collaborative responses in the health sector was further increased by the profound changes accompanying globalization, which have altered the ability of nation-states (and particularly low-income countries) to form and implement health policy (Buse and Walt 41). Globalization, a process of increasing interdependence and global integration, is mainly structured by private actors who have brought a qualitative shift in power relations (Buse and Walt 43). The result of this process is that, “short of a backlash at globalization, states will have little choice but to pool together their sovereignty to exercise public power in a global environment now mostly shaped by private actors” (Reinicke and Witte in Buse and Walt 41). Health is one of the various challenges that can no longer be met at the national level alone, but rather requires additional global interventions (Buse and Walt 41). The consequence of this necessity combined with the context of exploding globalization and the neoliberalism3 of the 1980s and the 1990s, has been the creation of not only new international organizations for health, but a specific type of organization that takes the form of a global public-private partnership (GPPP) (Buse and Walt 41-44; Lee and Zwi 26-27; Lee and

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3 Neoliberalism also emphasized non-state actors and the private sector, looking to non-state healthcare financing as an alternative to non-existent, weak, or “bloated” government programs (Lee and Zwi 27). GPPPs fit the mixed public-private approach that neoliberals emphasized for the health sector.
Goodman 98). A GPPP is an alliance formed between multilateral institutions, international non-governmental organizations (NGOs), commercial enterprises and governments, formed for the purpose of resolving a global problem, while meeting the objectives of both public and private actors and overcoming both the market and public failures (Buse and Walt 41-42, 53). Health GPPPs can also include civil society actors, non-governmental agencies, and donor agencies as partners (Buse and Walt 44). One such organization that was created to solve worldwide health issues, and took the form of a health GPPP, is the Global Fund to Fight AIDS, Tuberculosis and Malaria.

A. The Origins of the Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund (GF) was created in 2002 as a response to the obstacles that the three targeted diseases were imposing on social and economic development worldwide (GF, 2009 Brochure 5). The founders of the Global Fund understood the three diseases as, perhaps more than anything else, barriers to reaching basic health levels and an acceptable quality of life for the world’s most disadvantaged, threatening economic progress and potentially undermining the welfare of populations: “Beyond the devastating impact of millions of deaths, the burden of these diseases produces measurable economic loss, and in the worst-affected countries also increases the risk of social disintegration and political instability” (GF, 2009 Brochure 5). In hopes of a solution, the Global Fund was established to provide, and wisely distribute, significant new resources to allow the effected countries to answer these challenges with force.

“Over the past three decades, public health experts have identified a number of highly effective interventions to prevent and treat AIDS, TB and Malaria. If brought to scale, such efforts could change the course of these diseases. However, achieving this scale-up would require a substantial increase in resources” (GF, 2009 Brochure 6). The Leaders of the G8 countries saw this potential and after a discussion at the Okinawa G8 Summit in July 2000, the idea of creating a new international organization to increase funds was launched (Tan, Upshur and Ford 4; GF, 2009 Brochure 6). This discussion lead to Kofi Annan’s call to action in April, 2001 at a summit for African leaders in Abuja, Nigeria; he called for the creation of a global fund to provide a channel for massive amounts of additional resources (GF, 2009

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4 The civil society and local actors are included for a belief in the added efficiency that they can provide during implementation (Lee and Zwi 27).
Brochure 6). Following Annan’s urging, a United Nations General Assembly Special Session on HIV/AIDS in June 2001 committed to creating such a fund; this commitment in turn influenced the tone of the Group of Eight (G8) Summit in July 2001 (Tan, Upshur and Ford 4; GF, 2009 Brochure 6). Ultimately, this chain of events led the G8 leaders to pledge to form and finance a global mechanism for the distribution of aid targeted at the top three poverty related diseases. (Tan, Upshur and Ford 4; GF, 2009 Brochure 6). At the same time, the changed international context, resulting from the forces of globalization, led these leaders to form a mechanism that would combine the efforts of the various actors having an interest in global health issues. With that, the Global Fund to Fight AIDS, Tuberculosis and Malaria was born at the start of 2002, receiving administrative help from the World Health Organization (WHO) in order to accelerate the process of creating a new organization. The Global Fund was established as a unique global public-private partnership dedicated to attracting and disbursing additional resources to prevent and treat the three poverty-related diseases (GF, 2010 About). This partnership between governments, civil society, the private sector and affected communities was to be a new approach to international health financing, suited to addressing the health challenges of the new millennium in an efficient manner.

As a first illustration of its efficiency, within three months the Fund had approved its first Round of applications for funding. Though, for an application to be approved for funding it must first pass the necessary steps and be scrutinized by the various bodies of the Fund, following the Global Fund’s order of operations.

B. How The Global Fund Operates

The Global Fund’s purpose is to operate as a financial instrument, not an implementation agency, attracting, managing and disbursing resources but not operating the funded programs themselves (GF, 2009 Brochure 9). The Fund was created around the concept of “performance-based funding,” which essentially means that initial funding is “awarded solely on the basis of the technical quality of applications,” but renewed funding is dependent on quantifiable results and achieved targets (GF, 2009 Brochure 6). This emphasis on technical solutions, performance and efficiency can also be linked to the context of neoliberalist ideas, which stressed the importance of profitable payoffs (Lee and Zwi 28). Many of the founders and initial investors of the Fund were leaders of the G8 who expressed concern that these diseases were preventing optimal social and economic development. In order to verify that their donations were going to the best possible use and that the money put
into grants was returning actual results in improved health and development, the Global Fund put in place a rigorous system of guidelines and evaluation.

The procedures of the Global Fund have been designed around a series of principles, or causes, which shape the methods of operation. Goal number one is to increase the amount of resources available for financing aid to three of the most devastating diseases worldwide; the Fund aims to provide additional financing, not to substitute already existing government programs (GF, 2009 Brochure 13). Also, as a financing instrument and health GPPP, they aim to rely on the knowledge of local experts and to work closely with other multilateral and bilateral organizations involved in health and development (GF, 2009 Brochure 9). For this reason, they support programs that “evolve from national plans and priorities,” using what they call Country Coordinating Mechanisms to encourage alliances between various local actors, civil society, government, multilateral and bilateral partners and non-governmental organizations (NGOs); this model insists on the local actors’ initiative while providing for greater collaboration between the different sectors (GF, 2009 Brochure 10). Likewise, they aim to provide funds in a balanced manner, both in terms of the targeted diseases and how they plan on attacking the crises, financing both prevention and treatment schemes (GF, 2009 Brochure 10). Furthermore, regardless of the scheme, the Fund aspires to be transparent, accountable and effective; multiple precautions are taken in order to assure that money goes to technically sound programs that will have an impact. The Global Fund evaluates proposals and approves programs by using an independent Technical Review Panel (TRP), composed of experts of the diseases and of development, who are able to assess how the proposals will have an influence on improved health and poverty reduction (GF, 2009 Brochure 10). “At the time of grant signing […] targets and indicators are agreed upon between recipients and the Global Fund. Results are tracked at every point in the process” (GF, 2009 Brochure 6). All of these principles - additionality, collaboration, balance, transparency, accountability, and

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5 The latest statistics on the Global Fund show that via government donations, private sector initiatives, non-government donors, and individual donations; a grand total of 21,697,437, 575 USD has been pledged to the Global Fund and 16,474,465,265 USD already paid (GF, 2010 Pledges). Of these donors the three largest are: the USA-4,338,936,895 USD; France-1,948,916,105 USD; and the European Commission 1,204,088,118 USD (GF, 2010 Pledges). Other interesting statistics are the amount of donations coming from private sector initiatives like (PRODUCT) RED- 151,010,817 USD, and the amount coming from private foundations like the Bill and Melinda Gates Foundation- 650,000,000 USD. The Global Fund’s success is reliant on the commitment of all the various stakeholders. For complete donations statistics see the Global Fund document on pledges, available on their website (GF, 2010 Pledges).

6 The legitimacy of GPPPs largely depends on the expert communities that advise them since unlike the UN, they cannot pretend to have truly universal membership (Buse and Walt 55-57). For this reason, one can see why the Global Fund has two bodies, the Board and the TRP, that are composed of experts in the various aspects of health problems. Yet, only the TRP remains an independent advisory body, as the Board is the legislative organ of the Global Fund, as will be seen in the following section.
effectiveness - serve as the roots of the Global Fund’s configuration and procedure for financial approval.

i. The Organs of the Global Fund and the Grant Approval Process

Officially, the grant approval process begins with the Board of the Global Fund. The Board is composed of “20 voting members, which include representatives of donor and recipient governments, NGOs, the private sector (including business and foundations) and affected communities” (GF, 2009 Brochure 13). There are also four non-voting members, other key international development actors: WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Bank (WB)\(^7\), and the government of Switzerland\(^8\) (GF, 2009 Brochure 13). The Board is headed-up by a Chair and Vice-Chair, each serving for terms of 2 years and the positions rotating from donor and recipient constituencies in order to secure equal representation (GF, 2009 Brochure 13). Officially, it is the Board that fulfills the first step in the funding procedures, developing new policy guidelines for proposals and launching “calls for proposals”, known as Rounds. However, while this is the official claim of the Global Fund, some scholars contend that it is actually the executive branch of the Global Fund, the Secretariat, who in principle is not to interfere with the approval process, that actually “elaborates the guidelines and the proposal forms,” influencing the eligibility of proposals (Ooms, Van Damme and Temmerman 606). For the purpose of the research to be presented, both theories should be kept in mind, but in order to simplify the explanation of the approval procedure, only the official stance will be elaborated upon.

After the Round is announced, Country Coordinating Mechanisms (CCM) prepare proposals for funding in line with the Board’s guidelines and based on the local financial needs (GF, 2009 Brochure 29)\(^9\). Within the proposals, the CCMs designate one or more principal recipients (PR) for the funds (GF, 2009 Brochure 29). The CCMs themselves are country-level partnerships that develop and submit grant proposals. They include representatives “from both the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions, private businesses and people living with the disease” (GF, 2009 Brochure 14). To ensure effective CCMs, the Global Fund has implemented a number of specifications for their formation: one, members from the non-
governmental sector must be transparent and documented; two, there must be a representative of communities affected by the diseases; three, there must be a transparent and documented process of proposal development that takes into consideration the views of the various stakeholders; four, the nomination of the PR must be transparent and documented; and five, the CCM must have a written plan (GF, 2009 *Brochure* 14).

After the CCMs submit their proposals to the Global Fund, the *Secretariat* reviews their plans in order to be sure that they are in line with the guideline criteria for funding (GF, 2009 *Brochure* 29). The Secretariat is the executive branch of the Global Fund and is made up of some 300 staff members and headed by the Executive Director (GF, 2009 *Brochure* 14). They are in charge of a multitude of operations including day-to-day activities, managing grants, mobilizing resources, and providing legal, financial and administrative support (GF, 2009 *Brochure* 14).

Once the Secretariat declares a proposal’s eligibility, the *Technical Review Panel* (TRP) of the Global Fund is in charge of examining the technical merit of the proposal. As an independent review panel of health and development experts, the TRP suggests to the Board to either: fund; fund only if certain conditions are met; encourage resubmission; or not to approve funding (GF, 2009 *Brochure*). However, the TRP’s opinions are in theory only recommendations.

The grant approval process moves back to the Board after the TRP has weighed in. The decision to approve funding or not, for a period of two years, lies in the hands of the Board, who is to base its decision on the technical merit evaluation and the availability of funds (GF, 2009 *Brochure*).

As soon as a decision to fund a program has been made, once again the grant process falls into the hands of the Secretariat. At this point in the process, it is the Secretariat that negotiates the grant agreement and identifies specific, quantifiable results to be tracked (GF, 2009 *Brochure*).

To summarize, the Board begins the grant process by writing guidelines and “calling for proposals.” The CCMs then prepare proposals and submit them to the Global Fund, and after the Secretariat declares their eligibility the proposals are presented to the TRP for scrutiny. Relying on the TRP’s opinion, it is the Board that then has the final decision to approve and renew funds. At any point in the process, any of these actors may try to influence the scheme of funding based on their opinion of what is the most effective approach to funding health aid and development. Within the global health sector conflicting views exist. These views, or approaches to health financing, will be elaborated on in the following section.
III. The International Health Debate

A. The Three Different Approaches to Health Financing

Less than a decade ago, the biggest challenge for financing global health was a lack of funds (Garrett 1). Today, largely due to a worldwide interest in the eradication of the HIV/AIDS pandemic, international organizations have seen a surge in donations (Garrett 2). Now billions of dollars are made available and governments, along with thousands of non-governmental organizations (NGOs) and humanitarian groups, are looking to spend it, but “much more than money is required” (Garrett 1). The solution to HIV/AIDS, like Tuberculosis and Malaria, is not simply to treat the disease; besides the obvious fact that there is no cure, all of these illnesses are nested in larger issues of poverty and development, making “states, health-care systems […] [and] local infrastructure” necessary considerations for improving public health (Garrett 1-2). As with any world issue, in what concerns the crises of poverty related diseases, there are several possible outlooks, each with its own advocates and envisaged solutions. Two major points of view have existed for the duration of the global health debate: the horizontal and the vertical approaches. The debate between the two can be linked to the questioning of suitability of public and private schemes to health, that resulted from globalization and neoliberalism. The deliberation between horizontal and vertical approaches has been described as a pendulum swinging back and forth over decades, as one view was favored over the other in international politics and institutions (Uplekar and Raviglione). Out of this quarrel, a third approach has emerged, referred to as the diagonal approach. In the following subsection, the basic ideas and history behind each stance will be briefly summarized, a necessary step in order to fully understand the significance of the Global Fund’s evolution of policy.

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10 “The HIV/AIDS pandemic […] continues to be the primary driver of global concern and action about health” (Garrett 5). More than other headlining diseases, like Malaria or Tuberculosis, HIV/AIDS has been recognized as an impediment to development and prosperity, spurring an interest in world health and causing public and private donors to be more generous; it is a marvelous momentum for health assistance, which has succeeded at spearheading the global health agenda (Garrett).

11 The global health debate has truly gone on for decades. “The terms ‘vertical’ and ‘horizontal’ [are familiar] to most people working in public health” but many don’t recognize how “persistent the tensions have been between these different approaches” (Mills 315). Mills notes that in Gonzalez’s historical review of the debate he states, “that this problem of prioritization was recognized” as early as 1951, in the beginning days of the WHO (Mills 315).
i. Vertical

The vertical approach to financing global health has been described as “aiming for disease specific results,” which are “independent of the rest of the health care system” (Ooms et al. 1; Tan, Upshur and Ford 2). This stance focuses on short-term numerical targets that are based on epidemiology founded cause and effect, and medical or technical solutions that are quantifiable. “The ‘vertical approach,’ calls for the solution of a given health problem by means of single-purpose machinery” (Gonzalez 9). ‘Mass campaign’ is another term used to designate this line of attack (Gonzalez 9). Examples of tactics deemed compatible with this line of thinking would be the increase in the number of bed nets for the prevention of Malaria, an increase in the number of people receiving antiretroviral treatments for HIV/AIDS, and a decrease in the number of pregnant women diagnosed with HIV/AIDS (Garrett 1). These “vertical” solutions are so called because they are directed, supervised or executed to a large extent by specialized services using health workers wholly dedicated to the given task (Mills 315). Believers in vertical funding argue that these solutions will permit the rehabilitation of the larger health system by promoting more investment in aid. The infrastructure and general health system would be improved upon incrementally, but only as is found necessary for the implementation of these targeted plans of action12.

As one might presume, this type of selective approach was favored throughout the 1980s and 1990s after the resurgence of conservative economic and political forces, globalization and neoliberalism (Sanders and Chopra 105). These tendencies all favored the energetic efforts, technical solutions and economic rationalism that targeted vertical approaches to health could provide (Sanders and Chopra 106-107).

However, as with any debate, there are positive and negative arguments for each side. On the positive side, one “advantage of such vertical mechanisms is in the attention paid to all aspects of disease control, spanning the continuum from prevention to treatment to follow-up, and from government commitment to standardized clinical care” (Tan, Upshur and Ford 2). Such a thorough strategy of specific measures for certain diseases can rapidly improve health in the short term (Mills 315), making this approach suitable for dealing with widespread scourges that are immediately causing a hindrance in the social and economic development of a country (Gonzalez 4). The affiliation between targeted diseases and economic development may help explain why the disease specific approach attracts large donors, making it the most “effective at bringing billions of new $$$ to the table for global health, through schemes such

12 This is the main distinction with the diagonal approach, which intends to fill the gaps of health systems more generally, allowing the benefits to spillover into other health issues that are not specific to the targeted disease. The vertical approach only foresees health systems improvements specific to a disease program.
as the Global Fund” (Roy). Another key benefit of such targeted programs is their ability to be evaluated due to their quantifiable nature, which permits for clear evaluations. This in turn allows politicians and donors to use the numerical evidence of success to gain support and perhaps even further funding.

On the negative side, one risk is that by focusing on only certain illnesses, financed programs will be mere “islands of excellence in seas of under provision” (Buse and Waxman). Some donors may see their commitment to vertical programs as significant enough to be their sole obligation, leaving other parts of the health sector to become dilapidated and underfinanced. The potential downfall of such an approach is that they can be too limited to certain aspects of the population’s health while ignoring others, failing to build the necessary capacities for broader health benefits (Tan, Upshur and Ford 3). Vertical financing may fail to be a sustainable solution in the long run, as some studies suggest that only solutions that are embedded within a comprehensive approach, which includes the development of the larger health system and human capacities in the field, are long-term successes (Sanders and Chopra 107-108). This failure lies in basic needs and infrastructure that is inadequate, necessities that are emphasized in the second perspective: the horizontal approach.

ii. Horizontal

The horizontal approach to financing global health could be understood as “broader based approaches to improving health” (Tan, Upshur and Ford 2), or programs which aim to improve health systems as a whole (Ooms et al. 1). Such an approach focuses on basic needs and essential infrastructure as a prerequisite for further intervention and health improvement; addressing the socioeconomic determinants of health, not just the medical and technical aspects of targeted diseases, is seen as fundamental for reducing global inequalities and improving the health of the world’s poor (Parsons 1). “The ‘horizontal approach,’ seeks to tackle the overall health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as ‘general health services’” (Gonzalez 9). The main argument is that “the eradication of diseases will have only temporary effects if they are not followed by the establishment of permanent health services in those areas, to deal with day-to-day work in the control and prevention of disease and the promotion of health” (WHO, 1951 Annual). Channeling funds for specific diseases may help increase aid and, according to the vertical supporters, develop infrastructure through the means of targeted programs, but much experiential evidence goes against this theory of development, showing
that vertical aid brings money to the field but does not always have a lasting impact on health outside its niche (Garrett 6).

This approach has been highlighted twice over the course of the international health debate. In 1978, the declaration of Alma Ata underlined the trend of the 1970s, which was a belief in the basic needs approach to development and the necessity of not only targeting diseases but their underlying causes, including the larger health system (Sanders and Chopra 105). During this trend in primary health care beliefs, the horizontal approach to financing made more sense. However, as aforementioned the 1980s and 1990s saw resurgences in conflicting ideas and the switch to more vertical schemes. Nevertheless, the late 1990s experienced some new realities that again increased the general interest in horizontal approaches. The 1990s were a period of economic hardship for many nations in the world, and this combined with increasing globalization, resulted in a growing global health divide between the rich and the poor (Sanders and Chopra 112-115). This divide caused many leaders to reconsider the need to take into account the overall health systems of low income nations.

Advocates of the horizontal approach argue that vertical funds are not sufficiently harmonized; they do not provide the flexibility needed on the ground, sometimes imposing a “one-size-fits-all” approach without taking context into consideration; they weaken existing country systems by depleting in-country resources, primarily human; and they are not long term solutions. Horizontal funds, to the contrary, are by definition more encompassing and thus harmonized; they have the ability to adjust to changing disease patterns; they do not concentrate all resources in just one portion of the health system; and their solutions, the institutions they create and reinforce, remain over time and are sustainable. These are the main benefits of such a method of funding.

However, as with the vertical approach, this stance also has its downfalls. The obvious favoritism of donors (especially private sector donors) for investing in vertical aid makes a horizontal fund a weakness in terms of monetary pull. Little would be able to be accomplished if global institutions had to return to the problem of lacking resources as in past decades. Vertical programs have the advantage of easy planning that horizontal programs do not, due to their vast, all-encompassing nature. Also, as aforementioned, vertical programs, because of their very technical, quantifiable quality, are easily evaluated; this makes them appealing to politicians, who favor a capacity to show evidence of their successes in their political campaigns. Horizontal funds aim for change that may not be seen in all its glory for several years, or even decades. This makes it difficult to rely on such schemes as a crutch for political success, thus decreasing horizontal funds’ political support.
The go around that has existed between these two approaches has never amounted to a finalized agreement. There have been moments in favor of one or the other but neither has become permanent. Pros and cons remain on each side of the debate, always leaving something to be desired. For some, the solution is in a third approach that has regained momentum, after having been on the backburner for many years: the diagonal approach.

iii. Diagonal

Already in the 1960’s, at the beginning of the health debate, Gonzalez claimed that “the two approaches should not be seen as mutually exclusive: general health services and mass campaigns should be coordinated and combined in various ways, with the long term goal being a unified scheme of general health service” (4). Today, this idea is again earning acclaim.

The underlying thought of this approach is that programs for targeted diseases may not be fully effective or able to maintain long term changes in prevalence without the development and improvement of general health services that treat other ailments, and horizontal programs may not be able to see maximized development without first solving the burden of titular illnesses that are ravaging poor countries in terms of their socioeconomic situation. The proposed solution of advocates of a diagonal approach is to combine the best of both worlds. In one article, authors illustrated the diagonal approach by using a metaphor of “islands of sufficiency in a swamp of insufficiency […] While the vertical approach results in fragile, isolated islands of sufficiency, and while the horizontal approach leads to generalized insufficiency, the diagonal approach aims to build islands with a broad and solid base, and to gradually connect those islands, by helping fill in the swamp” (Ooms et al. 3). The concept is to employ a vertical strategy, which while drawing in large donations, can be used to strengthen the overall infrastructure of a country. Julio Frenk and Jaime Sepúlveda define diagonal strategies as those that aim to “use explicit intervention priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription and quality assurance” (qtd. in Ooms et al. 2). Thus, even for specifically targeted programs to succeed there is a dependence on the underlying health system at large.

The pros and cons of such an approach can be seen as the best and worst of both worlds. On the vertical side, there is a continual risk that non-lasting ‘quick wins’ will be encouraged in order to prove the efficiency of funding and justify further investment and
donations. On the horizontal side, difficulty is bound to be encountered when planning such schemes of action that will take many years and administrations before realizing their full potential. Diagonal approaches are a true mix of the former sides of the global health debate, and the good comes with the bad. Otherwise, if this outlook consisted of only the benefits and none of the weaknesses, there would be no more global health debate. As it stands, this is a valid perspective among others and the debate, like a pendulum, remains in full swing.

ii. The Global Fund’s Evolution

The long debate over the ‘best’ approach to financing global health crises has been described as a pendulum that has swung back and forth over decades. Because this debate was still omnipresent at the creation of the Global Fund (GF), and has remained so over the past eight years of its existence, it should come as no surprise that the Global Fund itself has shown signs of hesitation and change concerning their adopted position. This tottering could even be seen as symptomatic of its conception in an already existing era of deliberation and the mixed perspectives of its members, part of its nature as a GPPP.

From the very start, the Global Fund’s approach to health was ambiguous. Though the name, the Global Fund to fight AIDS, Tuberculosis and Malaria, implies a vertical approach, the Fund’s stated intentions were to contribute to strengthening health systems and to support programs that build on national policies, priorities and partnerships (Tan, Upshur and Ford 4-5). As early as Round 1, the call for proposals by the Board stated that proposals were required to take into account the institutional and absorptive capacity of the country, suggesting an obligation to consider health systems as an integral part of programs (Dräger, Gedik and Dal Poz 3). “Since then, the Global Fund has entered a kind of tightrope walk by focusing on its clearly defined goal to fight the three targeted diseases, but at the same time recognizing that adequate capacity of the health system is a prerequisite” for success (Dräger, Gedik and Dal Poz 3).

For the first eight years of the Fund’s existence, their policy approach has been a bit of a ‘rollercoaster’, moving towards more horizontal or diagonal policies, going back towards the stricter vertical approach, again toward health systems at large, and so on. As of Round 1, the guidelines said that proposals may include interventions to improve capacity but that should not be the primary focus, and if included, a clear link to the diseases was required.

13 Generally, private sector and more economically minded actors are described as being more vertical or selective in approach, and public sector and civil society actors are described as more horizontal or comprehensive.
So originally, the decision made by the Fund was to limit the scope of their financing, not being too “keen to fund health systems components” and rather “[favoring] disease specific programming” (Dräger, Gedik and Dal Poz 9; Tan, Upshur and Ford 5). Horizontal components were not entirely out of the question, but weren’t sought after per se.

Nonetheless, by Round 4 (June 2004) the vocabulary used changed from may to should include positive system-wide effects, and the guidelines permitted an “‘integrated’ proposal addressing a comprehensive response to the three diseases that focuses on system-wide effects” (Dräger, Gedik and Dal Poz 3). So in three Rounds’ time, the Global Fund’s approach had already shifted from nearly purely vertical to something that was more diagonal in nature, seeking solutions that would benefit the system via the disease programs, with hints of horizontalism regarding the potential for integrated proposals.

By Round 5 (September 2005) a shift towards a horizontal approach became apparent when a specific window for health systems strengthening (HSS) was made available to the Country Coordinating Mechanisms (CCMs) (Dräger, Gedik and Dal Poz 3). However, this window proved to be a huge failure as few quality proposals were submitted.

The reaction to this failure was that in Round 6 (November 2006) the HSS window was eliminated and the Fund’s approach again became more purely diagonal. Round 6 was the first Round that aimed to provide a common framework for the required linkages between “disease specific programs and health systems interventions” (Dräger, Gedik and Dal Poz 11). 2006 was a key year for recognizing and beginning open dialogue on the HSS problems. This year saw Board discussions around major strategy topics, including HSS and the role of the Global Fund, especially in relation to its partner institutions (GF, 2006 BM 13 Report). It was recognized that the Fund’s vertical approach would only work if other partners financed health systems. Health systems were seen as fundamental to getting results. However, partners weren’t deemed to be doing enough in the area of HSS and due to this lack of complimentarity, new strategy policies began to take form and the Fund’s financing approach began to solidify.

After deliberation on the objectives for HSS, in April 2007 (GF, 2007 BM 15 Report), the Board decided to reassert an emphasis on HSS and to continue funding health systems in a diagonal manner. By November of 2007, the Fund’s decision was reaffirmed and the Board set out to encourage integrated requests for HSS, solidifying their decision to maintain a diagonal approach, meaning HSS through disease proposals, but including a possibility for cross-cutting components (HSS for the benefit more than one targeted disease and possibly
others as well)\textsuperscript{14} (GF, 2007 \textit{BM 16 Report}). Since Round 7 (November 2007), countries have continuously been able to include funding for strategic HSS activities as an explicit part of disease specific grant applications, a significant indication that the Global Fund has defined their approach as diagonal for the duration.

Likewise, in April 2007, the Board of the Global Fund agreed to \textit{consider} comprehensive country health programs for financing (Ooms et al. 2). While statements like this and terms like \textit{consider} don’t impose the Fund’s approach, another public declaration makes their position clearer. The Fund, in a joint statement with Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Alliance for Vaccines and Immunization (GAVI), United Nation’s Children Fund (UNICEF), the United Nations Population Fund, the World Bank (WB) and the World Health Organization (WHO), announced that “We, as international partners committed to improving health and development outcomes in the world, welcome and fully support the International Health Partnership’s\textsuperscript{15} mission to strengthen health systems” (UNAIDS in Ooms et al. 2). This joint proclamation, at the very least, raised the bar for expectations of partner organizations regarding HSS and spurred the beginning of a new dialogue between partners, concerning how to make each global actor’s role complimentary to one another in this policy area.

In summary, the Global Fund for many years struggled to clearly define its approach due to a dilemma between their disease specific objectives and health systems prerequisites, but over the last eight years HSS’s determinant nature has been increasingly recognized. After several episodes of changing their approach from vertical to diagonal to horizontal and back again, in 2007 the Fund’s health financing approach seemed to settle on diagonal. That is to say that after several phases of indecision, in 2007 the Global Fund re-added integrated and cross-cutting health systems strengthening to their collection of actions. However, the delimitation of their potential actions in HSS remains incomplete and ongoing. Multiparty discussions continue to further define what the Global Fund’s actions on HSS should be in cooperation with their partner institutions; their global role is still taking shape.

Essential to the topic to be investigated here, is the realization that the policy changes in 2007 are reflective of a moment in the evolution of the Global Fund’s approach to

\textsuperscript{14}The details of the policy will be further discussed in the analysis.

\textsuperscript{15}The International Health Partnership (IHP) is a group of partners who share a common interest in improving health services and health outcomes by putting principles on aid effectiveness into practice (IHP, 2010 \textit{About}). It was launched in September 2007 (IHP, 2010 \textit{About}). IHP is open to all developing and developed country governments, and agencies and civil society organizations involved in improving health who are willing to sign the commitments of the IHP (IHP, 2010 \textit{About}). Of the intended benefits of the IHP’s work are the long-term predictable financing for strengthening health systems and the harmonization between agencies (IHP, 2010 \textit{About}). For more see the IHP’s website (IHP, 2010 \textit{About}).
financing health. The Fund went from largely participating in only vertical financing in the beginning, to allowing entirely horizontal proposals for a short while during Round 5, to finally settling on a form of policy that was decidedly diagonal in 2007, allowing for integrated health systems components as well as cross-cutting components that would have benefits extending beyond singular diseases. The 2007 policy innovated by blending the former vertical and horizontal perspectives. This resulting diagonal approach remains today.

Moreover, this determination of approach has been a part of the organization’s self-definition of role and identity, in the sense of taking on ways of acting and believing that are deemed important (Selznick 21). The ultimate decision to keep HSS as an integrated part of proposals shows the Global Fund’s transformation from what may have originally been described as a vertical approach to something decidedly diagonal. Associated to these approaches are specific methods of financing (vertical approach financing targets disease oriented programs, horizontal financing targets the larger heath system, and diagonal approaches look for a way to finance diseases in a manner that benefits spread to other health issues and the larger system as well). Accordingly, this means that if taking on particular beliefs and ways of acting is part of an organization’s development of identity, and this identity is what differentiates an organization from an institution, then the 2007 changes should be seen as a singular chapter in the Fund’s story of institutionalization.
IV. The Theoretical Foundations of this Research

A. Philip Selznick: Institutionalization

Changes can be expected as a new organization evolves and metamorphosizes into an institution. Hesitance regarding the best approach to acting could even be seen as indicative of the juvenile phase in the institution’s existence, the phase where an organization struggles to define its identity and place in the global scheme of things. This phase is the process of institutionalization.

Various institutionalist theories exist, each defining institutions and how they come to be in a different manner. The purpose of this paper is not to make a comprehensive comparison of these theories. Institutionalist theory is but a backdrop to the play to be seen here. For this reason, only the principle ideas of Philip Selznick will be revealed as they can help paint an overall picture of institutionalization, so that the singular changes of the Global Fund’s approach in 2007 might be understood in context. Selznick’s work insists on change and the idea of organizations as the key unit of institutionalization and loci of the process (Powell and DiMaggio 13-14). His theory is therefore suited to the topic at hand since the goal is to look at evolution within a specific organization, the Global Fund.

According to Selznick, the difference between an organization and an institution is that the former is a mere “technical instrument for mobilizing human energies and directing them toward set aims,” while the latter is more of a natural product of “needs and pressures - a responsive, adaptive organism” that is characterized by added value, a sense of identity and purpose (5). He recognizes, though, that these ideals are not exclusive, allowing organizations like the Global Fund to be a technical instrument with set aims, but also recognizing the potential for change according to the necessities of the environment. For Selznick, the manner in which an organization becomes more and is “infused with value,” is what he refers to as the institutionalization process (17).

“Institutionalization is a process […] something that happens to an organization over time, reflecting the organization’s own distinctive history, the people who have been in it, the groups it embodies and the vested interests they have created, and the way it has adapted to its environment” (Selznick 16). An organization transforms into an institution as it blends technical aims and procedures with desires and group interests, acquiring a “self, a distinctive identity,” which involves the “taking on of values, ways of acting and believing that are deemed important for their own sake” (Selznick 21). This identity is accompanied by “a struggle to preserve the uniqueness of the group in the face of new problems and altered
circumstances” (Selznick 21). For the Global Fund to fight AIDS, Tuberculosis and Malaria, this would mean their transformation into an institution occurred with the embracing of their identity as a new international finance institution for the benefit of the three targeted poverty diseases, believing in and acting in a vertical approach by definition. Changing that approach and possibly expanding their actions to the broader health sector would put their unique identity in jeopardy, there is therefore a counterforce against change and adaptation in favor of the preservation of the Global Fund’s distinctiveness. The hesitance of approach that can be seen in the first few years of the Fund’s life is illustrative of this struggle between preservation and adaptation.

When an institution takes form, choices are made regarding value commitments, “which fix the assumptions of policymakers as to the nature of the enterprise-its distinctive aims, methods, and role in the community” (Selznick 55). Regarding the subject at hand, this would mean that the original choices within the Fund led to the value commitments of being a distinctive financial institution, aiming to decrease the incidence of the three targeted diseases, fixing what is seen as acceptable funding to be primarily vertical in nature and in accord with the regulations and procedures set out in the Global Fund guidelines. However, many perspectives and interests are present at all times and their balance may change and with it the institution’s values.

Yet, “an organization’s ‘true commitments’ […] are not unchanging” (Selznick 73). While there is an original definition of values of the institution, there are also modifications of the mission, identity and methods deemed acceptable by that same body. “Institutional aims cannot be taken as given, for they are conditioned by changing self-definitions, by alterations in the internal and external commitments,” pressures and demands (Selznick 82). The end product, or institution with a more stable identity, is the result of adaptation and the coming together of many factors.

For Selznick, the study of institutions requires considering the enterprise “as a whole and to see how it is transformed as new ways of dealing with a changing environment evolve;” it requires a historical approach that identifies key developments and actors that have the ability to overturn resistance and actually cause institutional change (141). What allowed change in 2007? How did health systems strengthening (HSS) become part of the Global Fund’s public politics in 2007? Selznick says to look at key developments and actors. While agreeing with the latter, the research here calls for going into greater detail when asking the question: what makes 2007 particularly inclined to approach definition and policy change? Why 2007 and not 2006 or 2008? What developments and actors made that moment the moment for change and evolution of identity?
Recognizing that the Global Fund is a health global public-private partnership (GPPP), there are many potential ways of investigating such a moment. Several approaches in political science have recognized the porous nature of policy-making, and the importance of actors and forces that cross state boundaries, as is the case for the decisions of a health GPPP (Lee and Goodman 98). To name a few alternative theories, the approaches of Reich; Walt, Lee and Goodman; and Frenk could all have been used to investigate the Global Fund’s 2007 health policy reform. Michael Reich’s book titled Political mapping of health policy elaborates his concept of ‘political mapping’, which tries to capture the entire range of diverse actors and interests concerned with policy issues (Reich in Lee and Goodman 98; Reich). Such an all-encompassing perspective could explain changes in a health GPPP like the Global Fund. Similarly, the ‘international’ or ‘global policy networks’ approaches of Gill Walt, Kelley Lee and Hilary Goodman, seen in Health Policy in a Globalising World, could be relied on, in order to explore the role of inter-organizational relations and social networks specific to policy decisions, formal and informal relations that are likely in such a health GPPP as the Global Fund (Lee and Goodman 98-104). Likewise, Julio Frenk’s ‘comprehensive policy analysis approach,’ which appeared in the journal Health Policy, could help enlighten the combination of various problems, principles, purposes, proposals, and protagonists, which contribute to policy reform (Frenk in Lee and Goodman 98; Frenk). Any of these theories could serve to explain significant policy changes, but another comprehensive approach seemed best adapted to explaining the convergence of various factors and participants around a singular moment in 2007, which lead to the HSS reform at the Global Fund: the backbone theory of this work, John Kingdon’s theory on public politics and policy windows.

**D. Kingdon: Public Politics and Policy Windows**

Kingdon investigates and responds to the questions: What makes certain subjects tended to at any given time? What accounts for the emergence of an issue at the forefront of attention? How does an idea’s time come? His answers are based on studying policy developments within the American Federal Government. Nevertheless, Kingdon’s thoughts are valuable and have been highly influential on the research at hand, as many parallels can be established between his theories regarding how policy development occurs in the USA and how policy development occurs at the Global Fund. The research on HSS in 2007 is shaped around his ideas as to why a moment is the moment for change. Consequently, the following
section exposes Kingdon’s principle thoughts while specifically relating them to the Global Fund.

i. When the Time Comes: Policy Windows

“Through a drastic oversimplification, public policy making can be considered to be a set of processes, including at least the setting of the agenda, the specification of alternatives from which a choice is to be made, an authoritative choice among the specified alternatives […] and the implementation of the decision” (Kingdon 2-3). For what concerns how an idea’s time comes, the latter is of less interest. The agenda is key, it is “the list of subjects or problems to which […] officials […] are paying some serious attention at any given time;” (Kingdon 3). For the Global Fund the agenda would be the list of topics given serious consideration in deliberations of the Board, especially those subjects that are reoccurring, such as key strategy issues that are given enough importance to be delegated to Sub-Committees for even further contemplation. Once the agenda is set, alternatives for action are developed and considered, narrowing the options, so that some are more seriously considered than others (Kingdon 4). Finally, a decision is made and a policy is drafted.

“In general, two categories of factors might affect agenda setting and the specification of alternatives: the participants who are active, and the processes by which agenda items and alternatives come into prominence” (Kingdon 15). Pinpointing the exact origins of an initiative is nearly impossible. “When we try to track down the origins of […] a proposal, we become involved in an infinite regress. An idea doesn’t start with the proximate source. It has history […] There is no logical place to stop the process” (Kingdon 73). Thus, it’s much less interesting to understand “where the seed comes from” than to understand “what makes the soil fertile” (Kingdon 77). Generally, it’s the fact that several factors come together all at once, which is responsible for an item becoming prominent (Kingdon 76-77). Therefore, the goal is not to decide whether it was a single participant or process that caused a subject to be considered and decided upon, but rather the goal is to understand how various factors joined together to affect policy. Kingdon theorizes on this joint impact by relying on the earlier ‘Garbage Can Model’ of Michael Cohen, James March and Johan Olsen, which he adapts to agenda-setting and his concept of ‘policy windows’ (Kingdon 84).

Running through decision structures are separate streams, or processes, each with their own life: problems, policies and politics. Separately, each of these processes can serve as an impetus and raise prominence, or a constraint and lower prominence (Kingdon 18). Any
participant, in theory, can act on any process (Kingdon 87). “The key to understanding agenda and policy change is [the] coupling [of participants and processes] at critical times […] A problem is recognized, a solution is available, the political climate makes the time right for change and the constraints do not prohibit action” (Kingdon 88). There is an opportunity, when the conditions to push a subject to a higher priority are just right. “Policy windows [are] the opportunities for action on a given initiative,” which occur as the separate participants and streams (problems, policies and politics) come together and are coupled at these times (Kingdon 166). Despite the rarity of such windows, major policy changes result from the appearance of these openings. This is the hypothesis regarding how the 2007 HSS changes came to be.

ii. Participants

Participants are sources of initiative (Kingdon 16). They include various categories of players: the administration, the members of representative bodies, experts, outside forces, non-government actors etc. These individuals have a crucial task, since when the moment comes for discussion, they are the source of initiative that signals new topics according to their own interests, world views, conceptions, ideas, mindsets, and resources. Agenda setting may involve the transfer of items from a larger “systemic” agenda to the organization’s “formal” agenda, partly through the mobilization of key individuals, or by the diffusion of ideas in professional circles, among policy elites, or perhaps resulting from a change in personnel (Kingdon 16). No one dominates the agenda, at least not consistently (Kingdon 44). Participants float in and out of decision making as it suits their own interests; if a topic is particularly important to them and the time is right then they push forward, if not then they stay on the sidelines (Kingdon 84). Moreover, the players with the most importance are not always those who are suspected. Therefore, it’s important to establish “which players are important, which players are thought to be important but turn out not to be, and the ways they relate to each other and to the agenda-setting process” (Kingdon 21).

The first distinction among actors is between inside and outside participants (Kingdon 21). Among the most notable internal categories are the administration and the representatives. The administration includes the executive body and its staff. For the Global Fund this would be the Executive Director and the Secretariat. Generally, when the administration, and especially it’s leader (the Executive Director), considers something to be a top priority so do many other actors, making them very influential in setting the agenda.
The staff is typically more important on forming alternatives for action (Kingdon 21). The leader has many resources that help his interests, including the institutional resources that are given to him in official legislation and his command of public attention (Kingdon 24-25). It could even be that those with an idea wait for a leader with the same view before making the proposal on the agenda (Kingdon 25). According to the By-Laws of the Global Fund, the Executive Director is supposed to have an influence on policy and agenda, but it remains to be seen, by way of further investigation, if what the Executive Director and Secretariat esteem as important are actually given attention or if the administration is not as influential as one might assume.

The second internal category of participants worth mentioning is the representatives. The Global Fund has two bodies of individuals that fit this category: the Board and the Technical Review Panel (TRP). On the one hand this is the location of representatives with established responsibilities in terms of policy, but on the other hand each representative has their own agenda and their history, and they may not be able to coordinate, or they may lack expertise, leaving them vulnerable to the mercy of other participants (Kingdon 34). The latter of the two, the TRP members, as a groups of experts, are each meant to represent certain areas of expertise and individual countries. They are intended to only have a say on the technical merit of proposals, and eventually the technical merit of policy upon the Board’s request. The Board of the Global Fund is the true legislative body, and for major changes in policy and approach, new legislation is required. For this reason, the representatives, and especially the Board members, are in a more likely position to dominate the agenda setting than any other participant.

Outside actors include any other international organizations, governments, non-governmental organizations (NGOs), researchers, academics, consultants or interest groups that might have an interest in getting involved in a discussion on a particular subject (Kingdon 45). Sometimes it is difficult to draw the line between the inside and outside participants. Academics and researchers often have relationships with official representatives as “common values, orientations and world views form bridges” between them, but they can still be distinguished regarding their decision-making authority (Kingdon 45). Some officials even lead a “double life,” or inner-outer careers as Kingdon calls them (56). At the same time, they work for the Global Fund and for other international organizations or academic constituencies. This is often the case for the Board members, and even more so for the members of the TRP, who, since the TRP meets infrequently, tend to have jobs as experts at private institutions or other organizations. Nevertheless, it is difficult to assign full responsibility for the emergence of agenda items to purely outside actors (Kingdon 49). Their
role can have many forms: by putting pressure on the legislative body to vote the way that they want since they hold the money (governments, interest groups and other international organizations), by having a long term influence on thought (academics and researchers), by serving as a supplementary source of expertise (consultants), or by setting the scene for the global discussion in a policy area like health (international organizations, non-governmental organizations, governments). Regarding the Global Fund in 2007, these potential outside influences could be their partner organizations such as Global Alliance for Vaccines and Immunization (GAVI), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the World Bank (WB); NGOs; academics, especially those writing on HSS and the approaches to health worldwide; and eventually interests groups. However, it is unclear how lobbying the Fund might work since no literature on the subject exists due to its infancy. For this reason interest groups are not a focus of the research presented here.

iii. Processes

As aforementioned, there are three processes that actors can act on by which agenda items and alternatives come into prominence: problems, policies and politics. It is the coupling of these streams that leads to the opening of a policy window.

At any time there’s a long list of problems to attend to, but certain problems capture more attention than others. Sometimes it’s a systematic indicator, sometimes it’s a dramatic event or crisis, or sometimes its feedback from an existing program that makes a particular problem move up the list of priorities (Kingdon 90). Systematic indicators may show a problem exists as both officials and non-affiliates monitor various activities and generate data (Kingdon 90-91). In addition, studies on specific subjects can be commissioned and may suggest a problem (Kingdon 91). Such sources of information for the Global Fund might include official evaluation reports, commissioned evaluations on the Global Fund in regards to HSS and non-affiliated studies on health systems implications of current funding schemes. These studies could show data on health systems such as the number of doctors working in targeted disease sectors versus other sectors, the number of hospital facilities, the amount of aid made available versus the amount of aid that was able to be distributed etc., which all might indicate a problem with the health systems that constrains the efficiency of the Fund.

Another potential clue for the Global Fund could be the feedback from existing programs. “In the normal course of events […] officials receive feedback about the operation
of the existing programs […] This feedback often brings problems to their attention: programs that are not working as planned […] new problems that have arisen […] or unanticipated consequences” (Kingdon 100-101). The Global Fund may receive feedback on the efficiency of their current financing policies in either a formal way, via systematic evaluations, or in an informal way, via complaints from people actually implementing financed programs on the ground.

Finally, a special sort of problem might influence the agenda: the budget. More than anything the budget can be a constraint. “Budgeting considerations prevent policy makers and those close to them from seriously contemplating some alternatives, initiatives, or proposals, or at least obliges them to revise their proposals to reduce estimated expenditures” (Kingdon 106). Concerning the 2007 HSS policy decisions, the question to ask would be whether or not the budget, or resources available to the Fund, influenced the acceptance of health systems as a potential area of action.

A second contributing stream to the agenda is the policies stream. The policies stream is two-fold. First, it refers to the “gradual accumulation of knowledge and perspectives among the specialists in a given area, and the generation of policy proposals by such specialists” (Kingdon 17). In this sense specialists and officials learn from existing policies’ feedback. For the HSS problem, this would mean that existing policies such as the guidelines of the former Rounds, allowed the members of the Global Fund to gather more information on the best way to finance AIDS, Tuberculosis and Malaria. This accumulated knowledge can lead to new proposals for change. Second, the policies stream refers to the manner in which policy ideas are exchanged and developed amongst a community of specialists (Kingdon 116-129). These specialists may be internal or external actors. For the issue of HSS at the Global Fund they may be: Board members, TRP members, Secretariat officials, consultants, members of other international health organizations, members of NGOs, academics, activists etc. However, despite their diversity, these specialists have common concerns of problems and common interactions; they often personally know each other, their ideas and research (Kingdon 117). Each specialist has their ideas as to how policy should be and they consult their fellow specialists in order to test their acceptability and eventually improve them. In this way the policy of one institution develops in a sort of expert network and benefits from the policy learning, discussions and exchanges that occur in various milieu: other health organizations’ chambers, universities, informal discussions amongst specialists, and so on.

Finally, the third stream to consider concerns political processes that can affect the agenda and decision making. These typically “political” events include but are not limited to: changes in personnel, ideological distribution in the representative body, variations in the
public mood and consensus building by way of bargaining (Kingdon 145-159). Any of these political occurrences could have had an impact on the HSS agenda and decision. “A change in administration is probably the most obvious window in the policy stream” (Kingdon 168). Key changes in personnel included the transition from Executive Director Sir Richard Feachem to Executive Director Michel Kazatchkine in 2007, as well as changes in the Board members, the TRP members and their respective Chairs. Clearly, the new members could have an impact on the balance of beliefs on the best approach to financing within the Fund. Yet, the variations of the public mood, which for the Global Fund translates to the general mood on HSS within the international health scene, could have also made those members (new and old) more receptive to new policy. And, lastly, consensus building and coalitions in favor of HSS could have occurred by bargaining between members of the Global Fund.

To summarize, timing is essential for agenda setting and decision making. Policy windows open as simultaneously there is pressing for change in more than one stream. For example, indicators may show a problem but only after a change in administration, and thus of mind set, is that new problem put on the agenda. It’s the convergence of many factors that makes a moment the moment for a change in policy and approach: global context; important events; outside actors’ influence; internal actors, their interests and expertise; the bargaining between actors; a change in key personnel; the budget; and the indication of a problem either by way of systematic evaluation, feedback (informal or formal), or the accumulation of knowledge from existing policies. Because all of these factors can be related to the specific case of HSS policy decisions in 2007, Kingdon’s theory of policy windows has been selected as the true backbone theory to this research, in order to answer: How did HSS become a component of the Global Fund’s public politics in 2007?
V. The Method of Research

As the saying goes, “there’s nothing as practical as a good theory” (Lewin in Quivy and Van Campenhoudt 95). A quality theory, like Kingdon’s, furnishes us with concepts that allow reality to be looked at in a new and intelligent way, and gives us the tools and internal architecture that permit an efficient and fruitful investigation (Quivy and Van Campenhoudt 95). “As a model of analysis, a theory presents itself as a more or less sophisticated hierarchy of concepts […] and hypotheses […] from which observation can be organized in an adequate manner regarding the objective but also ordered and thorough” (Quivy and Van Campenhoudt 95). Thus the tools that the theory gives have to be operationalized during the development of a method of research. Such is the purpose of this section, where the method used to investigate health systems strengthening (HSS) changes in 2007 is to be clarified.

Each study is a unique experience that takes its own path, the choice of which is made due to a number of criteria including: the posed question, the hypothesis, the researcher’s prior experience, the available resources, and the institutional context and limitations of the research (Quivy and Van Campenhoudt 114). For instance, in what concerns studying a change in policy of the Global Fund, available means of inquiry are rather restricted. No literature exists on the specific subject of the Fund’s HSS changes in 2007 as a reflection of evolution in approach to financing. It’s an original inquiry, which makes studying it bound by the limited resources that are available: the Global Fund’s official documents and the testimonies of members of the Fund during the period in question. The challenge is to use the available means in a clever manner so as to respond to the research question and confirm or disprove the stated hypothesis. Consequently, the method at hand can be divided into two parts: document analysis and semi-directive interviews.

A. Document Based Research

The Global Fund aspires to transparency, which works in favor of research. For each official meeting of a Global Fund body, some sort of paper trail is left. For instance every Board Meeting sees the creation of multiple documents: meeting reports, committee reports, options papers, Board guidelines, Executive Director’s reports, Secretariat updates, decision points, Technical Review Panel (TRP) reports and so on. Accessing these official documents is easy thanks to the Global Fund’s website. Shortly after each meeting, the documents are posted for public viewing on the site. Each one of these sources can provide clues as to who
the most important actors were for HSS changes, as well the processes and interactions that lead up to the decisions on the subject in 2007. However, this access to information does not mean that there aren’t holes in the records. The Global Fund may aspire to transparency, but it’s first few years of existence left much to be desired. As an example, documentation is much less clear for the first three Board Meetings. These first meetings only published one singular report document each, and that document does not even have a clear listing of the participants of the meeting. Also, in what concerns the deliberations themselves, no summaries are available. Deliberations are meant to be confidential. Thus information is available at varying degrees of transparency. Nevertheless, each of the available sources and the bits of information they provide can help piece together the puzzle of answering how HSS changes occurred in 2007.

The first way that official documents were used was to establish a complete listing of possible influential participants. In order to be able to understand who could be in a position of influence prior to 2007, what their experience at the Fund was, and how these actors would have interacted with each other over time, a complete list of the ‘who’s who’ of the Global Fund needed to be established. The documents were used to compile the most complete possible listing of the members of the Board, the TRP and the Executive Director from the beginning of the Fund until the present. The entire Secretariat would be too large to analyze within the constraints of the research, therefore only the Executive Director was initially considered for the listing. Later on the Director of Communications was added to the list due to his being suggested as an interview candidate.

The second way that documents were used was to establish some primary assumptions as to the processes that the actors were involved in regarding HSS up to 2007. By analyzing the various sources, developments regarding all three streams: problems, policies and politics, were recognized as potentially having an impact on HSS. The goal of this step in the research was to establish which occurrences could be linked to the opening of a policy window that may have led to the 2007 policy. The purpose was to narrow what information needed to be further confirmed as influential via interviews, in order to verify the hypothesis. These initial indications of a policy window served as the foundation for questioning during the second phase of research: interviews.
B. Interview Based Research

As the necessary information is not entirely available in written documentation, another form of research had to be relied on to gather supplementary information. Semi-directive interviews helped fill the gaps. The advantage of this method was that by asking a few targeted yet broad questions, interlocutors could be directed in a way that their responses corresponded with the official data in order to cross-reference, but still remained broad enough that they could respond with additional information that did not appear in written sources.16

Prior to actually doing any interviews, a supporting instrument was made. For the interviews to be as fruitful as possible, a guide was prepared in a manner that possible questions were listed pertaining to each stream indicated in the initial document analysis. As interviews are always subjective, when possible it was attempted to test the validity of the interviewees’ responses by cross-referencing with the official documents. Ultimately, the goal of the interview and document analysis combined was to be able to confirm if the policy window that existed on paper actually existed in reality, and was the reason that 2007 was the moment for policy transformations. Secondarily, the goal of the interview analysis was to establish the interlocutors’ appreciation for each stream’s dominance. As the type of interview conducted was semi-directive, this guide really was only a reminder to collect pertinent information for the hypothesis. It served as a detailed and structured list of possible questions that could be relied on throughout the interview process, while tailoring these questions to each individual and the natural flow of the interview. Because each interview lasted around 30 minutes, the total group of questions was never asked to a single individual.

Due to the fact it was very difficult to procure interviews with individuals who today find themselves occupied with a number of organizations across the globe and the process of interviewing (scheduling, interviewing, transcribing and analyzing) is very time consuming, it was only possible to interview 13 individuals. As is often the case with semi-directive interviews, the criterion for selection of interviewees was to attain a maximum diversity of profiles regarding the question at hand (Quivy and Van Campenhoudt 151). This is a ‘characteristic’ sample group. For the research on HSS, this characteristic sample group was chosen so as to have at least: one member of the Board for each category of constituency (donor, recipient, civil society and private sector, and non-voting); one TRP member for each group of expertise, and at least one donor and one recipient country amongst these experts;

16 A good example of this advantage can be seen regarding the information brought by the interview with the Dr. Jorge Saavedra. The latter suggested possibilities in the political stream that were not imagined prior to the interview, as will be elaborated in the analysis.
one Executive Director; and one prominent member of the Secretariat. Through much perseverance, a characteristic group was established with one exception. No non-voting member of the Board was available for an interview, besides the already interviewed Executive Director. Those interviewed included: members of the Board: Dr. Lieve Fransen, Dr. Sigrun Mögedal, Dr. Marijke Wijnroks, Dr. Jorge Saavedra, and Mr. Rajat Gupta; members of the TRP: Dr. Indrani Gupta, Dr. Peter Metzger, Mr. Blaise Genton, Mr. Andrew McKenzie, Mr. François Boillot, and Dr. Assia Brundrup-Lukanow; and of the Secretariat: Executive Director Sir Richard Feachem and Mr. Jon Liden.\textsuperscript{17} Further information on the backgrounds and positions of key interlocutors shall be given as deemed interesting and relevant in the analysis.

Special efforts were made to interview people who were initially recognized as of potential importance to the issue during document analysis, such as: the Executive Director, Chairs of the Board and the TRP, and the Board and TRP members from Norway and the United Kingdom.\textsuperscript{18} This was partially successful, as the Vice Chair of the Board from 2006-2007, Dr. Lieve Fransen; Chair of the Board from 2007-2009, Mr. Rajat Gupta; Dr. Sigrun Mögedal, Board member from Norway in 2007; and Executive Director Sir Richard Feachem, Executive Director up until 2007, were all contacted and interviewed. However, the Board member from the United Kingdom during the studied period, the members of those countries who are part of the TRP, the other Chairs, and the second Executive Director as of 2007, Michel Kazatchkine, were not interviewed.

The collection of interviews for this work was not ‘traditionally’ performed. The question studied here emphasizes actors in the years 2006-2007. A minority of the people involved at that time still work with the Global Fund, but have rather moved on to other things or find themselves jointly employed by the Global Fund and elsewhere. The various individuals are now spread out all over the globe. For this reason, only one of the interviews was a traditional face-to-face conversation. The majority of the interviews took place over the phone or by e-mail correspondence, simultaneously in Brussels and other locations as far as California and Pakistan. This complication made interviews a bit more challenging in terms of scheduling, and in the case of correspondence, limited the discussion.

Taken as a whole, the interviews were very productive and helped verify the policy window theory. As is expected, some discussions were more intriguing than others, but generally the result was positive. The answers of consequence will be presented in the

\textsuperscript{17} The characteristic sample group is further categorized in the Annexes.
\textsuperscript{18} The importance of these members will be explained in the analysis.
following section, but summarizing tables can be found in the Annexes for additional information.
VI. The Analysis of a Policy Window for Health Systems Strengthening

A. A Time of Change for the Global Fund

The first thing to be confirmed by means of analysis was that 2007 was in fact a moment of change in the Global Fund’s (GF) policy and approach to health financing. Health systems strengthening (HSS) was in fact re-added to the Fund’s collection of actions, establishing a new phase in the Global Fund’s institutionalization. Thus, trying to understand what brought this significant change is indeed a valid topic for discussion. However, like Kingdon remarked, establishing the beginning of the processes that led to that decision is nearly impossible, and as one interviewee mentioned, health systems were considered since day minus one of the Global Fund (Anonymous). The focus is that there was in fact a moment that permitted this change in approach, and consequently in identity and role.

During the interview with one of the veterans of the Fund, Dr. Lieve Fransen, the gestation of the Global Fund was discussed. Fransen said that the original conceptions and discussions occurred here in Brussels in her offices in 2000-2001. After noting that what she was saying was nowhere to be found in documentation, she revealed that at that stage those in discussion had,

“different tracks in saying okay, health systems, health services, and health professionals are also important concerns but we believed […] that that part of scaling up would be possible through budget support and through direct support at the country level and in addition we needed to create the Global Fund, and specifically to scale up the specific interventions for the three diseases […] We were very much concerned that the specific interventions for the three diseases be diagnostic, treatment, training, drugs and intervention methods that were not available at a large enough scale or products that were affordable. That was [to be] the focus of the Global Fund […] we had this discussion. We cleared this discussion. We took the decision to have a disease approach Global Fund, counting on other mechanisms to support health systems, health services and professionals” (Fransen).

From this excerpt of Fransen’s interview we can confirm that a clear decision was made at the conception of the Fund that a vertical approach was the best solution to solve the problems of AIDS, TB and Malaria. Recall that Gonzalez defined the vertical approach as “calls for solution of a given health problem by means of single-purpose machinery” (9). From this segment we can see how the Global Fund was meant to be such single-purpose machinery and that more horizontal, health system wide issues were secondary and left to other actors. Jon Liden, the Director of Communications and another veteran of the Fund, further elaborated on that decision to have a narrow role.
“The Global Fund was created during an ongoing debate about the benefits of focusing development assistance in health towards disease specific interventions, or towards what was health systems strengthening […] There was a very strong debate all through the creation of the Global Fund. Was it meaningful to have a Fund focusing on the diseases or not? Was it useful or was it going to distort? This debate was going on all along. It was just that during the beginning of this debate there was a very strong political argument and force behind the need for disease specific programs, and as we went along and that success was shown, there’s always the swing of the pendulum […] [actors saying] now we’re focusing a lot on these specific diseases but you haven’t solved the issues around health systems. And this debate has been […] basically going back and forth, back and forth, and as a result of it, gradually, we tried to experiment to find a way where we make as good a contribution as we possibly can to help outcomes, including health systems strengthening” (Liden).

Liden made an allusion to Uplekar and Raviglione’s description of the international health debate as a pendulum, but applied it to the Fund individually as well. The Global Fund went back and forth on the best approach, eventually allowing for the emergence of new positions and change in its interventions.

Originally, the “Fund’s role was defined at its inception in response to the situation at the time,” but “the context in which the Global Fund exists has changed, and the Global Fund has learned from its experiences” (GF, 2006 BM 13 Report OP). This is to say that as the Global Fund matured, members of the Fund recognized that the Fund is “young […] so there is an expected adjustment period” (GF, 2006 BM 13 Report OP). There was a realization that some policies may need fine-tuning and improvement. One interviewee explained that changes in the Fund’s situation made new options a reality. As the Global Fund matured and the level of pledged resources rose rapidly, the possibility of enlarging the scope of funding became a reality, which lead to new opinions regarding the Fund’s response to health systems constraints (Anonymous).

Members of the Global Fund began to see that over several years of scaling up funds, the original plan to stick to vertical programs of finance was not working for various reasons. One such reason was that parallel interventions in health systems were not being fulfilled by other actors and the health systems themselves were left acting as bottlenecks to the Global Fund’s programs. Members realized that “we couldn’t wait on others to do this, so we had to if we wanted these drugs and interventions to really be delivered to people […] we need health systems to do this” (Fransen). This is to say that after enlarging the scope of funding became a real possibility, a real ‘Plan B’ for consideration became the financing of health systems directly by the Fund even though it was not part of their original role.

Some interviewees mentioned that health systems components were always a possibility for inclusion in proposals, even in the very beginning. Yet, since most actors
agreed that the initial decision was that health systems were not within the role of the Global Fund, but rather their partners”, countries too perceived this vertical emphasis and even when the opportunity for limited HSS was given in early years, the opportunity was not always taken. “People at the country level perceived that the Global Fund was very much to fund the AIDS, TB specific programs, so […] we saw […] that even health staff, or anything broader was not being included in the proposals” (Wijnroks).

There were definite flaws in the original ideas of appropriate policy, both because of the policy itself and the way it was perceived, and the unclear role of the Fund in relation to its partners. As part of the evolution of a developing institution, these mistakes were attempted to be corrected as the Global Fund adapted and learned. The first attempt was by making a separate health systems window for proposals. Such a health systems window was opened in 2005, Round 5. Thus, the Global Fund, having first decided to finance disease specific, more vertical programs, had decided to correct the faults of that policy by opening up their financing to horizontal, system-wide programs. Nevertheless, the horizontal window was far from perfect and turned out to be a real failure and unable to resolve the health systems constraints.

Accepting the failure of the HSS window, in April 2006, the Policy and Strategy Committee (PSC) of the Board put the wheels in motion for the Fund to again modify their HSS policy and role within the world health scene (GF, 2006 BM 13 Report). Health systems strengthening was accepted as an issue to place on the strategic options development agenda, delegating further discussion to the Secretariat workgroups, the results of which would later be presented to the PSC in July (GF, 2006 BM 13 Report). On paper it appears that the Secretariat conducted the initial HSS reflection by relying on the internal expertise of its members; incorporating the latest research, reports and evaluations; consulting external support as necessary; and following the guidance of the PSC focal point- Executive Director Sir Richard Feachem (GF, 2006 BM 13 Report). The Secretariat’s ultimate task was to present their findings in an options paper. This options paper presented in 2006, helped set the stage for further strategic discussion.

One interviewee, Dr. Marijke Wijnroks, elaborated on the occurrences within the PSC from that point.

“We had a small group in the Policy and Strategy Committee, that I was part of, […] and there was a discussion on should there be a separate window, should it be included in disease specific programs and how to encourage […] There was a task team that I chaired, to come to a compromise because our positions were quite divided at that stage, and I think that it was the compromise that had health systems included in the
disease specific programs that would then include the cross-cutting issues that are not easily related with just one specific program. That’s the compromise that we came up with” (Wijnroks).

The Fund had gone from a vertical financing policy at the beginning (with health systems only integrated within specific diseases), to allowing entirely horizontal proposals in Round 5’s separate health systems window, to settling on a form of policy that was innovative and decidedly diagonal, allowing for integrated health systems components as well as cross-cutting components that would benefit more than one targeted disease and possibly others as well19. The 2007 policy blended the vertical and horizontal perspectives and became something new. Recalling the earlier sections of this document, one can see how this is a change towards the diagonal approach. Recollect that the diagonal approach to health “aims to build islands with a broad and solid base, and to gradually connect those islands, by helping fill in the swamp” (Ooms et al. 3). If here the three disease programs are those islands, and the integrated HSS provides the broad base and begins to fill in the gaps, the cross-cutting components of HSS only further boost the interconnecting of the programs and the possibility for wide-spectrum benefits. For this reason it is esteemed that indeed the research shows the 2007 policy modifications reflect a change in the Global Fund’s policy to a diagonal approach.

The documents and interviews analyzed confirmed this understanding of the Global Fund’s new policy as diagonal. When asked if she would describe the Fund’s approach as diagonal, Dr. Lieve Fransen said, “Sure […] If we wanted to scale up funds and scale up health services and train professionals […] you need to create something specific for that and not just do it by the back door. So yes, why not call it diagonal” (Fransen).

However, while agreeing with the idea of diagonal financing, many members of the Fund, including Fransen, went on to say that they didn’t agree with the vertical versus horizontal debate. “It’s an absurd dichotomy […] I have never believed that these two are contradictory, surely not if you look at them in the developing world. You need both and before I compared this to a CD player […] you needed a player and a CD because otherwise you don’t have music” (Fransen). Likewise, Dr. Marijke Wijnroks said of the Point Seven delegation to the Board, that they believe “the whole debate between vertical versus horizontal is quite artificial, and that the diagonal approach is making sure that you achieve the outcomes that you intend to achieve but also influencing broader systems building at the same time. It’s very important” (Wijnroks). Yet, perhaps the most interesting of all of the

19 The relevant sections, for this paper, of the Board Decision Point on HSS can be seen in the Annexes.
“Originally, there was a dichotomy between these two approaches but I think that the Global Fund’s main role to play in this debate, in particular from the period 2006 onwards, has been to say that this dichotomy is actually artificial […] the Fund was specifically set out to fight the three diseases but […] as it matured, especially by 2006, it was easy to see that a substantial part of grants went towards health systems strengthening activities […] towards infrastructure, toward training, towards salaries, to help out towards capacity building, towards administration, all of these issues […] what we have argued is that […] you can’t actually fight these three diseases without strengthening the health systems […] because in fact you fight them through health systems […] but also you cannot strengthen a health system without having a clear purpose or set of targets for what you want to achieve […] what was wrong with the arguments around HSS in the 1990s and those that held the line that HSS was the way to go and that fighting specific diseases is a distraction in the effort to improve overall health care service delivery and HSS in countries, we felt that the weakness of that argument was that if you don’t have a purpose for how you strengthen health systems, why you do it, and set clear targets for what you want to achieve, you will actually waste the money […] That’s one of the reasons why health systems stagnated and deteriorated in many developing countries […] You give purpose to why health systems should be strengthened, you give a rational […] you give a set of targets […] motivation and a drive towards doing this, and you strengthen the health systems in the process. And, what we see is that this goes far beyond the three diseases […] What we saw from [the 2005 separate window for health systems,] once it was opened, was that it was extremely difficult to define what are health systems strengthening activities if you do not link them to a specific outcome. That’s why we refined that window in later Rounds to become a window that focuses on HSS within the context of the three diseases […] you need a clear purpose” (Liden).

This quote is particularly noteworthy for this inquiry because not only does Liden confirm an evolution in policy and approach post 2006, but he gives significance and meaning to the Fund’s stance, arguing that the diagonal approach that connects targeted goals to the larger system is important. He argues\(^{20}\) that this newly evolved diagonal approach is significant and necessary not only because it is the best way to achieve outcomes for the three diseases but because it provides purpose and definition for broader health systems interventions, which otherwise is ambiguous.

Finally, the official documents of the Fund show that Executive Director Kazatchkine also embraced the newly asserted diagonal approach in November 2007. He remarked at the Board Meeting that the Global Fund was among the first to measure and report progress while highlighting cases where disease specific funds could benefit health systems, and that the

\(^{20}\) Jon Liden argued in his interview, however it should be noted that as Director of Communications, Liden speaks from the official position of the Global Fund.
benefits of such diagonal funding were being acknowledged more than ever (GF, 2007 BM 16 Report).

The case being made that 2007 did actually witness a change in health systems financing at the Global Fund, the question that is still left to answer in this analysis is how this modification of approach came about. How did HSS become a component of the Global Fund’s public politics in 2007? The remainder of this analysis will look into this question through the lens of Kingdon’s policy window theory in order to determine if the primary hypothesis - that HSS became an issue and changes were adopted in 2007 due to the opening of a ‘policy window’ - is true, and that indeed the most likely explanation for the change in policy is that a convergence of factors permitted it by making a moment ripe for change. Throughout the document analysis and the interviews, various factors were indicated as having resulted in a window for HSS policy changes, with varying degrees of emphasis and agreement between interviewees. As a secondary focus, the additional hypothesis that the most importance should be given to the changes in the personnel of the key organs of the Global Fund will also be answered. In order to demonstrate the existence of such a policy window, the following sections will present the findings of most significance, utilizing Kingdon’s categorization of factors: participants; processes-problems, policies and politics.

B. Participants

“One logical place to begin our story is with the players of the game” (Kingdon 1). As previously mentioned, there are many potential participants, or sources of initiative within or outside the Global Fund (GF). These actors can intervene anywhere in the multiple processes that lead to a new policy decision (Kingdon 19). The most obvious sources of initiative were already touched upon in an earlier section. Here, the goal will be to catalog a more comprehensive list of possible participants as they arose during the analysis, and to establish which participants were esteemed of importance by more than one source of information. Some actors seem significant at first glance, but in reality are not valued to be by their peers. For this reason, the inventory will not be entirely exhaustive, as the research sometimes indicated participants no more than one time and without real conviction or corroboration from another source.

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21 The summary of the information discussed in each of the interviews can be seen visually in a series of two charts in the Annexes.

22 For a visual representation of the importance of the various participants, according to the interviews, please see the charts in the Annexes.
For our purposes, participants include both ‘macro’ and ‘micro’ participants. Macro, or large-scale, participants are collective bodies; they are either the organs within the Global Fund itself, or the other global organizations that had an influence on the Fund’s HSS discussion. Micro, or small-scale, actors are individuals or singular delegations to the Fund. Clearly, there is some overlap between the two as the small-scale actors are included within the larger, but at times in the analysis the influence of the two did not always correspond. Therefore, for clarity, the participants will be categorized as internal and external according to Kingdon’s categorization (21), and within each of these categories, first the macro level actors shall be presented followed by the micro level. This section only aims to indicate who the participants are, as the remaining analysis will reveal their involvement in the various processes.

i. Internal

Internal actors of the Global Fund include the various bodies within the institution - the Board, the Technical Review Panel (TRP), the Secretariat, the Board Committees - as well as the individuals and singular delegations that make up those bodies. These are participants which one has a logical reason to assume are involved in decision making, as their formal functions are defined by the Global Fund itself. Yet, it must be confirmed that their roles are as they seem.

Initially, official document analysis suggested that the larger scale participants included: the Board, the TRP, the Secretariat Strategy Teams, the Board Committees, and especially the Policy and Strategy Committee (PSC), as all having been part of the 2007 development of HSS policy (GF, 2006-2008 BM 13-18 Reports). All interviews came to the conclusion that the Board was definitely the body with the last word on HSS policy decisions, as its function as the legislative body suggested. Yet, the PSC seemed to be the real location for discussion on how HSS policy should be, dually established during both phases of analysis. To a lesser extent, the TRP also served as a source of input, but only concerning technicalities and policy wording issues. Documentation suggests that the TRP had a role of feedback, but interviews lead to the conclusion that the TRP input on HSS strategy was actually very minimal. Finally, the report of Board Meeting 13 pointed to the key function of the Secretariat Strategy Teams, who in conjunction with the PSC focal point (Executive Director Sir Richard Feachem) developed an Options Paper on different strategic issues, including HSS (GF, 2006 BM 13 Report). On paper that seemed to be the key starting point
for the HSS discussion that led to the 2007 policy decision. However, no interviewees confirmed these bodies as having had an indispensable impact on HSS policy.

Regarding the smaller scale internal participants, the document analysis called attention to both individuals and key delegations. Those individuals holding leadership positions within the Fund during the period from 2006-2008 were: Executive Directors (ED) Sir Richard Feachem and Michel Kazatchkine, Deputy Executive Director Helen Evans (during the transition period in 2007), the Chairs and Vice Chairs of the Board, and the Chair of the TRP (GF, 2006-2008 BM 13-18 Report). Interviews partially confirmed the leading roles of Feachem and Kazatchkine\(^\text{23}\), but no interviews indicated that Helen Evans played a significant role. Similarly, the Chairs and Vice Chairs of the Board: Chairs Carol Jacobs and Rajat Gupta, and Vice Chairs Lieve Fransen and Elizabeth Mataka (GF, 2006-2008 BM 13-18 Reports), though officially positions of leadership, upon further inquiry did not appear to have overly influential roles on HSS policy. The Chair of the TRP, Professor Peter Godfrey-Faussett, who, like the TRP itself, seems also to have had a minimal role (GF, 2007 BM 16 Report TRP Report).

Other micro level internal participants include the individual delegations\(^\text{24}\). The report of Board Meeting 16, suggested three individual countries - Norway, the United Kingdom, and Germany, and their constituency delegations to the Board, as having had an impact on the HSS debate due to their pushing ahead on their own and making strides in HSS by way of national programs (GF, 2007 BM 16 Report). Norway and the Point Seven\(^\text{25}\) Delegation’s efforts for the Millennium Development Goals 4 and 5 and their leadership in HSS discussion within the Global Fund was confirmed by the interview analysis. Likewise, the UK representatives, who had launched the International Health Partnership, were also recognized by a couple of their peers as having had an impact in HSS debate. However, Germany, who had made national efforts with the Providing Health Initiative, failed to be mentioned at all apart from the official document analysis.

A few additional delegations were mentioned over the course of the interviews that were not mentioned in the documents, both as either having had a positive impact in favor of expanding HSS policy or for favoring a limited HSS policy. Those in favor of HSS financing by the Global Fund included the non-governmental organizations (NGO) delegations

\(^{23}\) See the following sub-section on personnel change, within the political streams section, for more clarification.

\(^{24}\) It should be noted, that the European Commission (EC), which some might consider as an external macro level actor due to its nature, is actually considered to be an internal micro level actor in this analysis because they hold their own voting delegation on the Board. However, no part of the analysis revealed their influence to be determinant (besides the involvement of individual participants of that delegation, like Dr. Lieve Fransen), and for this reason the EC as a whole is not given much emphasis.

\(^{25}\) Point Seven is the Delegation to the Board, which includes the countries of Norway, Denmark, Ireland, Luxemburg, Netherlands, and Sweden.
(Wijnroks; Liden; Anonymous) and the African or other recipient delegations (Saavedra; Liden). Of those in favor of limiting HSS policy, the USA representatives (Fransen; Wijnroks), the Private Foundation delegation and the Private Sector delegation, were said to have “seemed to always be more critical for fear of diluting mandates […] [and] influential in narrowing the scope” of HSS policy (Wijnroks).

ii. External

External participants include any other international organizations, governments, NGOs, researchers, academics, or consultants that might have an interest in getting involved in a discussion on HSS. Again, for clarity the external actors have been divided in two categories, macro and micro, and, in addition, there is one sub-category of significance in both of these, inner-outer participants. Inner-outer participants hold positions or carry out action at the same time within an organization and outside of it (Kingdon 56). Another way of saying this is that ‘they wear two hats.’ The inner-outer actors will be revealed at the end of both the macro and micro portions, as there are both organizations and individuals that fall under this particular category of participants.

The purely external, macro level participants that were initially indicated in the Global Fund documents included the United Nations Children’s Fund (UNICEF) and the Global Alliance for Vaccines and Immunization (GAVI)26 (GF, 2007 BM 16 Report). None of the interviews confirmed the former’s impact, but GAVI was by far the most agreed upon external participant amongst the interviewees. GAVI actually proved more significant than assumed after document analysis. Nearly all interlocutors confirmed their role in HSS policy discussion. GAVI, though not a formal partner, was described as a “cousin” (Liden) and an initiator in developing HSS policy and the new joint health for all platform that is continuing to develop (Wijnroks).

Interviewees were also questioned regarding the influence of another large-scale actor that was not indicated on paper: the academic world (as a whole). However, few interviews led to the conclusion that the academic world had a significant impact, at least not as a solely

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26 The GAVI Alliance, like the Global Fund, is a global health partnership. They represent stakeholders in immunization from both private and public sectors: developing world and donor governments, private sector philanthropists, the financial community, developed and developing country vaccine manufacturers, research and technical institutes, civil society organizations and multilateral organizations like the WHO, the UNICEF and the World Bank (GAVI Who We Are). GAVI’s work is to offer accelerated access to these vaccines: yellow fever, pneumococcal, Hepatitis B, rotavirus, measles, pentavalent, Haemophilus influenzae type B (GAVI What We Do).
external participant (see micro inner-outer). They were described as not really having been catalysts or having driven the thinking process on HSS (Fransen).

Continuing with macro level participants, a few that fall into the inner-outer category are worth noting. The World Health Organization (WHO), the World Bank (WB), and Joint United Nations Programme on HIV/AIDS (UNAIDS) are all partner organizations of the Global Fund and sit on the Board without the right to vote, while maintaining their independent functions outside the Fund. All three were indicated by both the documents and interviews as having had a hand in the HSS debate (GF, 2007 BM 15-16 Report). However, the WHO was emphasized more during both phases of the analysis. The WHO was directly asked by the Board to hold a consultation or find another forum for discussion of appropriate HSS for the GF using WHO expertise on the subject (GF, 2007 BM 15 Report) and that collaboration did take place (GF, 2007 BM 16 Report). This expertise and consultation on health systems strengthening (HSS) can be explained by what was seen earlier in the section on the international health debate. Recall that the WHO was cited as one of the earlier organizations to consider horizontal actions and was part of the Alma Ata Conference and Declaration. In addition it was specified in the later documents that the HSS policy itself was based around WHO definitions of categories of HSS “building blocks” in order to maintain a coherent definition of HSS activities for applicants (GF, 2008 BM 18 Report TRP Report). In addition to documentation, WHO’s involvement was discussed by many interviewees and Dr. Lieve Fransen specifically mentioned the impact of the WHO consultation and that she headed up a health professional group in the WHO, which discussed the issue (Fransen). One interviewee described these various interactions as “inter-institutional dialogue” (Anonymous).

The purely external, micro level participants that are worth mentioning include external consultants and individual leaders at other international organizations. A few interviewees mentioned the involvement of external consultants, including some consultants that are university-based. Only one specific consultant was mentioned both in documents and interviews: Alexander Shakow (GF, 2006 BM 14 Report ED Report; Anonymous). However, he was only specifically mentioned in one interview. As regards the leaders of other organizations, Board Meeting 16 mentioned important changes in global leadership at the WHO and WB, the timing of which corresponds to the new emphasis on HSS and thus called for further questioning. Interviewees indicated that certain leaders of other organizations had an impact on the HSS debate globally and/or pertaining to the Global Fund. People of

27 The Annual Report of the Director-General for 1951 of the WHO was cited as the one of the earliest case of recognizing health systems prerequisites (WHO, 1951 Annual).
significance included: Andrew Castells\textsuperscript{28} of the WHO, the CEO of GAVI Dr. Julian Lob-Levyt (Fransen), and the WB Presidents Paul Wolfowitz and Robert Zoellick (Anonymous).

More interesting, and certainly more likely to have been influential, are the participants that fall into the micro level, inner-outer category. Over the course of the investigation, it was uncovered that many members of the Global Fund, on the Board and TRP especially, have one foot inside and one foot outside the institution, continuing to be involved with or coming from the academic world or other institutions. More than one interviewee suggested that much of the Global Fund is made up of personnel, which is recruited directly from the academic world (Fransen; Anonymous). Others mentioned how different institutions were connected via individual participants. As one example, Dr. Wijnroks noted that “a couple of us were involved with GAVI and the Global Fund Board at the same time” (Wijnroks). These inner-outer participants can serve as vectors for the external, macro actors to have an indirect influence on the internal deliberations of the Fund.

This concludes the inventory of participants. As Kingdon said, “Enough about the players, what about the game?” (16). Recall that regarding the “game,” any participant could be involved in any of the processes that led to a policy window (Kingdon 19). The next sections will illuminate how these actors were involved with the different streams (or processes) - problems, policies, and politics - which lead to the HSS policy of 2007.

\textbf{C. Processes}

\textbf{i. Problems}

The first process to be analyzed is the problems stream. Recall that at any given time there’s a long list of potential problems for an organization to attend to, but that certain problems capture attention more than others, leading certain issues to make it onto the policy agenda in lieu of alternatives (Kingdon 90). Why? Problems can be brought to our attention in a number of ways: dramatic events, systematic indicators and current policies, personal experience, or feedback from the field. The following section will present the information uncovered on the health systems strengthening (HSS) problems stream by splitting it into two parts: first, the aspects of the health systems problem that impacted the HSS agenda and

\textsuperscript{28} Within the WHO, Andrew Castells was Director for the work on the Millennium Development Goals, as well as Health and Development Policy. He was on the WHO Board and worked on the health systems issues (Fransen).
discussion at the Global Fund (GF) will be explained; and second, the means by which the problems were indicated shall be clarified.

\[a. \text{Aspects of the Health Systems Problem}\]

\[1. \text{Health System Constraints}\]

Nearly all interviewees agreed that the existence of health system constraints led to rethinking the Global Fund’s HSS policy. At many reprisals the term ‘bottleneck’ was used. The term bottleneck is significant itself, meaning that the performance or capacity of an entire system is limited by a single or limited number of components or resources. Dr. Lieve Fransen said that the health systems bottlenecks were preventing the programs financed by the Global Fund from being optimally efficient and effective (Fransen). Marijke Wijnroks also used the term bottleneck and said that if the Fund wanted to increase access to disease specific programs, these health systems barriers had to be tackled (Wijnroks). In summary, the general assessment was that because the health systems were weak or non-existent, the lack of infrastructure made it difficult to meet the goals set out by the Global Fund (Saavedra). These goals are two-fold, on one hand, the Fund is targeting the three diseases, but on the other, the Global Fund, since its conception, has had the aspiration of doing this in a way that results in greater health overall. Health systems constraints were recognized as a problem that inhibited both from being achieved, and thus spurred further contemplation of how the Global Fund should finance health in developing countries, so as to include HSS or not.

In relation to this primary bottleneck problem, many other facets of the health system problem influenced the decision on HSS policy. The four following segments shall explore these remaining components: absorption capacity, distortion, partner deficiencies, and budget.

\[2. \text{Absorption Capacity}\]

One specific aspect of the health systems problem that is integrally related to the constraints preventing the Fund’s goals to be met is the problem of absorption capacity, which was recognized as an issue in both phases of analysis. The main concern for absorption capacity in an implementing country is that, “the capacity of country health systems, which are an essential foundation for the implementation of funded programs, is sometimes poor leading to slow implementation” (GF, 2006 BM 13 Report OP). Furthermore, there was the concern that these insufficient systems were incapable of absorbing and coping with large and
continuous funds; there is a concern that these systems couldn’t put the grant money to use because of a lack of means (infrastructure, health professionals…), leading to either delayed or incomplete performance (Gupta, Dr. Indrani). This concern for absorption capacity rang out amongst all: Technical Review Panel (TRP) members, Board members and Secretariat personnel. The absorption issues were directly related to the HSS discussions, as illustrated in the following passage.

“In the early days […] the Global Fund had its opponents and there were some fairly loud voices […] Those opposing the Global Fund had a variety of arguments, one of which was absorption capacity. This argument was that the sums of money that the Global Fund intended to accumulate and invest would be simply impractical in light of the absorption capacities of the lower income, developing countries. And, that if you created this large pot of money and said, “please apply,” which was the Global Fund’s model, the limiting factor which would quickly begin to be felt would be absorption capacity. The countries could not make good use of these large amounts of money. That had a lot to do with health systems […] We had never tried to make large sums of money available to programs that were designed and owned in and by the developing countries themselves, and you can’t know [if it will work] until you try […] The reason the opponents said they were skeptical was because the health systems are so weak that they can’t possibly make use […] For the reason that the opponents of the Fund had it as one of their key arguments, were very much under discussion” (Anonymous).

The absorption problem brought to the attention of the Fund, directly and by its opponents, certainly gave cause to consider HSS financing as a way to increase efficiency and satisfy its critics. Yet, it was not the only aspect of the health systems problem that was involved in creating a window for HSS policy, there was also concern regarding a risk of distorting country health systems.

3. Distortion Problem

The distortion problem refers to the fact that the Fund, by its own focused financing, was inhibiting the accomplishment of its second goal to promote better health overall. The trouble is that the Global Fund’s targeted financing can have,

“a lot of negative impact in countries on other disease programs, like for instance mother and child healthcare, because people go where the money is. Other programs suffer because the Global Fund supports massively these three disease components. For instance, there’s a lot of money in TB so people tend to go to these programs because they have money. So they leave other primary health care programs to work in programs where there is money” (Metzger).
Though distortion is not noted directly in the Board documents, some mention of preventive measure for distortion problems are noted as having been discussed and in need of further reflection. At Board Meeting 15, Chair of the Policy and Strategy Committee (PSC), William Steiger, presented the PSC’s view that the Fund should invest in HSS activities to help reach better outcomes, but that the PSC could not come to a consensus on whether the Fund should supplement salaries in the public sector as part of the approach (GF, 2007 BM 15 Report Report of the PSC). Consensus or not, this statement signifies that there was recognition of a risk that health professionals were drawn from one sector to another due to better pay. While this is the only official record of this discussion, evidence of the issue being taken into consideration amongst the participants was recurring during the interview analysis.

Various interviewees mentioned that they (the members of the Global Fund) got feedback that with the same amount of staff and shortages in developing countries, implementers had to do much more work, and that this led to distortions. Since Global Fund programs are results based, countries were putting their limited resources in these necessary areas and sometimes at the expense of others because there was no broader system assessment. Good people and good results would be pulled from other programs to strengthen their results in Malaria, TB and HIV/AIDS, weakening the health system as a whole (McKenzie). The concern that funding “vertical systems would withdraw human and other resources from already weak systems and would thus threaten sustainability” was not only shared by members of the Fund but also by other organizations like the World Health Organization (WHO) and the countries themselves (Brandrup-Lukanow). These distortion problems in part “led to the discussions within the Global Fund about […] broader health systems components” (Wijnroks).

4. Partnership Deficiencies

Another problem, which evidence shows had an influence on considering the health systems issue, was the deficiencies in the financing and programs of partner organizations in the field of HSS. This problem was largely supported by the document analysis. As mentioned earlier, the Global Fund was conceived with the idea of restricting its financing programs to those targeted at the three diseases. The idea was that this vertical approach would be supplemented by more horizontal funding from their partners, especially from the WHO, Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank (WB), the partners who sit on the Global Fund Board. However, several years later horizontal funds had not been sufficient in ‘jump-starting’ health systems. In 2006, the Global Fund recognized
that the ultimate purpose of the Fund, to fight the three pandemics, was a “challenging task that no single entity can hope to achieve on its own,” but that the Global Fund, as a financing mechanism only, is part of a “a broader ecosystem of multiple actors […] and is] dependent on partners” for success (GF, 2006 BM 13 Report OP). Furthermore, since success of the originally defined role of the Fund was largely dependent on its partner organizations, inadequacies in the latter’s actions lead to implementation constraints. At Board Meeting 13 it was remarked that much had been learned in this regard, and that from those lessons the appropriate role of the Global Fund was being redefined, especially in relation to its partners (GF, 2006 BM 13 Report OP). The capacity of country health systems were accepted as a constraint, yet the Fund’s partners were not doing enough themselves to step in, some requesting “additional funding (from the Global Fund as well as other sources) in order to provide the requested amounts of assistance” (GF, 2006 BM 13 Report OP). There were inadequate provisions of services and, in order to resolve the tension between the Fund’s accountability for its programs’ efficiency and its role, the Fund had to consider altering its role and range of actions. Official documents show that as a result of this inadequacy, “the Global Fund has evolved somewhat from a model of pure financing to a model where it […] begins to enable on-the-ground performance” (GF, 2006 BM 13 Report OP). In summary, we can draw from these Board documents that because the Fund’s original vertical approach was dependent on others’ horizontal approach, and the later proved lacking, the Fund was driven to consider expanding its own approach to something more horizontal or diagonal.

Interviews confirmed that in some measure the partners’ failures to complete their roles, led to the evolution of the Global Fund’s role as a financing mechanism and to the HSS policy of 2007. As one example, Dr. Marijke Wijnroks noted that of the primary partner institutions, the WB had been reducing its funding on health and that the WHO is not a funding agency anyway, so even if “ideally, in a perfect world, partners would have had mandates to help […] and increase their funding to health systems […] that never happened […] in an ideal world yes the Global Fund would be totally additional to what other partners are doing […] but we aren’t in an ideal world” (Wijnroks).

Yet, even though the Global Fund decided to have an integrated HSS window and to partially combat health systems constraints on their own, their role is still evolving regarding health systems and their relationship with partners. Their precise role in HSS is still to be determined according to what their partners’ final role will be.

“Now there’s a big discussion about the common platform between GAVI, the Global Fund and the WB, to really take seriously […] and the big discussion about what
would be the proper role for the Global Fund looking forward in the health systems arena [...] I think that the answers to that are quite far from the mark and need a good deal more of design work and careful thinking about the comparative advantages of the three institutions [...] they’re talking about this a great deal right now because of the Gordon Brown-Robert Zoellick taskforce on innovative financing, which was launched at the UN General Assembly in September 2009, that a common platform to be created to sort out the current model of who’s responsible for what, and which comparative advantage of which institution suggests which role and responsibility [...] What should the World Bank do, what should GAVI do and what should the Global Fund do - that’s a really important thing to get right. There’s not a clear answer to that question” (Anonymous).

5. Budget

A final aspect of the health systems problem to be considered, regarding the debate and decision on HSS policy, is the Global Fund’s budget. Recall that Kingdon classified the budget as a special type of problem, one that could act as a constraint or a push - insufficient funds serving as a constraint, abundant funds serving as a push (Kingdon 106). From the fact that in 2007 the Global Fund’s budget was looking optimistic, one could draw the assumption that the ample budget facilitated the HSS policy changes, which were likely to increase expenses. A broader horizon of funding possibilities meant a potential for larger proposal demands. On the other hand, one might also question if, had the HSS decision taken place after the global economic crisis, whether or not the outcome of the HSS policy may have been different. In that scenario the budget could have acted as a constraint. As it was, the decision on HSS was taken at Board Meeting 16, at the end of the year 2007, when things were still looking up in terms of resources.

The Global Fund had recently significantly expanded the amount of money given to them by donors. As of mid-February 2007, 10 billion USD were entrusted, and after the Oslo Replenishment Meeting in March of that year, another 10.4 billion USD was pledged, and 7.1 billion USD paid to the Global Fund (GF, 2007 BM 15 Report Report of ED). By Board Meeting 16 (November), just after a second Replenishment Meeting in Berlin, Executive Director Kazatchkine announced that the Global Fund had become the largest multilateral financer for the three diseases (GF, 2007 BM 16 Report Report of the ED). The final decision to continue in HSS actions by way of an integrated HSS window with crosscutting components was taken at this Board Meeting as aforementioned. This was prior to the global financial crisis, which took full effect in 2008.

29 Interestingly, at the Oslo meeting, donors actually discussed HSS as a critical theme for the Global Fund.
The tone of optimism changed by Board Meeting 18 in November of the following year, when Executive Director Kazatchkine voiced a distinct tone of concern. “This Board Meeting takes place during a period of instability and uncertainty for the international community, with the global financial crisis giving rise to fears of economic recession in many countries. Resolving the tension between increased demand and currently available resources is a major challenge” (GF, 2008 BM 18 Report ED Report). Kazatchkine went on to call for looking into ways to decrease the cost of Round proposals. One gets the impression that the budget was facing serious difficulties. To further acquire an appreciation of the budget’s impact on HSS discussion, interviewees were asked their opinion.

For the most part, the interviewees agreed that the budget played a role in the development of the HSS policy, at least in so far as the more optimistic budget in 2007 did not put the same constraints on strategy decisions as it does today. For Marijke Wijnroks, the economic crisis and the prospect of a tighter budget would have been a good argument for those that were hesitant (Wijnroks). Along the same lines Dr. Lieve Fransen mentioned that had they waited a little longer and had the economic crisis been dominant in the political arena, there likely would have been even more hesitance and more calls to focus on the disease approach (Fransen).

This idea was reformulated by other interviewees who said that the budget was not a major constraining factor back then and that the 2007 decision was not put in jeopardy by the budget, but that today it is a growing concern (Gupta, Rajat; Anonymous).

“High quality demand now exceeds the ability to finance. And that is causing really tough questions about the investments stream in AIDS, TB and Malaria, and is bound to have a huge influence on the discussions about opening up any big additional effort in HSS […] because if you’re sitting on the Board you’ll say wait a moment we can’t guarantee finances for the HIV, TB and Malaria work today. That’s why we set the Global Fund up […] That will really weigh heavily on opening up any additional health systems field of work” (Anonymous).

However, not all interviewees indicated the same certainty that a change in resources or the economy would have influenced the HSS policy decision. On one hand, Mr. François Boillot, a member of the TRP since 2006, noted that as far as the TRP’s part in the HSS policy development and evaluation is concerned, the budget had little influence. He remarked that when the TRP members meet they are not made aware of the budget prior to their deliberations and it therefore would have had little impact on their determination of the utility of HSS financing in proposals (Boillot).
When talking to Jon Liden about the possibility that the decreased budget would lead to discussions about cutting back on HSS or prioritizing grants, he recognized that the economic crisis left a situation of scarcity of resources but he denied that that scarcity would have any impact on financing priorities. Rather, to the contrary, he suggested that there was an understanding that in a time of economic difficulties it was understood that health spending is important in developing countries and that it should certainly not be narrowed in terms of what to finance; “if anything it should be expanded” (Liden). Mr. Liden also acknowledged that the Global Fund was facing a new situation post-crisis, and that until recently “the Global Fund has been able to finance every single proposal that has been recommended for financing [by the TRP] which is fairly unheard of in the international context […] There is a substantive debate about whether or not that will continue to be possible in the future” (Liden). Yet, Liden maintained that, regardless of the new budget situation, there was no debate about prioritizing grants or whether or not to continue with HSS financing (Liden).

Despite some diverging opinions, the overall conclusion from the analysis is that the budget was a factor in the HSS policy, even if it only served to permit strategy decisions in favor of HSS. It may not have been an apparent push factor, but it was not a constraint in 2007.

b. Means of Indication

The problems that led to HSS reaching the policy agenda are many: health system constraints, absorption capacity, distortion, partnership deficiencies and the budget. The question left to answer for the problems stream is how these facets of the health systems problem were brought to the Global Fund’s attention. Kingdon’s theory mentions that problems may profit from a dramatic instance to grab the attention of policy makers, but that drama rarely carries an issue all the way to the agenda. Rather, it is more likely that it’s feedback from the field, personal observation, commissioned studies and/or feedback from existing policies and systematic indicators which makes a solid case for the problem to be scrutinized amongst officials. The analysis here confirmed the secondary nature of dramatic events, since neither the document analysis nor interviews revealed any attention-grabbing instance that drew the problem of HSS to the Global Fund’s agenda. However, all of the other cited means of indication were mentioned at one point during the research.
1. Feedback from the Field

As early as Board Meeting 13, in the Secretariat’s Options Paper, it is mentioned that one of the Global Fund’s specific lessons learned was that despite the large influx of money to countries, “it became apparent that funding - while critically important - was not the only constraint to achieving significant impact against the diseases,” going on to name HSS as one such implementation issue (GF, 2006 BM 13 Report OP). The words “it became apparent” suggest that there was a feedback of some kind which indicated a problem; but the official documents fail to announce the form of this initial feedback. In reality, it is safest to say that throughout the debate on HSS, from 2006-2008 or even before, feedback and lessons came in a variety of forms both formal and informal. Dr. Wijnroks said that feedback was “both and a lot of observations were done around the Global Fund, and we had all the informal feedback from the country level, which was quite consistent, and then these evaluations were done around the Global Fund [studies etc.] […] and all these were quite consistent” (Wijnroks). Rajat Gupta also said that there were “all kinds of inputs” (Gupta, Rajat). From this we can discern that even from the viewpoint of one member of the Fund, it can be hard to see which form of feedback had the most influence in bringing the problem to the forefront. The interview process was used to gain a better appreciation for each form’s importance, according to how the group of interviewees valued them.

One of the forms of feedback that many of the interviewees agreed had an influence, was informal feedback, or word-of-mouth from people in the field of healthcare at the country level. For example, Dr. Jorge Saavedra noted that a lot of the information on the health systems problem was coming from people at the country-level in Africa who then would address the Board (Saavedra). Of course, in terms of absorption capacity and distortion problems, these issues were also generally brought to the Fund’s attention because of feedback from the country-level actors who were witnessing the problems.

2. Personal Observation or Experience of Delegates

A second means for drawing a problem to the Global Fund’s attention is by the personal observation or experience of delegates. On one hand, personal observation refers to the possibility that the delegates may have had the opportunity to directly witness the health systems constraints in developing countries; or, on the other hand, they may have had the

See the Processes Chart in the Annexes for a visual representation of the interviews’ collective appreciation of means of indication.
experience of living in these countries making them intimately familiar with the problems that health systems impose on program implementation. Both are forms of experiences but with varying degrees of awareness.

The clearest account of this means of indication came from Dr. Jorge Saavedra, a Board member from the recipient constituency of Latin America and the Caribbean, who explained how the Board members were exposed to health systems problems via personal observation.

“Once every year the Board meets in a developing country or implementing country. And, at least two times I went as a Board member, as well as other Board members, to African countries to see how the Global Fund programs were performing. Many of us realized that there was a need for health systems strengthening because a lot of the issues being addressed in terms of care were being based in community facilities and they were not exactly the best facilities in terms of having all of the health services. They were just, like, facilities adapted to provide HIV care. So that was a reality that we were seeing in Africa, besides the African delegates raising the issue almost at every Board Meeting” (Saavedra).

Saavedra went on to describe these types of feedback as informal, noting that the key information on the problem was not really coming from official studies or publications, though those studies exist, but from these first-hand observations by some delegates and the long-term experiences and pleads of others (Saavedra).

Additionally, most members of the Board and TRP of the Global Fund are in fact experts in health and have had previous experience with HSS problems. This means of indication is related to the Policy Stream segment to be seen later on, where the influence of specialists shall be elaborated. For what concerns means of indicating problems, it suffices to recognize that personal observation and experience played a part.

3. Studies

An additional form of indication based on expertise is the results from studies, both independent and commissioned. Certain studies influenced or initiated discussions at the Global Fund by indicating a problem with health systems and suggesting the appropriate role of the Fund in relation to HSS. As the Global Fund is results-based in their financing, studies are frequently consulted to gain perspective on outcomes.

A few interviewees directly referred to studies as a source of information. Both Dr. Lieve Fransen and Dr. Marijke Wijnroks mentioned reference to studies’ results and how the European, and especially Scandinavian countries were interested in these.
“We were always very much a keen to monitoring progress and measurement...we financed several studies, Europe with others, we financed several studies to monitor the effect on health systems, for example. There’s an early study that we financed which monitored the positive or negative effect of big funds like the Global Fund on health systems. It was actually monitored by a Danish group, we co-managed it, but that’s an important study” (Fransen).

Dr. Wijnroks went on to discuss the same tracking studies\(^31\) that they (European nations, and specifically UK, Denmark, Ireland, Netherlands) independently performed and which came to consistent conclusions regarding the necessity to address health systems problems (Wijnroks).

Another study, which was commissioned, served to gain information on the problem of the Global Fund’s role in HSS actions in relation to its partners: the Shakow Report (Shakow, 2006)\(^32\). Alex Shakow, an independent consultant, completed the study. The report was cited during both phases of analysis. One interviewee noted that the “Shakow Report [...] looked into the roles and responsibilities of the WB and the Global Fund [...] and came to some rather clear conclusions” concerning HSS (Anonymous). These conclusions were quoted by Executive Director Sir Richard Feachem at his final Board Meeting while he argued for limiting the Fund’s role in HSS. Feachem quoted the Shakow Report saying, “the true needs in health systems strengthening - the in-depth consultations, analysis, and planning, the long-term financing windows, and much more - are best met by the World Bank.” (GF, 2006 BM 14 Report ED Report). As opposed to the studies mentioned by Fransen and Wijnroks, this study would have served to advocate limiting the Fund’s HSS actions, whereas the abovementioned studies called for the need to expand those actions. Regardless of what they pushed for, both types of studies do appear to have influenced the HSS debate by indicating issues to consider.

4. Existing Policies or Systematic Indicators

In continuation with the idea that the Global Fund is performance-based, evaluation is not only done by independent studies but monitoring and evaluation policies are an integral part of the functioning of the Global Fund itself. Therefore, another means for indicating problems with current policies is the formal feedback that comes from these policies and the systematic indicators associated with the evaluation processes. On one hand, there is feedback

\(^{31}\) More precise information on these studies was not able to be located.

\(^{32}\) The information in the bibliography is the latest source information available, however this study is no longer available on the site of the Global Fund or the World Bank and the original was unable to be located for the research here.
from past policies and Rounds; and on the other, internal evaluation reports provide information on the areas that need improvement.

The most frequently cited example of HSS learning from policy feedback and evaluation is the feedback that took place after the Round 5 proposals. Recall, that Round 5 (2005) was the moment when the Global Fund briefly attempted to have a separate financing window for health systems strengthening before again terminating this policy. Part of learning from existing policies is to see where problems are in current approaches and then to ‘tweak’ the policies by incorporating the lessons learned. The failure of the policy in Round 5 was certainly a moment of learning for the Global Fund as the weaknesses of the health systems strengthening proposals and policy became apparent (Liden).

“In 2005, a decision was taken [and] actually passed through the Board quite easily, to establish separate health systems windows. You could apply for funding for AIDS, TB, Malaria or health systems [...] but there were not lots of guidelines, and very unfortunately it proved to be a major disaster [...] countries just put up basically everything. It was very unclear, the relationship of how that would then contribute to AIDS, TB and Malaria, which doesn’t mean it should be disease specific, but in many cases it was quite unclear [...] I remember one striking example of one proposal from an African country that applied for half a billion dollars in infrastructure. That’s really what started people wondering about whether the Global Fund should be the institution that funds everything or are there other partners that are equipped to fund health system infrastructure?” (Wijnroks).

Wijnroks, in this passage, clearly indicates that former policies had a great impact on the 2007 HSS debate. One can gather that because of feedback from Round 5 guidelines and proposals, pure horizontal funding was ruled out by the Global Fund, and new debates on approach began, which ultimately led to the more diagonal policy they adopted in 2007.

This policy feedback was the most important moment of involvement for the TRP in the HSS discussion. Because of the way the TRP functions and its official mandate, the TRP
mostly deals with current policy results and evaluation, and few other forms of feedback reach the TRP (Boillot). They have little input on strategy but mostly serve as consultants to the Board on technicalities and performance. An example of how they're involved in this form of policy feedback can be seen post the 2007 decision on HSS. At Board Meeting 16, the Board stated to have recognized the lessons learned by the TRP in previous Rounds and the PSC Report requested that the TRP and the Secretariat review the results of Round 8 in regards to the new decision on HSS and to report back to Board Meeting 18 (GF, 2007 BM 16 Report). The Board seconded this request. In this manner, the TRP served as a kind of formal feedback organ within the Fund, commenting on policy concerns and technical issues. This feedback did occur at Board Meeting 18, when the TRP made multiple comments on what still needed to be improved in the HSS policy in order to take less time to screen proposals and for countries to have a better understanding of the guidelines (GF, 2008 BM 18 Report TRP Report). However, the specifics of that feedback go beyond the question at hand.

Another form of feedback and policy learning was via the Global Fund’s self-evaluation policies. Two reports that came from these policies were mentioned in the Fund’s documents and presented interesting arguments for the need to fine tune their health systems policy: Partners in Impact-Results Report 2007 and the Technical Evaluation Reference Group (TERG)33. The difference with the reports mentioned in the previous section is that these evaluation studies were performed internally, in direct contact with the Global Fund, as opposed to having been carried out by independent agents.

The first of the two, the Partners in Impact Report, was created by the Global Fund for the purpose of presenting a self-evaluation to the second voluntary Replenishment meeting in Oslo in March 2007 (GF, 2007 Partners in Impact). During Board Meeting 15, the chief results of the report were presented and the importance of addressing the use of vertical funds for HSS was mentioned (GF, 2007 BM 15 Report). This report gave many reflections on HSS improvements, actually providing an entire subsection for the question. It recognized that “health system and human resources gaps are a very immediate reality for those implementing AIDS, TB and Malaria programs. [and] They require multiple donors and disease programs to play their role” (GF, 2007 Partners in Impact 36). The report also recognized the risks of distortion in saying that AIDS, TB and Malaria programs can certainly serve to re-energize health systems, but if not appropriately addressed they have the potential for negative system-wide effects, going on to say that not only salary, but sufficient means and drugs are also essential in order to retain health staff (GF, 2007 Partners in Impact 36-37). It called for a

33 To clarify, the summary of this report is included in the report for Board Meeting 16.
need to incorporate more solutions for distortion in financing programs in order to have a positive rather than a negative impact on health systems (GF, 2007 Partners in Impact 37).

The Partners in Impact Report, as its name might suggest, also recognizes a need for enhancing partners’ role in HSS but that the Global Fund’s partners’ work won’t entirely be sufficient. The “WHO and the World Bank play leading roles in these areas […] However, Global Fund grants will also need to increasingly coordinate” (GF, 2007 Partners in Impact 36). It calls for an urgent need for partners,

“to prioritize substantial, long-term health systems and infrastructure strengthening with additional finance […] The systematic, long-term development of fundamental health infrastructure is beyond the mandate and resources of the Global Fund. However, it is important that the Global Fund finances not have a negative impact on health systems and contribute to sustainable service delivery capacity” (GF, 2007 Partners in Impact 37).

The report calls for the WB, the WHO, the GAVI Alliance, and the Global Fund to learn from programs already in place in select developing countries in order to further understand how disease initiatives can better support health systems initiatives. The report states that this “will provide important lessons, both positive and negative, to help learn how “vertical” finances can support “horizontal” health systems […] [and that] We should be careful about simplistic distinctions between horizontal and vertical funding - more “diagonal” country programs can often use finances effectively to deliver services while building capacity” (GF, 2007 Partners in Impact 36-37).

This internally produced report clearly helped set the stage for redefining HSS policy to be more diagonal (encouraging programs of this type openly), leaving pure horizontal financing to partner organizations. Yet, by not allowing the Fund to be entirely vertical, called for the Global Fund to help pick up the slack in health systems.

It is interesting to note that following the publication of the Partners in Impact Report, delegates requested even more attention be given to HSS and human resource bottlenecks; and HSS became one of the key topics of discussion at the Oslo Replenishment Meeting in March 2007 amongst donors who recognized that the Global Fund HSS contributions would be key for impact (GF, 2007 BM 15 Report). Thus, the report had at least a partial role in bringing problems to the attention of the various actors and developing the HSS policy discussion.

The second report mentioned in official Board documents is the Technical Evaluation Reference Group or TERG Report from October 2007. The report presented to the Board consisted of a summary paper on the 5-year evaluation of the Global Fund, which had been
put in motion by a 2003 Board Decision (GF, 2007 BM 16 Report TERG Report). It is therefore a formal, internal feedback. The TERG found that after 5 years, the Global Fund had still not fully defined its role which was in continual expansion (GF, 2007 BM 16 Report TERG Report). However, the evaluation group did recognize that the previous 5 years had shown the Fund to have a high level of adaptability and referenced several new strategies and initiatives under way, including HSS (GF, 2007 BM 16 Report TERG Report). Yet, the report expressed that the Fund needed to be more explicit in its vision, mission, and consequent actions and suggested that the future development of the Global Fund would require adapting the founding principles to new circumstances like HSS (GF, 2007 BM 16 Report TERG Report). This echoes the quote from Jon Liden mentioned earlier about the need for purpose and the reason why past policies were confusing. New actions (Round 5 for example) were too horizontal in a vertical vision and adaptation was necessary in order to merge the two. This realization set the stage for the decision at that same Board Meeting, Board Meeting 16, to maintain HSS within the disease programs, but with the addition of a HSS cross-cutting component. Thus, the outcome was an adaptation of former policies, relying on the past vertical vision but broadening it as well.

ii. Policies

The policies stream is two-fold. First, it refers to the gradual accumulation of knowledge and perspectives, that specialists learn from existing policies’ feedback which may lead to new proposals for change (Kingdon 17). Second, the policies stream refers to the manner in which policy ideas are estimated and built up amongst a community of specialists, who may be any of various actors, external or internal (Kingdon 116-129). This section will elaborate on this dual stream, however, as the first facet (gradual accumulation of knowledge from existing policies) essentially is the same as the final means of indication presented in the problems stream section (feedback from existing policies), this facet will not be repeated here. Vis-à-vis Kingdon’s theory, it is very difficult to clearly draw a line between portions of these two streams. This section, based mainly on the interview phase of research, will focus only on the second facet of the stream; that is the manner in which health systems strengthening (HSS) policy ideas were exchanged and enhanced amongst a community of health specialists coming from within the Global Fund (GF) and outside of it. These specialists, from diverse backgrounds and current positions, each have their own idea as to how HSS policy should be and they discuss these ideas within the specialist community, test the acceptability of their
plans and eventually adapt them to be more suitable to the other experts. It is in this way that new or revived policy ideas, like HSS, develop and take concrete form. One can’t help but notice that this particular stream of Kingdon’s theory parallels the ideas of Walt, Lee and Goodman briefly seen earlier, whereas their ideas of international or ‘global policy networks’ explore how a network of experts have inter-organizational relations, social networks, formal and informal relations that all participate in the experts’ development of policy decisions (Lee and Goodman 98-104).

Due to the nature of the Global Fund and the issues it addresses, a large number of experts are interested in their work. By definition, two of the main organs of the Global Fund are made up of experts, the Board and the Technical Review Panel (TRP). Their expertise varies from disease expertise to policy development, from AIDS to Malaria, and from laboratory experiments to on the ground implementation. Just within the Fund alone the specialists form a diverse group to an extent that some members of the Fund esteem the range of knowledge as sufficient. For example, Andrew McKenzie, speaking as one of the TRP, stated, “There’s about 35 of us and we’ve got a fairly broad range of expertise and experience and we can master the issues ourselves” (McKenzie)34. However, this opinion is generally only shared by TRP experts due to the way that the TRP functions and their minimal input on strategy issues. The overwhelming majority of the Global Fund interviewees agreed that some external influence existed. This subject will be discussed later on in the Politics Stream section. Here, the only concern is whether there were external-internal interactions amongst individual specialists, related to HSS policy discussions.

Again, due to the nature of the Fund, the analysis showed that such inner-outer specialist interaction was to be expected. Jon Liden reasoned that this was because “the Global Fund isn’t an organization as such. It is a network, or a partnership. It has an office in Geneva, a Secretariat in Geneva, but the Board is inhabited by various actors that have voices and opinions on these issues in many other fora” (Liden). This comes back to what was said about inner-outer actors in the previous section on participants. These actors facilitate specialist communities expanding beyond the confines of a singular organization like the Global Fund. Several interviewees mentioned the relationships and discussions between Global Fund specialists (the various members of the Board and the TRP) and other diverse specialists: academics, members of the Global Alliance for Vaccines and Immunizations (GAVI), members of the World Health Organization (WHO), non-governmental organization

34 Note that McKenzie doesn’t deem the TRP is influenced by outside forces, as seen later in the section on external actors’ influence.
These specialists grew to know each other and rely on each others’ expert opinions. As one example, Dr. Lieve Fransen - Board member and Vice Chair of the Board, representing the European Commission (where she was Head of Unit for the Human and Social Development, Directorate General for Development Cell), and holder of a PH.D in public policy - elaborated on her experiences of interactions with other specialists regarding the various issues that touched the Global Fund during the development of their financing approach.

“This whole group of people were very much cross-fertilizing one way or another, because I still know most of these people […] Sigrun Mögedal [Board member for Point Seven and the HIV/AIDS Ambassador for Norway] chaired committees at the Global Fund, but she was also head of this health professionals group in the WHO. The CEO of GAVI, Julian Lob-Levyt, was one of the people with me here, before the Global Fund was launched” (Fransen).

This passage clearly illustrates another idea of Kingdon’s that the specialists in a community often know each other personally, their ideas, and their research, facilitating policy discussions (117). These policy ideas don’t just float around; they bump into each other, combine, some die, some live, some evolve (Kingdon 131). Proposals that survive are tolerable in cost, technically feasible, and in line with the vision of the majority of specialists. In the policy stream, ideas catch on gradually and coalitions are reached by careful persuasion amongst colleagues and associates\(^\text{36}\). In this fashion, the HSS policy of the Global Fund would have developed in a sort of expert network and benefited from the policy learning, discussions and exchanges that occurred amongst diverse experts in many positions.

Unfortunately, there are more findings specific to the policy stream to further confirm this type of specialist community interaction. This is, for a second time, in part due to the fact that Kingdon’s streams are not always easily delineated. These community interactions overlap with a following section in the politics stream, which discusses the influence of international actors on the mood towards HSS. However, acknowledging the explicit quotes seen here, combined with the previous recognition of inner-outer actors and the upcoming section on external actors’ influence, it’s a fair assumption that this type of progressive policy development did occur, both within the Global Fund and beyond, affecting the receptivity of an HSS policy and the end product of the proposal for the Global Fund’s policy. Plainly, such a process would have been part of creating a policy window that allowed for HSS changes.

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\(^{35}\) See the section on context in the Politics Stream section for more.

\(^{36}\) As opposed to the Politics Stream where bargaining is involved.
iii. Politics

a. Changes in Personnel

Independently of all other streams, the political stream can influence the problems added to the agenda and the value given to those problems (Kingdon 145). The most obvious political factor that helps open policy windows is a change in personnel (Kingdon 168). Agenda changes likely occur because either the leaders’ opinions change or the leaders change (Kingdon 153). Regarding the question at hand, one can easily remark in the official Global Fund (GF) documents that over the period of 2006-2007, surrounding the 2007 health systems strengthening (HSS) policy decision, several changes in leadership occurred at the Global Fund. This led to the secondary hypothesis of this paper, that between the various converging factors that led to the HSS ‘window of opportunity,’ the changes in the personnel of the key organs of the Global Fund are given the most importance. The answer to this hypothesis is not simple because the various personnel changes are not given the same significance. The Chair and Vice Chair of the Board changed from Carol Jacobs - Chairman of the National HIV/AIDS Commission of Barbados - to Rajat Gupta - Managing Director of McKinsey & Company in the Private Sector, and from Dr. Lieve Fransen - Head of Unit for Human and Social Development with the European Commission - to Elizabeth Mataka - Executive Director for Zambia National AIDS Network, a developing country NGO, respectively (GF, 2007-2008 BM 15-17 Report). Likewise, the Chair of the Technical Review Panel (TRP) changed from Jonathan Bloomberg- a crosscutting expert from South Africa - to Peter Godfrey - Faussett - an AIDS expert from the United Kingdom (GF, 2007-2008 BM 16-17 Report). However, upon further inquiry these changes in leadership appeared to be less decisive than may be assumed on paper. Little emphasis was given to these individuals during the interview process and therefore these changes will not be elaborated further. Nevertheless, a third category of personnel change can be seen as more interesting both from document analysis and by way of conversation with those who witnessed the change: the replacement of Executive Director Sir Richard Feachem by Executive Director Michel Kazatchkine in the spring of 2007 at the first Special Board Meeting37.

The documents give a distinct feeling of change in approach from one Executive Director to the next. Sir Richard Feachem, the first Executive Director of the Fund, has, aside from the Global Fund, been the Director of Health Nutrition and Population of the WB, the Dean of the London School of Hygiene and Tropical Medicine, Chairman of the Foundation

37 Michel Kazatchkine was the effective Executive Director as of April 23, 2007 (GF, 2007 BM 15 Report).
Council of the Global Forum for Health Research, Treasurer of the International AIDS Vaccine Initiative, and holds a Ph.D in Environmental Health and a Doctor of Science in Medicine to name but a few of his accomplishments (GF Sir Richard Feachem). His history makes him an experienced and established specialist in global health. Taking this into account, it’s interesting to observe that Sir Feachem openly spoke out against expanding the Global Fund’s actions to more health systems strengthening at his last Board Meeting (BM 14 in 2006). While outlining what he deemed as key priorities for the future of the Fund, Feachem proclaimed that,

“our unwavering focus on our essential but limited role in the fight against the diseases has been a critical factor in the progress we have achieved over the past five years. That focus will be increasingly difficult to maintain […] increasing pressure to expand beyond our founding mandate […] will require constant vigilance. We must be wary of even the seemingly smallest steps away from our founding model. “Mission creep” is so called because dilutions of mandates do not occur overnight, but through a long chain of mundane and minor events […] That is not to say that the many other tasks in the fight against the diseases, from implementation support to financing health systems, are not important. Rather, it is because we believe them to be important that the Global Fund should not seek to take on those tasks, leaving them to other partners who are better suited to fill those roles […] There are […] areas that, however important, fall outside our mandate. The financing of health systems is one of these. Support for the long-term development of health systems is currently one of the largest gaps in developing finance […] That gap must be filled […] But […] it is not the role of the Global Fund to do so. We were designed to finance the fight against three specific deadly diseases, to measure and act on rapid progress in that fight […] None of these are in line with the work that must be done to improve health systems […] We must trust and support our partners in filling their roles” (GF, 2006 BM 14 Report ED Report).

This excerpt clearly shows a man decided against any horizontal actions by the Global Fund. Feachem makes a clear case that the Global Fund was designed to be vertical, targeting three diseases and that outside of this constituted ‘mission creep’ and was outside their role.

Yet, in spite of the fact that Sir Feachem’s speech was so determined against expanding HSS, Helen Evans38, Deputy Executive Director39 took the floor at Board Meeting 15 (with the presence of Executive Director Michel Kazatchkine), and recognized that HSS had been an issue of debate for the previous two years and that it was to be seriously considered at the 15th Board Meeting (GF, 2007 BM 15 Report). She noted that at this time of

38 Helen Evans’ background is not elaborated on since she is only a secondary actor. Her role was mostly to facilitate the transition to Executive Director Kazatchkine. Her speeches, for instance, were always in the presence of the latter.
39 The Deputy Executive Director helped to facilitate the transition between Feachem and Kazatchkine, and at Board Meeting 15 in 2007 spoke in place of the Executive Director. This function was temporary and only lasted for this one meeting.
change in the Global Fund it was necessary to clarify the Fund’s roles and responsibilities in relation to their partners, and especially “pressing” issues like HSS (GF, 2007 BM 15 Report). This term “pressing” indicates that the new leadership gave a greater level of importance to the question. Executive Director Kazatchkine’s intervention at Board Meeting 15 was brief, but he nevertheless mentioned that the GF had grown very quickly in its first years, to become an important actor in global health and that this growth called for a need to reevaluate where continuity and change for improvements are needed (GF, 2007 BM 15 Report). This suggests that Kazatchkine, too, was already looking at ways to improve the Global Fund’s financing programs. It was at this Board Meeting that the Policy and Strategy Committee (PSC) was asked to consider HSS and what the Global Fund’s position and policy should be, and to report back with a proposition at Board Meeting 16 (GF, 2007 BM 15 Report). This seems to be a turning point when compared to Feachem’s parting speech, which clearly states that HSS is outside of the Global Fund’s mandate.

Executive Director Michel Kazatchkine fully executed his new task at Board Meeting 16, by delivering the Executive Director’s Report entirely by himself, however his tone was little different from Evans’. To begin, he recognized that the Board Meeting came at a time of significant change and opposition and that the focus on HSS had intensified during the year 2007 (GF, 2007 BM 16 Report). He also commented that it was a time of new leadership and that within such a context managing growth and change are important, including the addressing of key priorities and challenges, going on to assert that HSS would be discussed at that meeting and that he was personally concerned with any approach to fight the three diseases that did not consider the truly global nature of the epidemics (GF, 2007 BM 16 Report). His final observation concerning HSS was to remark that though the vertical versus horizontal debate had dominated the international health agenda for much of the year, it risked giving rise to false dichotomies and that while the Global Fund seeks to increase health systems benefits, it will continue to do so through disease specific interventions (GF, 2007 BM 16 Report). This approach he labeled as diagonal, and Kazatchkine was persuaded that the benefits of such an approach would be increasingly recognized (GF, 2007 BM 16 Report). It was at this meeting that the new integrated and cross-cutting health systems provisions were adopted.

One possible reason behind Kazatchkine’s more favorable tone towards HSS policy pertains to his history both within the Fund and outside of it. Sir Richard Feachem was the founding Director and maintained that position throughout his time in Geneva, but Kazatchkine had experienced various facets of the Global Fund, allowing him to witness necessary areas of change first hand. He was at one time a Member of the Board, the Chair of
the TRP, the Vice Chair of the Board, and the new Executive Director (GF, 2007 *BM 16 Report*). He would have had significant contact with the various experts and delegates presenting strategic issues for consideration. Kazatchkine also has spent over 25 years working on AIDS issues outside of the Global Fund as a physician and clinical immunologist, as a researcher and professor at the Université René Descartes, as an administrator and head of the Immunology Unit of the Georges Pompidou Hospital in Paris, as Chair of the WHO’s Scientific and Technical Advisory Committee on HIV/AIDS, as a diplomat and French Ambassador on HIV/AIDS and communicable diseases, and Director of the National Agency for Research on AIDS in France, to name just some of his endeavors (GF *Michel Kazatchkine*). Kazatchkine truly has an all-encompassing past both within and outside of the Fund, which perhaps explains his adaptability and open mind to change. Perhaps, for Feachem, who was one of the creators of the Global Fund and who continually held its highest leadership role during his time there, the Global Fund’s project was too dear to him to imagine changing or adapting it.

In summary, what can be assumed from the document analysis is that there was a significant change in the approach of this key leadership position, which could have had an impact on the HSS agenda. It seems that Feachem remained in favor of a vertical approach, when faced with the possibility of increased horizontal financing. While it appears that Kazatchkine (and temporarily through an intermediary - Helen Evans⁴⁰), though not entirely for generalized health systems financing, saw absolutely no conflict of mandate in regards to health systems interventions by way of a diagonal approach. It’s a logical assumption to look at the timing of change in leadership within the Fund, the leaders’ varying outlooks, and the timing of decisions on health systems, and come to the hypothesis that the change in the Executive Director was a political stream of nearly determinant significance.

However, the second phase of analysis was less decided. As Kingdon himself noted what appears is not always so, some players are thought to be important but turn out not to be as key as imagined (Kingdon 1). Despite, the apparent decisiveness of this change in the documents, from the interviews collected (amongst those willing to talk about personnel change)⁴¹, the conclusion to be drawn is decidedly less certain as to the importance of this factor for health systems strengthening policy. Interviewees’ replies varied from a rather decided yes to no to somewhat unsure. Of course, interviews are always subjective and cannot be considered as entirely true unto themselves. However, due to a lack of other sources of

⁴⁰ Recall that Helen Evans was the Deputy Executive Director that helped in the transition from Sir Richard Feachem to Michel Kazatchkine, by fulfilling some of the tasks of the Executive Director at Board Meeting 15.
⁴¹ Because of the sensitive nature of this topic, all interviewees in this section are named Anonymous.
information on the influence of Executive Directors, our conclusion has to be satisfied with
the aggregate data from official documents and interviews.

Of the interviewees that felt the change in Executive Directors was a factor, it was
agreed that the reality of the problems the Global Fund was facing (bottlenecks, partnership
deficiencies etc.) made it so that even if Sir Richard Feachem was correct in the beginning,
the perfect world that corresponded to the Global Fund’s vision was not real and there was a
need to change visions embodied by the Executive Director. Michel Kazatchkine provided
that change.

“Richard was very good in the beginning and he became very difficult after some
time. I think that it was generally agreed to by most of the Board that he had to leave,
one way or another. The atmosphere became a bit difficult, and that was not just to do
with health systems, it was much more than that. That was his opinion but the Board’s
opinion was different […] I think it’s a question of personalities but also of focus. In
the beginning I would have agreed with Richard, that in the beginning phase the core
of the declaration, the core of business was the disease approach, not the health
systems approach. And, had history shown that we were successful in supporting
health systems differently, I would have fully agreed with Richard that we didn’t have
to create the Global Fund for health systems support, but basically that didn’t happen
[…] Partnership approach was the vision of the Global Fund, that partners would feed
health services and not the Global Fund. That didn’t work. Some of the visions didn’t
work…so when the corrections came it made it maybe a painful way for Feachem, and
maybe a gentler way for Kazatchkine, for him to come in, to change personalities and
change strategies in the Global Fund itself” (Anonymous).

However, the opinions of interviewees were nuanced. Certain individuals were clearly
decided against the influence of personnel change on HSS policy; they did not esteem that it
was a factor. One interlocutor remarked that though policy changes had occurred and
Kazatchkine was sensitive to various aspects of the issues, they didn’t feel that the changes
were due to him, though it’s difficult to say. Rather, it was due to a number of factors, not just
the Director. Another interviewee expressed the belief that the two Directors were not all that
different and that it was the environment that they were in that influenced their vision.

“No it was more the environment of the day and what were actually the pressures on
the Global Fund rather than the positions of the Executive Directors. I don’t think that
there’s any difference in attitude between Feachem and Kazatchkine on what the
Global Fund should finance and should not finance. But, between 2002 and 2006, the
environment was much more; it was a much tougher environment for the Global Fund.
We didn’t have any results of significance to show, we only had the promise of future
results. It was a very tough environment to work in. We had to fight for every dollar
we got and there, I think Richard’s tone was a little more aggressive and a little more
focused on the three diseases and it was more defensive in response to accusations that
we were undermining health systems or that […] it was an either or situation […] and
I think Richard said you need to fight these three diseases, that’s what we’re here to do, that’s what our mandate, but I think that if he had been Executive Director today, he’d say exactly or similar things to what Michel Kazatchkine says, that you can’t do one without the other” (Anonymous).

This quote is clearly of the opinion that the change in leadership itself was not the decisive factor in opening a policy window. Finally, some interviewees were less opinionated either way, neither sure of the change of Directors being or not being key.

In summary, what can be said for the secondary hypothesis? Was change in personnel the factor that led to a policy window, which was given the most importance? The answer to the most importance of personnel change as a whole - including Chairs, Vice Chairs and Directors - would be no. As a whole, personnel changes were not found to be decisive, neither in documents or interviews. Yet, the significance of one type of personnel change, the Executive Director, is more nuanced. However, if the hypothesis was that the change in Executive Directors was the factor most valued as opening a policy window, it could only be partially confirmed at best. From document analysis the impression is clear that this change is pivotal, but the interviews show that other members of the Global Fund are less decided as a group. Some think it was a major factor, some don’t and some don’t know. At most, we can say that it was one factor amongst others, and even then given varied appreciation. Let us move on to more of these other factors.

b. Bargaining

During the analysis process, some of the more interesting discoveries only occurred in the second phase of research via the discussions with interviewees, as aforementioned regarding the early gestation period of the Fund. Another such insight concerns the political stream. Recollect that the political stream for Kingdon does not only consist of personnel changes, but also the general mood (to be discussed in the following section) and the possibility of delegates bargaining in order to reach a consensus. This is to say bargaining regarding their constituency’s interests and advantages gained as regards the issue at hand. Generally, this type of exchange is not recorded in official documents. However, the interview that took place with the Board member representing Latin America and the Caribbean, Dr. Jorge Saavedra, provided one such insight on how the interests of particular delegations played a role, at least behind the scenes, in the decision on HSS policy.
“We [Latin America] […] this issue of strengthening health systems, we thought it was really helpful but mainly for African countries where there is no health system in place. For Latin America […] that doesn’t mean that we have a perfect health system, but at least we do have a health system more or less developed, of course not with the standards of developed countries. But, it was an issue of helping the most in need […] African countries. They really needed supporting of health systems strengthening because funds for antiretrovirals were there at the Global Fund but there was no infrastructure, no trained doctors […] This issue was not the main issue for Latin America, as it was in those years, the eligibility criteria. We were actively involved […] to change those eligibility criteria because most of the countries of Latin America, in terms of population […] a big portion of [the] population was excluded from the Global Fund because of eligibility criteria. So we were mainly focusing […] to change the eligibility criteria, which we finally succeeded in doing it at the last session of the Board in 2007. Nevertheless, we voted in favor of opening the Global Fund to health systems strengthening because we knew that this was going to benefit Africa, and, on the other hand, by helping African countries on this issue, we could obtain their help to change the eligibility criteria […] So in 2007 after successfully supporting the idea of health systems strengthening for mainly Africa […] for us, it was about helping them and also expecting African countries to help us on eligibility criteria. Like they did in the last Board Meeting […] in 2007” (Saavedra).

In summary, this excerpt of Dr. Saavedra’s interview provides a clear example of the bargaining that Kingdon wrote about in the political stream. The bargain was that in exchange for Latin America supporting a policy that was in Africa’s interests, Africa was in turn to support a policy change that was in Latin America’s interests. The last part of this excerpt ends in saying that exchange did take place and both parties’ goals were accomplished; Latin America got their eligibility and Africa got HSS financing. This more than suggests that there was in fact bargaining to meet a consensus, which was a factor in the policy change of 2007.

c. Context

The final aspect of the political stream, which can be observed as having influenced HSS policy are the “swings in mood” concerning the subject (Kingdon 17). For the issue of HSS within the Global Fund, swings of mood translates to the attitude toward health systems and horizontal financing within the international health scene. Essentially, what were other international health actors saying about health systems strengthening; or in other words, what was the global context while the HSS debate was going on? The context that prepared the Global Fund for HSS financing can be divided into three sub-factors: other international actors’ influence; leadership changes within other international bodies; and domestic politics and interest in HSS.
1. International Actors’ Influence

Both phases of analysis revealed that international actors’ had an impact on the tone of the HSS discussion within the Global Fund. As the new Executive Director, Michel Kazatchkine, recognized a need for HSS policy adaptations within the Fund, he and Deputy Executive Director Helen Evans made references to significant changes in the international health scene and that HSS had been debated amongst partners for the last couple of years (GF, 2007 BM 15-16 Reports). This suggests that the international context and mood towards HSS issues had some influence on the Fund’s agenda. More specifically, official documents emphasize the importance of certain international organizations’ stance on the subject more than others, including: the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Bank (WB), United Nation’s Children Fund (UNICEF), the Gates Foundation, and Global Alliance for Vaccines and Immunization (GAVI) (GF, 2007-2008 BM 15-17 Reports). Yet, the interviews estimated the impact of external actors with varying degrees of conviction; both regarding the weight that the international mood (as a whole) has on decisions, and regarding the variations in the impact of one external actor from another. As mentioned before, these actors are not all entirely external, the WB, the WHO and UNAIDS sit on the Board of the Global Fund without voting rights. Yet others are entirely external, such as UNICEF, the Gates Foundation and GAVI. GAVI especially was recognized by interviewees as having a great impact on the discussion within the Global Fund. As can be seen from the charts in the Annexes, interviewees gave two external actors more influential worth than the others: GAVI and the WHO. Nearly all interviewees cited one or both of these organizations as having influenced the Global Fund’s discussion on HSS. They shall be the focus here in order to sum up the estimation of external actors’ influence.

Of the two, the actor or organization that really stood out as influencing the Fund’s tone on HSS was GAVI. This is the most surprising find since unlike the WHO, GAVI is not formally part of the Global Fund’s Board and does not have a voice in their internal discussions. However, as we can see from the following passage GAVI, another health GPPP, has many structural similarities and faces similar issues as the Global Fund, the result of which is that GAVI and the Global Fund look to each other for answers and dialogue on problems.

“The Global Fund’s health systems discussion, it’s in many ways just the continuation of the international debate in the different organizations. GAVI doesn’t sit on our Board, but GAVI and us we look at each other like cousins and our debates are very,
very similar and the challenges we face are very, very similar. So we have a constant
dialogue around these issues where we try to help each other and evolve our
perceptions and understandings of the issues. The communication is ongoing and
constant and free flowing in a way […] there’s really not a big difference between the
discussion that goes on outside the Global Fund and the one that goes on inside the
Global Fund except that the one that’s inside focuses on what the Global fund can do”
(Liden).

This quote from Jon Liden definitely expresses that GAVI’s opinion, though external,
could influence the Global Fund’s debate. Along the same line, Dr. Marijke Wijnroks
commented that not only discussion corresponded but also that GAVI actually started their
health systems window at nearly the same time as the Global Fund (Wijnroks). In addition,
recall from the presentation of participants that several individuals had dual roles in GAVI
and the Global Fund at the same time, further facilitating the transfer of tone from one to the
other. Dr. Lieve Fransen elaborated on this point.

“I’d say the discussion was wider. The discussion took place in GAVI and there were
two or three meetings that I was a part of, or that I’m aware of, that took place about
health systems and public-private partnerships. So GAVI, Global Fund but also
UNITAID, the Malaria Fund, TB Alliance […] they were all together discussing how
to deal with health services and health professionals […] A lot of cross-fertilization I
think. It was a very creative time, people were all creating new things and there were a
lot of discussions” (Fransen).

The second organization that was recognized as a “key actor and advocate in this
discussion” was the WHO (Brandrup-Lukanow). Though equally significant, this conclusion
is less surprising both because the WHO has a history in health systems as aforementioned,
and because the WHO, though technically external because they have no voting power on the
Board, is able to directly influence the Global Fund at Board Meetings due to their presence in
discussions alone.

Besides interviews, documents record an official request of the Global Fund to have
WHO consultation. Board Meeting 15 highlighted the importance of involving the WHO in a
dialogue on HSS, drawing on the latter’s expertise to address the points the PSC had raised
regarding HSS (GF, 2007 BM 15 Report PSC Report). The Board formally requested the
WHO\textsuperscript{42} to identify a suitable forum to provide input on HSS as pertaining to the Global Fund
and its partners, before the 16\textsuperscript{th} meeting (GF, 2007 BM 15 Report PSC Report). The WHO
organized the requested forum in July of 2007 in the form of a two-day Stakeholders

\textsuperscript{42} Recall that the WHO is an inner-outer organization and is therefore present at Board Meetings.
Consultation. The key questions posed by the Board and to be addressed at the WHO consultation included:

- “Whether the Board should continue to fund Health Systems Strengthening (HSS) interventions exclusively within disease components or, in addition, establish a separate HSS component for proposals to the Global Fund;
- The appropriate parameters for allowable HSS activities;
- The possible use and nature of conditionality for applying for HSS funding;
- The possible use and nature of ceilings for HSS funding” (WHO, 2007 Consultation).

Clearly, as the Global Fund directly asked for the WHO’s input, they valued what this actor had to say on HSS. It is not much of a stretch to say that the mood or tone of one would have influenced the other.

One interviewee, Dr. Lieve Fransen not only discussed how international actors influenced the HSS debate directly but also indirectly by an emphasis on other subjects. Fransen called this the impact of ‘fashions’ in global policy. A fashion causes one item to make the agenda and others already on it to recede and be given less emphasis. Fransen suggested that in 2007 the fashions were in favor of HSS expansion; there was a lot of talk about AIDS and global health. Whereas today, “we’re talking more about climate change now, there’s much more other things that have become high on the agendas” and global health is less of a central focus (Fransen). These fashions, in turn, impact the donors (who are often the same for various programs - USA, the European Commission, etc.) and whom they are willing to give the biggest check to. In this way, the fashions amongst international actors have an impact on the Global Fund’s agenda via their relative emphasis of one issue compared to another. Moments of emphasis on global health help the budget and permit thoughts of expanding finances; other trends serve as constraints to their ambitions.

Finally, it should be noted, that although the interviewees generally agreed upon the influence of other international organizations, some interviewees were less convinced of their impact. As one example, Andrew McKenzie, a member of the TRP, was more inclined to believe that external actors didn’t have much influence at all on the Global Fund’s approach to issues, at least within the TRP. “Not really. I mean we’ve had briefings about the partners like Rollback Malaria, WHO, and UNAIDS, on what the current issues are. But, we’re not in agreement on the issues and the best solutions” (McKenzie). Yet, it should also be noted that in theory, the mandate of the TRP stipulates that it is meant to be a closed and independent body, therefore making it less likely to be influenced by the outside. Nevertheless, the
certainty of this is not shared by all interviewees and the widespread opinion is that other international organizations did impact the HSS debate at the Global Fund.

2. New Leadership at Other Organizations

A second aspect determining the international mood towards HSS is the change in leadership at other organizations discussing the issue. Agendas can change either because the people in positions of authority change their priorities, or those people change (Kingdon 153). The same applies for the various actors in international health.

Despite that little was found on changing leadership elsewhere during the analysis, the little that did appear invites one to at least consider it as a partial factor in the HSS debate. Recognition was given to a context of new global leadership, both in documents and one interview. It was recognized that there were new leaders not only at the Global Fund, but the WHO, and the WB as well (GF, 2007 BM 16 Report). The Director-General of the WHO passed from Anders Nordström to Margaret Chan in January of 2007, and the President of the WB changed from Paul Wolfowitz to Robert Zoellick in July of 2007 (WHO, 2010 Director-General; WB, 2010 Office of the President). Official documents elaborated no further on their impact but one anonymous interviewee recognized that the Shakow Report, cited by Sir Richard Feachem at Board Meeting 14 (which had concluded that the WB would be better suited for HSS than the Global Fund), was in part not followed up due to the change in leadership at the WB, to Zoellick, shortly after the publication of the report which had been commissioned under Wolfowitz (GF, 2006 BM 14 Report ED Report). New leadership brought new concerns and priorities other than HSS. Assuming, that the other organizations do indeed influence the Global Fund, by relation of cause and effect one can gather that such a change in leadership and priorities would influence the regard at the Global Fund as well. In the case of the Shakow Report, despite the clear conclusion that the WB was best suited for HSS, moving past this report at the WB coincided with moving past it at the Global Fund, and the eventual adoption of the 2007 policy.

3. Domestic Politics

A final factor that makes up the context and affects the international mood on a subject are the domestic politics of the various actors. This aspect of the context was not discussed in

43 Who was previously involved in the establishing of the Global Fund (and their approach) in 2002, as the Interim Executive Director (GF, 2002 BM 1-2 Report).
the official documents but a range of interviews mentioned the push for change and the importance of domestic attitudes towards the subject, coming from both donor and recipient nations. “Decision-making [...] may not always be based on technical realities. Countries have a huge role to play here, and if countries can make their views heard and considered, that [...] brings forth real change” (Gupta, Dr. Indrani).

Both Dr. Lieve Fransen and Dr. Marijke Wijnroks mentioned the role of national policies influencing the Global Fund’s attitude on the subject of HSS (Fransen; Wijnroks). Fransen specified that prior to real decision for change in the Global Fund, the European member states had already been discussing what they deemed to be the best approach for health systems, and that some states, like Norway, had already started their own HSS initiatives (Fransen). Another interview confirmed the leadership of the Scandinavian delegates in pursuing a dual approach to health (joining vertical and horizontal financing) and to not be satisfied with the traditional platforms’ results because these nations have national opinions that the only programs that will work have to help build functioning systems for the duration (Anonymous). Representatives of this at the Fund helped lead the debate and influence it in favor of more HSS in line with their views on the subject. This is to say the domestic opinion transferred itself onto the international, or Global Fund, opinion in this way.

However, domestic politics do not only play in favor of a subject; they can try to influence the mood in opposition of it as well. One anonymous interviewee mentioned that domestic politics played a role of resistance towards HSS changes, and that of those who resisted health systems funding through GAVI or the Global Fund, “their resistance was often a matter of politics combined with products and technologies rather than the messy policy domain of health reform and health system investment” (Anonymous). The same interviewee noted that these things are very political and in no country is organizing and funding healthcare just a technical or academic issue (Anonymous). And, just as representatives can try to influence the international mood in favor of HSS, the representatives from nations against further HSS can do likewise in order to restrict or limit the scope of HSS changes, in line with their attitudes on the subject.

In conclusion, to a certain extent, all of these factors - international actors’ influence, new leadership and domestic politics - affected the mood in the international health scene. Each facet was integral in creating a popular opinion amongst global actors and “the way health and health programs have been considered in the last five years” (Anonymous).
D. The Last Words on Confirming a Window of Opportunity

In summary, what can be said of a policy window for health systems strengthening (HSS)? According to Kingdon’s theory, did the analysis confirm the hypothesis that HSS became an issue and changes were adopted in 2007 due to the opening of a 'policy window,' and that between the various converging factors that led to this 'window of opportunity,' the changes in the personnel of the key organs of the Global Fund are given the most importance? After having seen the results from the combined analysis of both phases of research, one can only conclude that hypothesis is partially confirmed. Let us split the hypothesis into its primary and secondary parts in order to elaborate.

All evidence points to the confirmation of the primary hypothesis - the existence of a policy window that led to the adoption of the new HSS policy in 2007. However, despite the fact that the first phase of research pointed to the certainty of the secondary hypothesis - that the changes in personnel were the central factor that led to this policy window, the interview analysis suggested otherwise and that personnel change, and specifically the change of Executive Directors, was but one factor amongst others that led to a policy window. This secondary hypothesis was already largely answered for in the section on personnel change, thus, so as not to duplicate the analysis, let us move on to looking at the larger picture and what can be said of the primary hypothesis alone.

To come to the point, both phases of research point to the genuine existence of a policy window that was born out of the convergence of various participants and processes. The analysis has shown that by applying Kingdon’s theory, one can easily find evidence of the existence of many diverse participants and all three process streams: problems, policies and politics.

One easily observes that many distinct actors of various types all had a hand in one or multiple processes. Internal actors both macro - the Board, the Technical Review Panel (TRP), and the Secretariat - and micro - individual representatives at the Board and the TRP and the Executive Director - were involved in indicating different aspects of the health systems problem, exchanging policy ideas between specialists within the Global Fund and the larger health scene, key personnel changes, bargaining policy interests, and influencing the international mood via domestic schemes. Likewise, external actors both macro -other international organizations, non-governmental organizations (NGOs), and the academic world - and micro - individual specialists, external consultants, and the leaders of other organizations - were also involved in indicating different aspects of the health systems problem and exchanging policy ideas between specialists of the larger health scene, as well as
were involved in creating an international context favorable to HSS via their own policy opinions and personnel changes.

These various participants and processes converging made changes in the Global Fund’s HSS policy possible. As Mr. Rajat Gupta acknowledged “Which factor was key is difficult to detect” (Gupta, Rajat). It cannot be said with certainty if it was an aspect of the problems stream, the policies stream, or the politics stream that was the final straw, that created a window of opportunity. What can be said is that the documents and interviews show the heath systems issues existing long before the 2007 decision, even as early as the Fund itself, but that something made 2007 a year of change towards a diagonal approach to financing AIDS, Tuberculosis and Malaria. Members of the Fund confirmed what the documents suggested: the moment came for change because of the simultaneous existence of real problems; policy feedback and experts accumulating knowledge; personnel change, bargaining interests, and a favorable international environment. Dr. Marijke Wijnroks summed it up by saying that “it was very much evolving and things coming together” which lead to the 2007 policy (Wijnroks). Similarly, Dr. Assia Brandrup-Lukanow credited the change in approach to a “convergence of factors and ‘ripeness of time’” (Brandrup-Lukanow).

But, not only did the time come for HSS policy to be integrated into the disease approach permanently, the moment came and “that time, that ‘window of opportunity’ was used well” (Fransen).
VII. Conclusion

International organizations have never been as central to world health politics as they are today. Furthermore, global health issues and the profound changes that occurred due to globalization, have led various states and actors to come up with collaborative responses to health policy. Globalization has made it so that states have little choice but to work together, with the involvement of the private sector that today is largely the shaper of the global environment. The consequence of this necessity combined with the context of neoliberalism in the 1980s and the 1990s, has been the creation of not only new international organizations for health, but a specific type of organization that takes the form of a health GPPP - an alliance between the various actors - formed for the purpose of resolving global health problems while meeting public and private objectives and overcoming both the market and public failures. One such health GPPP is the Global Fund to Fight AIDS, Tuberculosis and Malaria, created in 2002.

Still an infant, the Global Fund is in the process of defining its own specific identity. According to Selznick, this is the process of institutionalization that transforms an organization into an institution via the acquiring of a distinctive identity and the adoption of values, ways of acting and believing that are deemed important by the organization. Young organizations, like the Global Fund, go through this transformation gradually as they adapt to the environment and undergo the influence of the people and groups that they embody. In this way, their distinctive identity is a reflection of the organization’s history and their incremental changes combined.

This paper has investigated how certain types of action and a certain identity of the Global Fund came to be assembled and evolve. More specifically, we have inquired about how one specific form of action was adopted, health systems strengthening (HSS) financing: How did HSS become a component of the Global Fund’s public politics in 2007?

HSS was chosen as a specific program of action to investigate for its underlying significance. The Global Fund was born in a time of an ongoing international health debate between those in favor of horizontal, broad ranging health financing that takes the health system as a whole into account, and those that are in favor of vertical, targeted health financing that intensely focuses on specific diseases and problems. Out of this debate came a third approach, the diagonal approach, which tries to combine the other approaches by funding targeted initiatives that will have benefits that spread to other issues. Each approach has its advantages, disadvantages and ways of acting. The 2007 HSS policy is significant
because it reflects a change in the Global Fund’s vision and actions, thus of their distinctive identity as an institution in the making. For many years the Global Fund struggled to clearly define what they believed to be the best way of acting, due to a dilemma between their disease specific objectives (as their name indicates) and acknowledged health systems prerequisites, but HSS’s determinant nature was increasingly recognized. After various phases of revising their approach from vertical to diagonal to horizontal and back again, in 2007 the Fund settled on a diagonal approach to health systems financing. This determination of approach is part of the organization’s self-definition of role and identity, in the sense of taking on ways of acting and believing that are deemed important. Associated to these approaches are specific methods of financing. Therefore, if taking on particular beliefs and ways of acting is part of an organization’s development of identity, and this identity is what differentiates an organization from an institution, then the 2007 HSS changes should be seen as a singular chapter in the Fund’s story of institutionalization. Researching how HSS has become a component of the Global Fund’s programs of action has provided a unique opportunity to investigate this singular moment in the Global Fund’s process of institutionalization.

In order to answer the how of our question, another theory was relied on for the purpose of developing a coherent hypothesis and research method. Of the many possible theories available to study public politics, John Kingdon’s theory of public politics and policy windows was chosen as the backbone of the research seen here. Kingdon’s theory responds to how an idea’s time comes. According to Kingdon, pinpointing the exact origin of a new initiative for action is nearly impossible. Ideas have history and it’s much less interesting to determine their origin than to understand what makes them acceptable at a given moment. For Kingdon, it’s the fact that several factors come together all at once which is responsible for new programs, for action being adopted. He categorizes these factors into two major categories: the participants who are active sources of initiative, and the processes by which agenda items and alternatives come into prominence. The latter category is subdivided into three types of processes, or streams: problems, policies, and politics. Each process could be a constraint or a push factor, and any participant, in theory, can be involved in any of them. The key for change is the coupling of processes and participants, their simultaneous occurrence at critical times, which opens a policy window or opportunity for change. Despite the rarity of such windows, Kingdon’s theory claims that major policy changes result from the appearance of these openings. This was the hypothesis regarding how the 2007 HSS changes came to be: HSS became an issue and changes were adopted in 2007 due to the opening of a ‘policy window,’ and that between the various converging factors that led to this ‘window of
The hypothesis was tested by structuring a two-phase analysis around Kingdon’s theory. A first phase of official document analysis was used to gather assumptions about possible factors that could have led to a window of opportunity, and a second phase of interviews was used to confirm or disprove the influence of those factors, as well as to discover other factors that were not in documentation.

The analysis confirmed the hypothesis of a policy window, or convergence of factors that permitted a diagonal HSS policy to be adopted in 2007, altering the Global Fund’s health financing identity. The analysis made it clear, that as Kingdon held, it would be nearly impossible to pinpoint the primary factor that led to the Global Fund’s change in policy. Rather the key years of 2006 and 2007, leading up to the change, were filled with a multitude of actors and processes, which were esteemed as having some hand in the transformation. Different actors - macro and micro, internal and external, public and private - were all sources of initiative at some point, by drawing attention to or being involved in one or more of the various facets of the three process streams - indicating different aspects of the health systems problem, exchanging policy ideas between specialists, key personnel changes, bargaining policy interests, or influencing the international mood towards health systems financing. Determining with certainty which factor is of most importance was unfeasible, which made the secondary hypothesis investigated here only partially confirmed. At first glance it seemed that major personnel changes would have been the key to the Global Fund’s change in policy, especially in the case of the change of the Executive Director, which led to the secondary hypothesis seen above. However, after the second phase of analysis, it could not be confirmed that these events were any more fundamental than the indication of problems with the current policy. The fact that this secondary hypothesis was proven false, or at best partially true, only strengthens the argument that the primary hypothesis of a policy window for HSS is valid. More than anything, the analysis revealed that the how of our research question can only be answered by the confluence of people, problems, policies and politics that led to a moment ripe for change, and that that moment was seized by those in favor in order to push for a diagonal HSS policy in place of vertical or horizontal actions. The Global Fund did evolve and move forward in its process of institutionalization, and this moment of change and development was not due to a singular grandiose occurrence but a window of opportunity made from multiple factors.

The advantage of applying Kingdon’s theory of public politics and policy windows to the Global Fund’s policy changes in 2007, has been the comprehensive investigation of the
many factors involved in changing a singular policy and developing an institution’s identity as a result. Such a widespread understanding is advantageous in order to truly grasp how things come to be. Furthermore, the method used to investigate the validity of this theory has resulted in the unveiling of some unique findings regarding the decisions in the beginning days of the Global Fund and the processes involved in getting the votes for HSS, such as the bargaining between delegations. In this way, the analysis has exposed new information that is nowhere to be found in other written documents.

However, despite the broad picture and the new data, the realization that some information only came to the surface during the second phase of analysis brings up a possible weakness of this research. Because only thirteen interviewees were questioned, due to the difficulty of procuring interviews and the human capacity available in performing the research, even though a characteristic sample group was used, it is likely that there are yet other factors that could be revealed by interviewing other participants in the Global Fund’s HSS debate. It remains most plausible that there was not a singular occurrence but a window of opportunity that led to the 2007 changes, but is also probable that the list of factors creating that window is even longer than what has been seen here. For example, perhaps other instances of bargaining occurred or other delegations were more directly involved with the academic world. The complete picture cannot be known without being entirely exhaustive in the analysis and interviewing process. This first investigation has been but a starting point for understanding the entire collection of factors that led to singular policy changes, and is certainly only a beginning to understanding all the factors involved in the larger institutionalization process of the Global Fund.

The goal of the research here has been to grasp how the Global Fund came to adopt the new HSS policy in 2007, in the process of developing its identity. However, no attempts were made to explain why a diagonal HSS policy was added or became acceptable for participants. This could be an interesting topic for further research, especially if the why was investigated in regards to the nature of the Global Fund as a health GPPP. Questions to be explored might include: why was a diagonal HSS policy favored by the Global Fund, a health GPPP? Did all public actors and all private actors have similar opinions and interests in the 2007 HSS policy? And do public actors favor a horizontal approach and private actors a vertical approach, the result of a health GPPP like the Global Fund being a compromise between the two, or diagonal approach? All of these questions inquire as to why the Global Fund finally settled on a program of action that was diagonal and could be very intriguing for further research because of their complementarity with the research seen here and because they would shed light upon the specific implications of health GPPPs on policy decisions.
VIII. Abbreviations

AIDS.................................................................................... Acquired Immune Deficiency Syndrome
ATM.................................................................................... AIDS, Tuberculosis and Malaria
BM.................................................................................... Board Meeting
C.................................................................................... Chair
CCM.................................................................................... Country Coordinating Mechanism
ED.................................................................................... Executive Director
EU.................................................................................... European Union
Fund.............................................................................. Global Fund to Fight AIDS, Tuberculosis and Malaria
GAVI............................................................... Global Alliance for Vaccines and Immunization
GF.................................................................................... Global Fund to Fight AIDS, Tuberculosis and Malaria
GPPP............................................................... Global Public-Private Partnership
G8.................................................................................... Group of Eight
HIV.................................................................................... Human Immunodeficiency Virus
HSS............................................................... Health Systems Strengthening
IHP.................................................................................... International Health Partnership
NGO.................................................................................... Non-Governmental Organization
OP.................................................................................... Options Paper
PR.................................................................................... Principal Recipient
PSC.................................................................................... Policy and Strategy Committee
TB.................................................................................... Tuberculosis
TERG............................................................. Technical Evaluation Reference Group
TRP............................................................. Technical Review Panel
UK.................................................................................... United Kingdom
UN.................................................................................... United Nations
UNAIDS...................................................... Joint United Nations Programme on HIV/AIDS
UNICEF............................................................. United Nations Children’s Fund
USA.................................................................................... United States of America
USD.................................................................................... United States Dollars
VC.................................................................................... Vice Chair
WB.................................................................................... World Bank
WHO.................................................................................... World Health Organization
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Annexes

A. The 2007 Health Systems Strengthening Policy Decision

“Decision Point GF/B16/DP10:
The Board refers to the principles set forth in its decision GF/B15/DP6 and reaffirms that the Global Fund should continue to support the strengthening of [...] health systems by investing in activities that help health systems overcome constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria (“ATM”).
The Board decides that the Global Fund shall provide funding for health systems strengthening (“HSS”) actions within the overall framework of funding technically sound proposals focused on the three diseases and that such funding shall be based on the following principles:

1. The Global Fund shall allow broad flexibility regarding HSS actions eligible for funding, such that they can contribute to system-wide effects and other programs can benefit. With this principle in mind, the Global Fund shall develop guidance with few prescriptions for applications for HSS funding […]
2. The Global Fund shall encourage applicants, wherever possible, to integrate requests for funding for HSS actions within the relevant disease component(s). Such HSS actions will be assessed by the Technical Review Panel (“TRP”) as part of its review of that disease component.
3. Recognizing that some HSS actions (“cross-cutting HSS actions”) may significantly benefit more than one disease, the Global Fund shall allow applicants to request funding for such HSS actions by completing a distinct but complementary section (a “cross-cutting HSS section”) within a disease component […]
   b. Where cross-cutting HSS actions are proposed, the applicant shall articulate how they address identified health systems constraints to the achievement of improved ATM outcomes.
4. In reviewing a disease component which contains a cross-cutting HSS section, the TRP may recommend for funding either:
   a. The entire disease component, including the cross-cutting HSS section;
   b. The disease component excluding the cross-cutting HSS section; or
   c. Only the cross-cutting HSS section if the interventions in that section materially contribute to overcoming health systems constraints to improved ATM outcomes […]” (GF, BM 16 Report, Decision Points).
B. Interviews

i. Characteristic Sample Group

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<td>Face-to-face</td>
</tr>
<tr>
<td>Point Seven</td>
<td>Dr. Sigrun Mögedal (Norway)</td>
<td>By correspondence</td>
</tr>
<tr>
<td></td>
<td>Dr. Marijke Wijnroks (Netherlands)</td>
<td>By phone</td>
</tr>
<tr>
<td>Recipient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>Dr. Jorge Saavedra (Mexico)</td>
<td>By phone</td>
</tr>
<tr>
<td>Civil Society and Private Sector</td>
<td></td>
<td></td>
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<tr>
<td>Private Sector</td>
<td>Mr. Rajat Gupta (McKinsey &amp; Company)</td>
<td>By phone</td>
</tr>
<tr>
<td>Non-Voting</td>
<td>(See Executive Director)</td>
<td></td>
</tr>
<tr>
<td>Technical Review Panel45</td>
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<tr>
<td>AIDS</td>
<td>Dr. Indrani Gupta (Recipient country- India)</td>
<td>By correspondence</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Dr. Peter Metzger (Donor country- Germany)</td>
<td>By phone</td>
</tr>
<tr>
<td>Malaria</td>
<td>Mr. Blaise Genton (Donor country- Switzerland)</td>
<td>By phone</td>
</tr>
<tr>
<td>Cross-Cutting</td>
<td>Mr. Andrew McKenzie (Recipient country- South Africa)</td>
<td>By phone</td>
</tr>
<tr>
<td></td>
<td>Mr. François Boillot (Donor country- France)</td>
<td>By phone</td>
</tr>
<tr>
<td></td>
<td>Dr. Assia Brundrup-Lukanow (Donor country- Germany)</td>
<td>By correspondence</td>
</tr>
<tr>
<td>Secretariat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Director</td>
<td>Sir Richard Feachem</td>
<td>By phone</td>
</tr>
<tr>
<td>Director of Communications</td>
<td>Mr. Jon Liden</td>
<td>By phone</td>
</tr>
</tbody>
</table>

45 Note the difficulty of categorizing TRP members in order to assure a representative sample. The TRP is split into expertise categories, but the members are also affiliated with donor and recipient countries. To be as representative as possible, the goal was to have a TRP member of each expertise group and of those individuals at least one donor and one recipient country representative.
ii. Summary Tables

The following pages contain two tables, which present a qualitative summary of the key subjects discussed during the different interviews. Both tables are presented with the list of interviewees on the vertical axis and the factors discussed on the horizontal axis. These tables permit a visual representation of the frequency of a factor’s discussion during the interview process, and allow the reader to see which factors were emphasized as contributing to HSS changes by the characteristic sample group as a whole.

An X indicates that the subject was discussed as a contributing factor by that interviewee. Note that ‘discussed as a factor’ means only that; it does not signify that the factor was discussed as a constraint or a push factor. An X is neutral in that sense (for more opinionated information, refer to the interview transcripts themselves). An X is also placed when the subject is referred to both directly and indirectly - directly meaning that the subject was verbally stated by the interviewee; and indirectly meaning that the subject was hinted at either by suggesting it individually via another topic (such as referring to the results of feedback without discussing the act of feedback itself), or it was hinted at collectively when the interviewee included it in an indecisive statement on multiple factors.

Following the structure of Kingdon’s theory, as in the main document analysis, Table 1 first presents the summary of participants discussed. For clarity the participants are grouped into four main categories: Board, Secretariat, TRP and External, according to what kind of member they are within the Fund or outside of it.

Table 2 summarizes the different processes discussed: problems, policies and politics. For clarity, the problems stream was subdivided into aspects of the problem and means of indication, and the politics stream was subdivided into changes in personnel, bargaining and context factors.

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46 This ambiguity is maintained for the reason that certain subjects are delicate, such as personnel change. Only X marks allows for summarizing the information discussed without revealing opinions that interlocutors would prefer to conceal.
### Table 1

<table>
<thead>
<tr>
<th>INTERVIEWS</th>
<th>Participants</th>
<th>Secretariat</th>
<th>TRP</th>
<th>External</th>
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</thead>
<tbody>
<tr>
<td>1. Dr. Lieve Fransen</td>
<td>X X X X X X</td>
<td>X X</td>
<td>X X</td>
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</tr>
<tr>
<td>2. Dr. Marijke Wijnroks</td>
<td>X X X X X X</td>
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<td>3. Dr. Jorge Saavedra</td>
<td>X X X X X X</td>
<td>X</td>
<td>X X</td>
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<td>4. Mr. Rajat Gupta</td>
<td>X X X X X X</td>
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<td>5. Dr. Indrani Gupta</td>
<td>X X X X X X</td>
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<td>X X</td>
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<tr>
<td>6. Dr. Peter Metzger</td>
<td>X X X X X X</td>
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<td>X X</td>
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<tr>
<td>7. Mr. Andrew McKenzie</td>
<td>X X X X X X</td>
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<tr>
<td>8. Mr. François Boillot</td>
<td>X X X X X X</td>
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<td>X X</td>
<td>X X</td>
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<tr>
<td>9. Dr. Assia Brundrup-Lukanow</td>
<td>X X X X X X</td>
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<td>X X</td>
<td>X X</td>
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<tr>
<td>10. Mr. Jon Liden</td>
<td>X X X X X X</td>
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<td>11. Anonymous</td>
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</table>

**Participants**
- Board
  - Board Meetings 11, 12, 13, 14, 15; 2005-2007; Latin America and the Caribbean
  - Board Meetings 13, 14 and 15; 2006-2007; European Commission
  - Board Meetings 16, 17, 18, and 19; 2007-2009; Private Sector
  - Board Meetings 16, 17, 18 and 19; 2007-2009; Developing Country NGO
- Portfolio Committee
- U.S.A. Delegated
- France Delegated
- U.K. Delegated
- Norway or other Point
- Germany Delegate
- Dutch Delegated
- African Delegates or others
- Private Sector Delegation
- NGOs Delegates
- Chair Carol Jacobs
- Vice Chair Elizabeth
- Chair Ruth Black
- Vice Chair Richard Feachem
- Chair Michel Kazatchkine
- Vice Chair Helen Evans
- Chair Jaap van Gijn
- Vice Chair Jonathan Broomberg
- Chair Peter Godfrey-Fausset
- Chair Rajat Gupta
- Chair Assia Brundrup-Lukanow
- Chair François Boillot
- Chair Gilbert Hamel

**Processes**
- See Table 2

**Factors**
- Board
- Secretariat
- TRP
- External

**Reading**
- Board Meetings 11, 12, 13, 14, 15; 2005-2007; Latin America and the Caribbean
- Board Meetings 13, 14 and 15; 2006-2007; European Commission
- Board Meetings 16, 17, 18, and 19; 2007-2009; Private Sector
- Board Meetings 16, 17, 18 and 19; 2007-2009; Developing Country NGO
- Executive Director until April 1, 2007; Last Board Meeting - Board Meeting 14
- Executive After April 1, 2007; First Board Meeting - Board Meeting 15
- Led Board Meeting 15; April 25-27, 2007
- Round 5 and Round 6; 2005-2006; South Africa, Cross-Cutting Expert
- Round 7 and Round 8; 2007-2008; U.K., AIDS Expert
- Including inner-outer academics, people who are from the academic world within the Fund.
<table>
<thead>
<tr>
<th>12. Anonymous</th>
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<tbody>
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</tbody>
</table>
### Table 2

**Factors**

<table>
<thead>
<tr>
<th>Processes</th>
<th>Problems</th>
<th>Means of Indication</th>
<th>Policies</th>
<th>Politics</th>
<th>Bargaining</th>
<th>Context</th>
</tr>
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<tbody>
<tr>
<td>Absorption Capacity</td>
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<td>Distortion Problem</td>
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<tr>
<td>Health Systems Constraints (Boilerplate)</td>
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<td></td>
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</tr>
<tr>
<td>Participants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- See Table 1</td>
<td></td>
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</tr>
</tbody>
</table>

#### Aspects of Problem

- Absorption Capacity
- Distortion Problem
- Health Systems Constraints (Boilerplate)

#### Means of Indication

- Indicated by Personal Experience
- Indicated by Observations
- Indicated by Feedback from the Field
- Indicated by Indicators
- Indicated by Studies
- Systematic Indicators

#### Changes in Personnel

- Accumulated Knowledge of Experts
- Feedback from Programs
- Feedback from Earlier Interventions
- Feedback from the Field
- Feedback from Delegates
- Feedback from Literature

#### Bargaining

- International Health Scene
- Consideration of HSS Issues
- International Health Organizations

#### Context

- Domestic Health Systems
- Interest in HSS
- International Commitments

### Interviews

1. Dr. Lieve Fransen
2. Dr. Marijke Wijnroks
3. Dr. Jorge Saavedra
4. Mr. Rajat Gupta
5. Dr. Indrani Gupta
6. Dr. Peter Metzger
7. Mr. Andrew McKenzie
8. Mr. François Boillot
9. Dr. Assia Brundrup-Lukanow
10. Mr. Jon Liden
11. Anonymous
12. Anonymous
13. Anonymous

- X indicates presence
- Blank indicates absence