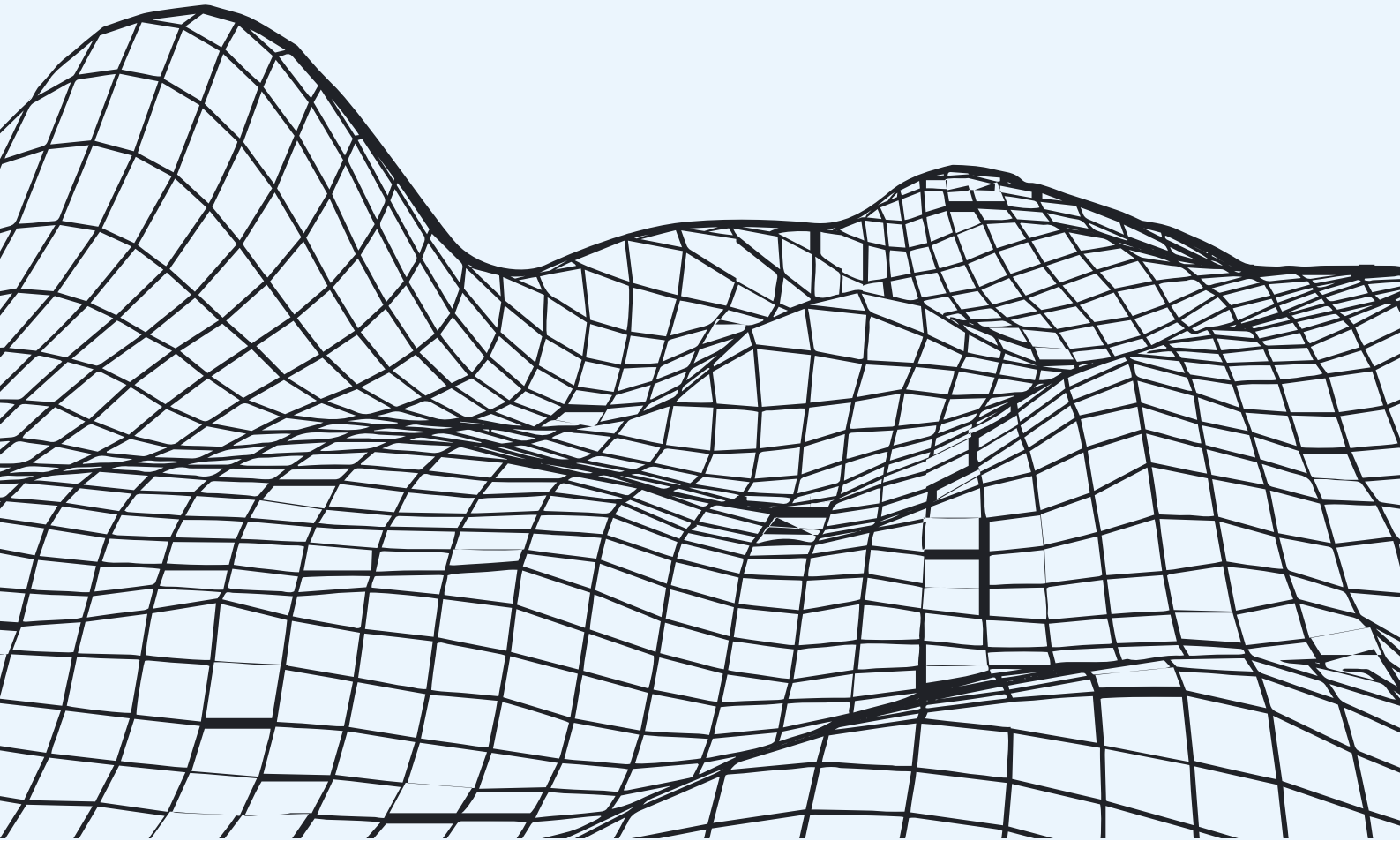
GENEVA GRADUATE INSTITUTE

World Health Organization

SHAPING THE GLOBAL HEALTH ARCHITECTURE FOR GREATER NATIONAL GOVERNANCE & ACCOUNTABILITY

Applied Research Project:
Gender, race, and diversity track



ABOUT THE TEAM

The research team is composed of two students, Ramata and Mirette, from the Geneva Graduate Institute. The students worked under the supervision of the teaching team: Professor Claire Somerville and the teaching assistant, Bram Barnes. The team also worked closely with Dr. Alastair Robb, the project focal point from WHO.

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I. Acknowledgements

We would like to acknowledge and give the warmest thanks to our WHO partner Alastair Robb, for his continued engagement and support throughout the project. We are very grateful for the insightful conversations we had with you and for all your assistance in connecting us with some of our interviewees. We would also like to extend our gratitude to our academic supervisor, Claire Somerville and our teaching assistant Bram Corydon Barnes for all their support and guidance throughout the past few months. We highly appreciate your consistent help and active engagement with our team, which helped us overcome the challenges we faced along the way. Additionally, we would like to express our sincere gratitude to our interviewees, particularly, Josephat Kakoma, Cecilia Senoo, Carole Presern, Kate Thompson, and Gavin Reid for taking the time to speak with us and provide us with critical insights about the dynamics of global health financing. Finally, we want to warmly thank our families and friends for their continued support during this project.

II. Executive Summary

The Global Fund has made a significant impact on HIV, TB, and Malaria by contributing significant financial resources that have enabled countries to scale up interventions and reduce both disease and deaths. Despite the notion of country ownership as a principle of the Global Fund, there are concerns that the fund's efforts to uphold country ownership undermine the sovereignty of decision-making, national governance, and accountability in health financing. We also evaluate the power asymmetries that exist at various levels of the Global Fund and take insight from beneficiaries and engaged stakeholders to understand how to solutionize through a decolonial framework, the structural barriers to centering the key populations most impacted in decision-making and program development for better outcomes. The research reviews the effectiveness of systems like the Country Coordination Mechanisms (CCM) of the Global Fund meant to center country ownership and its impact on national accountability mechanisms. We reviewed CCMs across various countries in the sub-Saharan African region and developed an accountability framework (upward vs. downward accountability) situated within the discourse of decoloniality and Mohan Dutta's Culture Centered Approach. We apply the notions of co-creation of strong communicative infrastructures in alignment with our hybridized accountability framework as an approach to improved community engagement and overall country ownership.

Note: All figures, infographics, and tables in this document are designed by the authors of this report.

III. List of acronyms

AAI: Aids Accountability International

ACTA: Anti-corruption, transparency, and accountability framework

CCA: Culture Centered Approach

CCM: Country coordinating mechanisms

CSOs: Civil society organizations

CSS: Community systems strengthening

DAH: Development assistance for health

EPA: Eligibility and Performance Assessments

FBO: Faith Based Organization

GF: Global Fund

IDUs: injection drug users

KP: Key Populations

LMICs: Low and middle income countries

M&E: Monitoring and evaluation

MSM: Men who have sex with MEN

NGOs: Non-governmental organizations

PLWH: People living with HIV

PR: Principal Recipient

SR: Subsidiary Recipient

SW: Sex Workers

WHO: World Health Organization

IV. Introduction

Global health financing institutions such as the Global Fund have made a significant impact on tackling various diseases such as Malaria, AIDs, and TB. They do so by raising and distributing financial resources that have enabled countries to scale up interventions and reduce disease burden and deaths. Recently, the Global Fund (GF) has achieved a pledge record of more than 14 billion dollars to support the partnership's work over the next three years (The Global Fund, 2022). As a major global health financing institution, the GF focuses on four main principles: partnership, country-ownership, performance-based financing, and transparency (GF Agent Manual, 2014:2).

Figure I: Infographic presenting the four principles upon which the Global Fund is based

Our research assesses and critically analyzes the principle of country ownership and the impact of the GF on country leadership, governance and accountability. The principle of country ownership entails that with adequate resources and support, countries should be able to set their own priorities and carry out their responses to the three diseases (*ibid.*). Through its funding model, the Global Fund established the Country Coordinating Mechanism (CCM) which are national committees that submit and oversee grants on behalf of their countries (GF, 2022). More specifically, we will explore the critical question of how the Global Fund impacts the axis of

accountability between governments and their people. We are primarily interested in examining the extent to which the GF funding model sustainable

The CCM could be considered as a tool created to foster country ownership of donor funding from the GF (more details are provided on the CCM in the literature review section). Nonetheless, our literature review revealed that this funding model does not always guarantee that recipient countries always have control over donor-funded programs. Matthews & Onokwai (2022), among others, argue that the country ownership rhetoric is becoming a buzzword that "disguises the continued use of the greater power of the international donors and does not represent a meaningful shift in power toward the agents of the recipient countries." However, despite the foundational element of country ownership present in the GF, the partnership needs better evaluative and accountability frameworks as they have been cited to undermine national sovereignty by limiting decision-making power, and in some ways restricting governance capacity. Our research will review the structures and processes of global health financing institutions that affect national accountability mechanisms.

Moreover, the project will review the current structures, processes, and incentives of the Global Fund juxtaposed to issues around who decides within a dynamic geopolitical context and an understanding of who is running global health. It will focus on the structural features in current global health financing institutions that reinforce global inequalities in access to decision-making, resources, and ownership of health interventions. The research will be attentive to how colonial legacies and hierarchies based on the North/South divide impact the current workings of these instruments. The most relevant concepts for our research are accountability, stewardship, and national governance.

Our research will assess each of these key concepts within the framework of the Global Fund as these themes are foundational to the Global Fund Framework and notions of country ownership.

- **Accountability:** Accountability entails holding various actors responsible for their actions. The concept of accountability in global health is complicated and contentious since it entails multipolar relationships amongst many different stakeholders (Wafula et al, 2014). Transparency and participation are becoming the defining elements of the accountability agendas for many global health financing institutions (*ibid*.). Our research aims to assess the effectiveness of accountability mechanisms for the Global Fund. It will investigate whether this institution truly upholds the values of transparency and participation or if they are merely buzzwords included in their accountability agendas.

- **Stewardship:** The concept of stewardship in the health space was essentially first introduced as a sort of practical framework for approaches to strengthening health systems. In the World

Health Report 2000, the WHO denoted stewardship as "a distinct dimension of governance" where… "At international level, stewardship means mobilizing the collective action of countries to generate global public goods such as research, while fostering a shared vision towards more equitable development across and within countries. It also means providing an evidence base that contributes to countries' efforts to improve the performance of their health systems" (World Health Organization, 2000) (Brinkerhoff et al., 2019). Since this report the concept of stewardship as a practical and theoretical framework has expanded from this foundational definition introduced.

- **National Governance:** Governance is "about the rules of collective decision-making in settings where there is a plurality of actors or organizations" (Chhotray & Stoke., 2009). National governance is often a synonymous concept of the political system or state structure and refers to "the pursuit of sociopolitical and socioeconomic order within a state" (Brown, 2018). We will examine how the concept of national governance is applied within the Global Fund's framework.

V. Research Objectives and Questions

To assess the current practice of global health financing institutions with a specific focus on the Global Fund, we developed the following research questions to navigate the literature and existing data.

- **Research Question 1:** How can the Global Fund better adapt its strategy for the country partnership to support national governance, stewardship, and accountability through the CCMs?

  This is a necessary guiding question for a better understanding of how global financing institutions could contribute to building national authority and accountability relative to what is already being done or what already exists. Gathering evidence on what is being done and evaluating how it is detrimental or supportive to countries is critical to beginning to unpack how implicating global financial institutions into national funding operations can undermine national governance and state sovereignty.

- **Research Question 2**- How can local perspectives be incorporated into global health financing decision-making in a way that redresses power asymmetries?

  Power asymmetries that exist between international funding financial instruments/corporations and the receiving countries are greatly the focus of this research. The undermining of states' sovereignty by these global funding institutions through financial partnerships/ relationships is usually informed by historical, political, and global economic power asymmetries based on a hierarchical structure of high-income countries and low-middle-income countries. The North-South dichotomy frequently has significant effects on the degree to which recipient countries and their local dynamics are involved in decision-making processes regarding funding allocation and health issue prioritization. Poorer countries, which are generally historically marginalized or formerly colonized, receive aid from richer countries, which are typically former colonizing countries. This question will allow us to delve into the literature about country participation on the more micro level as we will consider community and local level involvement through the country coordinating mechanisms (CCMs) of the Global Fund.

VI. Background

Overview of the Global Fund

The Global Fund is an international public-private partnership, established in 2002, whose aim is to raise and administer increased funding for AIDS, tuberculosis, and malaria prevention and treatment. This collaboration between governments, civil society, the private sector, and affected communities is part of an innovative approach to global health financing. The Global Fund was created in response to a lack of a prompt and efficient global response, as well as the necessity for funding to combat the three devastating diseases (Kohler et al., 2021). The Global Fund contributes to the fight against the three diseases in close partnership with other bilateral and multilateral organizations. Since the creation of the Global Fund two decades ago, the partnership proposes a system based on four new international principles: “partnership, country ownership, results-based financing, and transparency” (The Global Fund, 2022). The innovative partnership adopts a new approach to public health financing that is built on shared accountability across all stakeholders.

The Global Fund brings together experience, knowledge, and innovation from the public and private sectors to develop effective and sustainable health systems. Its board of directors brings together members of donor governments and implementing agencies, NGOs, the private sector, foundations, and communities. Originally, the partnership is supported by donor contributions over a three-year cycle, corresponding with the so-called "replenishment periods" of donors. The majority of the funds come from donor governments, while less than 10% of the money is raised from the private sector and other organizations (GF, 2022). The partnership manages its operations through a central secretariat. Beneficiary countries request grants from the Secretariat through their national coordinating organizations.

The Global Fund’s Secretariat has been considerably reformed, most notably with the implementation of a new funding model in 2012 to improve country alignment and delivery efficiency. The new funding model constantly evolves in response to new priorities and circumstances. It acknowledges that multi-stakeholder partnerships are the best approach to end the epidemic of the three diseases. This multi-stakeholder partnership includes governments, civil society, disease victims, technical partners, the commercial sector, and a variety of other participants (Koenig-archibugi, 2017). According to the partnership’s official reports, since its establishment, the GF has disseminated over $50 billion to programs fighting AIDS, TB, and Malaria in around 155 countries (GF results report, 2022). The majority of the partnership’s investments are based in the Global South, with a focus on the Sub-Saharan region, which receives 74% of the partnership’s investment (GF, 2022).

The Global Fund and its links to Country ownership and National Governance

When the Global Fund was first established in 2002, it lacked appropriate and functioning accountability mechanisms. Kohler et al. (2021) argue that the Global fund's corruption episodes of 2011 as well as the loss of donor confidence can be linked to the partnership's failure to establish key anti-corruption, transparency, and accountability (ACTA) frameworks to prevent fraud and corruption in its grants. With its adoption of the new funding model in 2012, the partnership shifted towards emphasizing accountability as an integral part of its operations. The Global Fund has taken several important steps to strengthen its accountability mechanisms. The Global Fund's mandate asserts that given the "diversity of interests and perspectives represented by its stakeholders, it is imperative for the organization to operate in a balanced, ethical, collaborative, transparent and open manner" (GF ethics report, 2014:3).

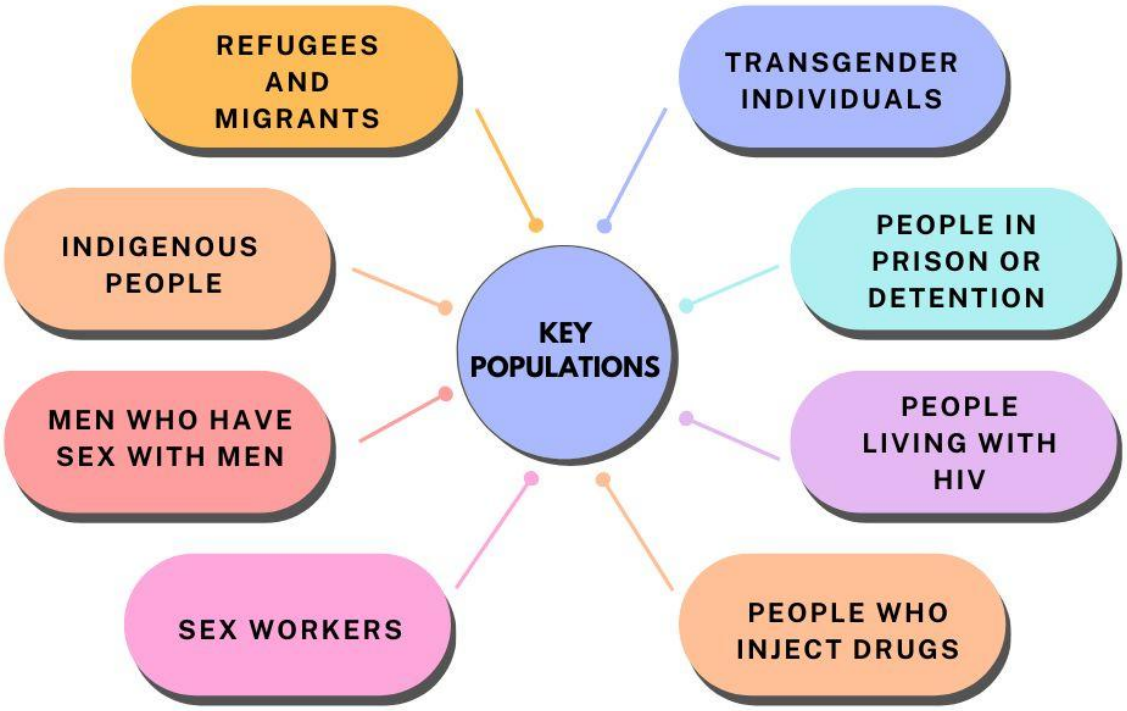
In evaluating the organization's relationship with country leadership and national governance, as well as the impact of the GF on the accountability axis between recipient countries and their citizens, we need to take into account several different factors. First, donor countries significantly influence the architecture and funding model of the Global Fund. Koenig (2017) asserts that Western nations, who are also the main donors, wielded the biggest influence in the development and implementation of the Global Fund as a global health financing institution. They exert significant influence over decision-making, agenda-setting, and the allocation of funds. For instance, major donors insisted on designating the Global Fund as a financial mechanism that only finances HIV/AIDS and TB rather than supporting other types of interventions like reinforcing basic healthcare facilities (Koenig, 2014:19).

Donor governments avoided a "classical intergovernmental model" in the creation and implementation of the GF (*ibid*.) Thus, the board provides voting rights to donor governments, the private sector as well as NGO representatives of communities affected by all three diseases (GF, 2022). Within the voting members, the board encompasses a group including regional representatives of implementer constituencies. Nonetheless, the voting board members of the GF do not include local government representatives from the low- and middle-income nations that are most affected by the three diseases. Thus, the GF's participation model presents an accountability vacuum due to a lack of active representation and communication with recipient countries' leadership and local governance. Hence, the communities that are most affected by the three diseases lack the proper channels of accountability with the GF since their governments lack democratic accountability in this case.

If all recipient countries on the board were granted certain voting rights within the board of the GF, the organization may have a funding mechanism that bridges this accountability gap and corresponds to patterns of disease-affectedness. Members of the GF board are referred to as "representatives of constituencies." Yet, who are they really accountable to and how can they be held accountable to the people most impacted by their decisions? Regional representatives can hardly be held accountable on a country level. Koeing (2014: 26) argues that "decision-makers should be accountable to specific constituencies in proportion to the power they wield over those constituencies." Therefore, there is a need for more balance of power and representation within the Global Fund's board. Stronger collaborative dialogue amongst the voting board secretariat and leadership at the country-level can be critical to ensuring transparency, accountability, and the effective allocation of funds to the correct beneficiary communities for the necessary purposes. The current context of global health is characterized by certain global power asymmetries that influence key decisions that impact the health and well-being of certain key populations who are not consulted holistically and can account for the resistance of certain health inequities. Through our project, we will examine the shortcomings of the GF's model and how they might reinforce those power asymmetries, using country-specific examples. We will also aim to further evaluate the funding model and how it impacts the axis of accountability between governments and their people.

Figure II: Key Populations explained

The table below highlights the various stakeholders and communities that fall within the term "Key populations" according to the Global Fund definition.



VII. Methodology

The research will be undertaken primarily through literature review and key informant interviews with the Global Fund secretariat, partner institutions (including WHO), implementers, CCMs, and community and public health stakeholders. We will use a mixed-methods approach that will employ heavier qualitative research methods such as interviews, documents/reports reviews, and case studies. For our approach, we will focus on discourse (thematic textual analysis) and an in depth review of various CCM case studies through community driven shadow reports.
As our research progresses, we aim to focus on a certain region or country-specific case studies, particularly the Global Fund projects in Sub-Saharan Africa, to understand how donors work with national governments to ensure public health accountability to their citizens, particularly the most vulnerable.

The primary literature for our research is publicly-available official reports published by the Global Fund. To ensure a risk-mitigating approach with regard to confidentiality, we intend to leave the option of anonymity available for any persons who work with us throughout the course of this investigation and report. The anonymity of the interviewees for risk mitigation will be ensured through the creation and use of an alphanumeric tool which will assign code names/numbers to anonymize the interviewees that would prefer this level of confidentiality.

We will ensure transparency and professionalism throughout the course of the work by making sure all ARP communications are conducted through our group email (ARP2022.Global-Health-Architecture@graduateinstitute.ch) or other official Graduate Institute emails.

VIII. Literature Review

The Funding Model and its link to Accountability

The Global Fund did not always maintain a stellar reputation across countries. For instance, in 2011, there was a media storm about episodes of fraud and corruption by grant recipients (Mcoy et al., 2012). As a result, the Global Fund suspended or terminated several grant agreements due to the misappropriation of funds uncovered by its inspector general. In December of 2011, the Fund announced that $34 million had been misappropriated in four African countries, Djibouti, Mali, Mauritania, and Zambia (GF, 2011). These acts of fraud led to the loss of large donor funds, resulting in the suspension of an entire funding round (Round 11), as well as the resignation of the partnership's executive director and numerous senior personnel (Mcoy et al., 2012).

This crisis jeopardized the Global Fund's credibility and reputation and pushed for additional reforms and reconstructions of the partnership. Moreover, when allocating its funds, the Global Fund tends to overlook the disproportionate burden of the three diseases, which remains high in the Global South (Ford, 2003). For instance, even though African countries account for 90% of the global malaria burden, they only receive less than 50% of the partnership's malaria funding (Teklehaimanot, 2002). Furthermore, when the Global Fund was first established in 2002, it lacked appropriate and functioning accountability mechanisms. For that, the partnership’s new funding was redesigned to improve how countries could apply for funding.

One of the main reforms of the Global Fund was the creation of the new funding model at the end of 2012. Following World Bank data, the new model classified countries into “categories” based on disease burden and income level (GF, 2013). The new model eliminated the initial “rounds-based” system in which calls for applications were released regularly and where countries competed for funds. The new model also shifted towards an approach that further conditions grantee readiness. Under this new approach, the Global Fund will allow countries to apply throughout the year based on their national budget calendar.

The essential aspect of the new model is that each country will know how much money they will be able to apply for and receive at the start of each three-year budget allocation cycle. The new model allows countries to access two distinct funding streams: indicative and incentive funding. The indicative funds are distributed following a Board-approved allocation formula based on disease burden and "ability to pay" while the incentive funds are structured competitively. Extra funds will be awarded for high-impact interventions that go above and beyond the indicated budget (GF, 2013:3). The updated model's purpose is to adopt a "holistic approach" to

fundamentally alter the way the Global Fund collaborates with partners and national implementers (*ibid*.).

The main features of the new model include a country dialogue which is a formalized stakeholder engagement process that includes technical experts, representatives of people affected by the three diseases, government leaders, civil society, and other relevant parties. The participants of this country dialogue will come together and represent the country coordinating mechanism (CCM). The CCM will develop a document called the national strategic plan (GF, 2013). Consequently, based on the country dialogue and the national strategic plan, the CCM will develop and submit a concept note which will be reviewed by an independent technical review panel and the Global Fund's grant approval committee. The approval of the funding by those two bodies marks the beginning of the discussion and negotiation on how the program will be implemented.

This stage is called grant-making and it happens before the Global Fund signs off on the final grant. Once the board has signed off on the grant, the money will be made available for project implementation. The research will explore whether the new funding model managed to enhance the Global Fund's accountability mechanisms to better support national governance and stewardship or not. The research will also focus on critically examining the aforementioned power asymmetries of the Global Fund and incorporate country-specific case studies to highlight those shortcomings and present recommendations on how to enhance the impact of the Global Fund on country leadership, governance, and accountability.

The CCM could be considered as a tool created to foster country ownership of donor funding from the GF. Nonetheless, our literature review revealed that this funding model does not always guarantee that recipient countries always have control over donor-funded programs. Matthews & Onokwai (2022), among others, argue that the country ownership rhetoric is becoming a buzzword that "disguises the continued use of the greater power of the international donors and does not represent a meaningful shift in power toward the agents of the recipient countries." However, despite the foundational element of country ownership present in the GF, the partnership needs better evaluative and accountability frameworks as they have been cited to undermine national sovereignty by limiting decision-making power, and in some ways restricting governance capacity. Our research will review the structures and processes of global health financing institutions that affect national accountability mechanisms.

Past and Present Trends in Development Assistance for Health and Global Health Financing

A decolonizing approach to solutionizing sustainable Global Health financing for low middle-income countries, has to do with breaking away from the north-south donor recipient power complex that development assistance for health (DAH) and aid funding is deeply founded in. When we evaluate the literature that details how global health financing has been characterized over time, insight into the extent of the power asymmetries can be revealed.

This portion of the literature review will evaluate work that has examined and analyzed trends in global health financing and development assistance for health funding disbursements over the last three or so decades. Here we take a look at how the principal Global Health funding agencies, specifically the Global fund, have been not only necessary for country support but also a norm-setting actor in the landscape of Global Health financing and initiatives. This portion of the literature review will also highlight some of the difficulties that exist within the dynamics of funding and sustaining health and development work whilst navigating decision-making power complexes and sovereign capacity.

The paper, "Development assistance for health: past trends, associations, and the future of international financial flows for health," evaluated annual reports, audited budget statements, and project record data of various international agencies that dispersed development assistance for health (DAH) from 1990 to the end of 2015 for the purpose of analyzing patterns in health financing over the years to predict future trends. The findings of this study highlight the changes in spending fluctuations based on time period, health issues, and sociopolitical era.

From 2000 to 2009, DAH disbursements increased at a greater rate than in the decade before. According to Robert Hecht and Raj Shah's chapter, "Recent Trends and Innovations in Development Assistance for Health published in Disease Control Priorities in Developing Countries published in 2006, the reason for increased DAH during the first decade to the next could be very well associated with the genesis of major funding agencies and the new availability of funds during 2000-2002 especially. Hetch and Shah's findings are supported in the third Global fund Replenishment report on trends In Development Assistance and Domestics Financing for Health in Implementing Countries, which shows the Global Fund, GAVI, special funding for HIV/AIDS from the US, as well as intense growth in grant awards from the Bill & Melinda Gates Foundation and World Bank International Development Association (IDA) grants as canonical funding sources in the beginning of the DAH landscape.

Furthermore, funding that was associated with MDGs was seen to have increased the most during this time period and stagnated around 2010 onward. This could have likely been due to the global socio-political shift from Millennium Development Goals to sustainable development

goals. This report also highlights the role of principal funders like The Global Fund and GAVI in not only shifting but also creating the space for multilateral approaches to financing health. The Global Fund especially, catapulted the agenda for financing for health for HIV/AIDs, TB and Malaria during the beginning of the first decade of the 2000s (Shah et al., 2006). Despite significant developments in financial flows for health within the landscape of the MDGs, in an era of intense geopolitical and sociocultural change, there are still inherent difficulties concerning public health bureaucracy that have fixed certain countries in favorable positions over others along the lines of deep-rooted power asymmetries. The interpretation of the findings of this paper is that low-income countries can be expected to continue being dependent on development assistance.

Since the ushering of a new era with Sustainable development Goals and today at the midpoint of the 2030 agenda goals of these SDGs, there have been several complex and multilayered issues highlighted regarding the sustainability of financial flows for health projects and initiatives. The article's overview slightly reveals how social and demographic transitions impact how funds for health are disbursed in terms of duration and amount. Most importantly it shows how health issues associated with a certain level of profile and associated positionality can dictate the likelihood of funds being disbursed as we saw that the Millennium development goals were a necessary catalyst to begin a landscape for global health funding for HIV, TB, and Malaria, especially in the low middle-income countries wherein many of these health issues, were hyper-concentrated.

A decolonizing approach to global health financing critically considers the donor-recipient power dynamics wherein the Global north Global south Dichotomy present influences financial flows and sustainability of interventions. The inherent coloniality of global health reveals itself in many ways within the realm of health financing, particularly through the limited accountability mechanisms for health funding agencies and transparent evaluative tools to measure and track health expenditure, commitment, and country ownership. Because of existing power asymmetries existing between LMICs and global health funding agencies, financial arrangements amongst the two entities sometimes handicaps these countries by diminishing their agency and governance capacities in efforts to tackle certain health issues. Critical reflection on what has happened and what is the current narrative helps situate our contextual analysis for examining the Global fund and its country relations.

To further explore how power plays an immense role in the success, sustainability, and efficiency of financial flows for health by big funders it is helpful to look at how trends in disbursement to lower-income countries, spaces relegated to the global south; and (or) the "recipients" in the "donor -recipient" dichotomy have unfolded through from the beginning of the Millennium to the current times where Global Health Initiatives and global health funding are being evaluated for reform.

In the paper entitled Factors associated with the disbursements of development assistance for health in low-income and middle-income countries, 2002–2017, the authors extracted data from the Creditor Reporting System of the Organization for Economic Co-operation and Development, Institute for Health Metrics and Evaluation, and the WHO National Health Accounts database to examine "the characteristics of assistance that may be associated with committed assistance that is disbursed" (Moitra et al., 2021). The very recent paper highlights the limited but necessary nature of literature that examines the patterns in development assistance and how aid disbursements commitments are realized and sustained. It is already understood that DAH is a critical source of funding for many lower-middle-income countries, and within this existing space there are multileveled complexities especially with regard to examining disbursement trends because limited data as well as metrics from many different sources make measuring DAH challenging.

It is also well known that the proportion of committed DAH does not always align with the amount disbursed. The results from this examination reveal that certain characteristics are associated with either more or less DAH resource disbursement for LMICs. For instance, through the years, the trends for DAH resources that have to do with attributing more than 15 percent of resources to administrative expenses usually have lower disbursement relative to the committed amount, when the public trust is more fervent and perceptions of corruption are lower this is associated with higher disbursed commitment associated with commitment (Moitra, Cogswell, & Maddison et al., 2021).

Furthermore, when there is a greater political fragility, this is also associated with lower disbursement relative to commitment. This paper highlights how administrative expenses associated with the funding and sociopolitical and governance indicators of perceived corruption or fragility are critical indicators for how financial assistance for health funding flows. To expand on the exploration of trends of financial flows for health in the global health space, this next article situates the relational discrepancies between an LMIC and principal funding agencies with regards to sustainability and trust.

In this study, alternative financing mechanisms for ART programs in health facilities in Uganda: a mixed-methods approach, researchers sought to identify the funding strategies adopted by different health facilities in Uganda, by exploring the varied dynamics of health financing mechanisms in the global health apparatus (Zakumumpa, H., Bennett, S. & Ssengooba, et al., 2017). This paper adds a necessary nuance revealing national efforts to sustain health projects in LMICS that are the main recipients of many principal health financing funds. To explore the varied financing mechanisms that different health facilities used, 195 different health facilities between 2004 and 2009 in Uganda as a preliminary test and then there followed in-depth studies

of 6 health facilities, semi-structured interviews with clinic managers, and lastly qualitative data analysis (Zakumumpa, H., Bennett, S. & Ssengooba, et al., 2017).

The financing mechanisms were differentiated by facility type, the study found that private not-for-profit providers were more externally focused (multiple grants, philanthropic aid); for-profit providers were more client-oriented (fee-for-service, insurance schemes); and public facilities sought other funding streams not dissimilar to other health facility ownership-types (Zakumumpa, H., Bennett, S. & Ssengooba, et al., 2017). This specific study focused on financing for ART and found that for the most part the health facilities in Uganda leveraged alternative forms of funding for ART deviating from using GHI funding. To extend, the qualitative evidence showed that the funding coming from government and GHIS for ART delivery specifically was not enough, in that drugs and commodities were covered as principal components of ART but not the rest of the facts that make up the complex intervention, for instance, cost for treatment of HIV-associated opportunistic infections (OPIs) are not a part of the main ART package from principal funders. The interviewees detailed the areas which are not supported by their main funder which are critical elements in where supplemental funding is used. Interviewees also detailed that they looked to multiple funding channels because of the "time-limited nature of GHI funding". Also, the issue of having to navigate abrupt ends to project grants, and discontinued funding was mentioned. Again, all this is specific to ART programs which have varied socio-political implications given the "sensitivity" surrounding HIV/AIDS and vulnerable people groups living with HIV (LWHIV). In this case, health facilities diversified funding streams as a strategic approach to keeping ART programs afloat, to increase sustainability (Zakumumpa, H., Bennett, S. & Ssengooba, et al., 2017).

The study also found that most of the core funding for ART programs that facilities relied on came from traditional finding partners like Global fund and PEPFAR. Though revealed through the research that the facilities were more desiring of a multitude of approaches through which they can potentiate more sustainable funding streams for programs, the integration of Global Fund grants into national budgeting could have made their presence more pronounced than normal. The evidence in this paper revealed that the health financing mechanisms that exist are not always sufficient on their own. From the highlighted challenges and subsequent approach to remedy the detrimental effects of partnerships not being as sustainable as needed, multiple funding sources provide an interesting take on how countries could collaborate with principal funding agencies and other funders to ensure that health projects and programs are sufficiently sustained and they can provide the health services/resources necessary.

From the primary review of literature, it is clear that a deeper understanding of in-country stakeholders, community leaders, and civil society advocates needs to be present to better contextualize notions of country ownership and accountability. There exists a wide range of scholarly commentary on the term country ownership. The Paris Declaration on Aid

Effectiveness (2005) and the Accra Agenda for Action (2008) which resulted from a series of forums held by the Organisation for Economic Co-operation and Development are the principal foreground for the notion of "country ownership". It was meant to symbolize a shift from an era of conditional aid in international development where financial institutions asserted an imperialist hegemonic control over governments through structural adjustment programs to a new time where the receiving countries are principal agents and have ownership over the policies and actions that concern their development (Brown 2017) (Black 2020). The discourse in scholarship on country ownership overall has ranged from light skepticism to arguments for its disuse (Black 2020).

The literature reveals that a major reason for this is the complexity inherent in the term and how it manifests practically in varied contexts and in different forms (*ibid*.) (Onokwai & Matthews et al., 2022). The Global Funds CCM Policy defining the policies that "the global fund will apply to appraise CCM performance" published in May of 2018, states that core principles of The Global Fund Framework are central to the CCM model and express the TGF's commitment to "*reflecting national ownership through respecting country-led implementations processes…"* (The Global Fund, 2018). The policy document states that as signatories of The Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) they are "fully committed to seeing aid effectiveness principles applied, where they underscore the declaration and agendas call for '*harmonized and aligned delivery'* (*ibid*.).

In Onokwai & Matthew's case study on country ownership, they examine Ghanaian CCM functions in practice to see if country ownership is actually realized through CCM. Through a qualitative analysis in which the primary data collected was from a range of stakeholder interviews, they found that Ghanaian CCMs were quite reflective of conditional ownership due to the limited agency. This limited agency was seen through the mediation of CCM operations by the Global Fund 's stipulations and regulations in a way that is restricting. For instance, in developing proposals, donor preferences are very well understood and known in the receiving communities so proposal are tailored in this light even if it the not necessarily what the recipient community aligns with to a certain level of internalization of these donor preferences from long years of these provisions and conditionalities (*ibid*.) (Saliba-Couture, 2011).

The paper provides reflections from stakeholders from the Ghanaian Government where they detail that there is a tendency to "to tell donors what they want to hear" to secure funding because of the deep-rooted influence of donors on recipients. (ibid) Not only this but with regards to technical assistance and mechanisms for review, the study highlights that the role of consultants offered by donors are highly driven by donor ideology and predilection whereby these consultants who are meant to aid in the development of funding proposals focusing on technical issues and technical demands of this sort of proposal writing, have the power to actually decide the "fate" of the proposal because of how much powers exist in review. (ibid)

The issue of a sort of blurring of lines in relation to how counter power imbalance mechanisms like the CCM, apply practically is of concern here. Like Onokwai and Matthew assert, their findings demonstrate issues of country ownership and donor recipient power relations that extend beyond the Ghanian context.

While there were mixed impressions amongst agents and stakeholders of CCM, with some finding that active involvement of Government and civil society in CCM is demonstrative of country ownership, others expressed that there are many ways in which the CCM processes undermine country ownership (*ibid*.). Moreover, Onokwai and Matthews conclude that their Ghanaian case study suggests that the use of *country ownership* by TGF officials is only rhetorical as it obfuscates the larger issue at hand which the intense power asymmetries between greater power international donors and recipient countries, particularly those in the global south and especially in sub–Saharan Africa.

There does not seem to be a meaningful shift in this power and this is not representative of the conducive partnerships that are meant to uphold country ownership that the TGF bases its CCM strategy on as a signatory of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action (*ibid.*) would. Though TGF CCMs are meant to center the countries agency and provide power imbalance through partnership and active involvement, in this case and others it seems that there still exist with CCM donor- recipient relations that carry certain paternalistic undertones that doesn't take into account the intense fiscal dependency and imbalances of power. The paper further reveals the complexities existent in Country ownership and tools to counter power imbalances like the GF's CCM.

The literature allows us to situate some of the dynamics of country ownership and accountability in a way that highlights their complexities. Often, we find that DAH or any type of health funding delivered through collaborative and engaging partnership does not always practically manifest in a way that is centering of country priorities and local perspectives. All the while, still being vertical in approach, despite their being mechanisms in play to counter past devastations of overt hegemonic imperialist control from powerful donors to poorer global south recipient countries, it is becoming clear that certain technicised tools for change are failing to effect real structural differences.

Through interviews with individuals representing these different stakeholders we explore certain intricacies between policy in praxis. The double nexus between governments and donor agencies and governments and their citizens is a crucial crossroads to evaluate as we find that the literature does not easily account for the subtle manifestations of power asymmetries in places of concern like the governing board of the Global Fund or the way Country Coordinating Mechanisms engage with implementing partners or principal recipients.

IX. Research Findings and Results

The CCMs and incorporating local perspectives into global health financing decision-making

Figure III: The diagram below highlights the structure of the country coordinating mechanism (CCM) of the Global Fund*

*(Information in the diagram is derived from the Global Fund official website, 2022)

The CCM represents an innovative global health model that ensures that GF grants advance rather than merely complement national health initiatives and enhance the quality of the health programs they support (Sands, 2019). Structurally, the CCM seems to promote transparency, country ownership, and inclusivity by representing all sectors involved in the responses to the three diseases. The CCM encompasses stakeholders ranging from government officials, and the private sector to NGOs and beneficiaries. According to the Global Fund's recommendations, a

CCM should have about 40% civil society representatives (Sands, 2019). Consequently, this model shows a high level of local engagement when it comes to the implementation and monitoring of the GF's grants. The main objective of the CCM is to strengthen country ownership by providing recipient countries more influence over projects supported by donor-funded programs. Nevertheless, both our literature review and interviews showed evidence that CCMs have not always been effective in delivering health programs that are well-tailored to the community's needs.

Multiple case studies highlight issues with transparency and inclusivity within the dynamics of the CCMs. Taddese (2015) highlights a case of politicization of the CCM in Ethiopia which greatly impeded the active and meaningful participation of civil society organizations (CSOs) in the decision making process. Even though one of the CCM voting members is a representative of local NGOs, their vote was hardly ever taken into consideration given the consensus-based decision making approach that dominated the Ghanian CCM. This situation, thus, leads to "asymmetric levels of compromise" on the part of the various stakeholders who take part in the CCM (Taddese, 2015:102). Asymmetric compromise entails a consensus that does not necessarily mean all parties agreed equally with the decisions taken (*ibid.*). In the case of Ethiopia, interviews with CSO members revealed that these community organizations often carry the burden of the compromises required to reach consensus. Based on extensive interviews with CCM members and participants in CCM meetings, the author further highlights that voting and non-voting members who participate in CCM meetings often revert to consensus-based compromises on the basis of "collective interests" and the "national importance" of the CCMs. Therefore, the CCM as a mechanism becomes politicized rather than merely constituting technical matters aimed at improving the national health situation. As a result, members of the civil society and communities affected by the three diseases end up lacking the proper voices and agency in the decision-making process since most decisions are highly influenced by political motives. Furthermore, in our interview with Cecelia Senoo (executive director of a local NGO in Ghana), emphasized that the voices of local NGOs are often overshadowed by those of the government and the public sector. Therefore, for CCMs to properly fulfill their inclusion and transparency function, all stakeholders, including CSOs need to have a voice, agency and be actively involved in the decision-making and empowered to question the implementation of the funds.

Upward/downward accountability framework

To address our main research question evaluating the effectiveness of the Global Fund model in strengthening national governance and accountability, we will first introduce the distinction between two types of accountability: **upward** and **downward** which constitute the accountability framework we developed for our research. Then, we will evaluate the importance and interlinkage of both accountability types in shaping global health architecture for greater

national governance and accountability while examining the power asymmetry between donors and recipients. The major focus in an upward accountability system is the accountability between donors and decision-makers which can generally be achieved through monitoring and evaluation (M&E) mechanisms. A downward accountability system, on the other hand, focuses on improving accountability between governments and their people to ensure that beneficiaries (those affected by/living with different diseases) are truly benefiting from aid projects and initiatives.

According to Morkel and Sibanda (2022), the dynamics of international development aid can be connected to an "upward" system of accountability, particularly in African states, where there is a significant power asymmetry between the donor and recipient parties. In this upward accountability system, the main focus is on results-based management and data-centric approaches rather than strengthening holistic interventions and people-centered strategies that place the beneficiaries at the center of intervention efforts. The authors emphasize that for development aid to be truly effective and benefit the most vulnerable populations, there is a need for more localized techniques that respond to communities' needs rather than simply fulfilling an upward accountability agenda. Table I below summarizes the key differences between the two types of accountability.

Table I: Upward accountability vs. downward accountability*

The table below provides a detailed explanation of the accountability framework that we developed to evaluate the effectiveness and transparency of CCMs through various case studies examined in the next section.

	Upward Accountability	**Downward Accountability**
Main Focus	Relationship between decision-makers/ governments and donor countries/ Global Health financing institutions (e.g. The Global Fund)	Relationship between governments and their citizens
Main Approaches	Technical and data-data driven approach Results-based approach	Citizen-driven approach Community-centered approach
Main Mechanisms	Monitoring and evaluation (M&E) strategies	Advocacy and community outreach strategies
Main Features	Primary accountability	Primary accountability

	towards donors and funders	towards the beneficiaries (citizens and the civil society have an active role)

*(comparison is based on the text of Morkel and Sibanda 2022).

Sands (2019) argues that when health initiatives are developed and administered by local specialists rather than by outsiders, they may be more efficient and tailored to the country's context. Thus, a high level of involvement from local stakeholders, particularly people affected by specific diseases, would yield more effective health programs. When we asked our interviewees how to improve the axis of accountability between governments and their citizens in the context of the implementation of the GF projects, the majority of the responses emphasized the importance of incorporating downward accountability in M&E strategies, particularly improving civil society engagement in decision-making. Through our interviews with members of civil society organizations who work closely with the Global Fund, we found that downward accountability can be achieved when local civil society organizations (CSOs) are highly involved in the decision-making when it comes to the allocation of funds and implementation of GF's projects. Our interviewees emphasized the need of implementing community systems strengthening (CSS) framework, which entails substantial participation of local communities and organizations in the implementation as well monitoring and evaluation (M&E) of the GF's projects and initiatives. The Global Fund defines CSS as an approach that "promotes the development of informed, capable and coordinated communities, and community-based organizations, groups, and structures" (CSS framework, 2011:1). Therefore, following a CSS allows for a more community-driven approach (i.e. downward accountability) when it comes to submitting grants proposals and implementing GF projects.

A CSS framework is essential in improving national health priorities as local and civil society organizations have the necessary capacity to interact directly with the affected populations (i.e. the beneficiaries in this case) and respond to local needs through community outreach and advocacy. Nonetheless, this framework can promote improved policy and programmatic settings in health outcomes only when civil society organizations and affected populations have robust and sustainable systems in place to support their activities and services (GF, 2011). For that, Cecelia Senoo (NGO delegate to the GF) contends that community organizations and people living with diseases should be at the center of the Global Fund's strategy. This argument implies that establishing the proper channels of communication to involve the beneficiaries in the implementation of GF projects is equally important as establishing national M&E systems that often lack citizens' participation (Pérez- Yarahuán & Maldonado, 2020).

CCM case studies Aids Accountability International CCM Shadow Reports

Aids Accountability International(AAI), an African-led civil society organization that works to improve accountability to the most marginalized, publishes Civil society and community CCM shadow reports based on participatory action research that is developed, conducted, analyzed, and written by in-country national civil society actors to assess CCM performance from the perspectives of both CCM members as well as the perspective of other stakeholders such as principal recipients and sub-recipients. The significance of these particular reports is that AAI expands on the Global Fund CCM Progress Assessment Tools, including critical questions that are not a part of the original audits done in Geneva. Furthermore whilst the Global Fund Supported Eligibility and Performance Assessments (EPAs) are executed through a consultant-facilitated top-down approach, civil society residents in-country facilitate the Country CCM Shadow Report through a bottom-up mode that interviewed both nonCCM members as well as Principal and subsidiary recipient implementing agents that engages with the CCM. With these reports, AAI expects three outcomes: A long-term goal of more accountable CCMs; a medium-term objective of increased transparency around CCM performance and improvement plans; and the Short term aim of empowering civil society and community. The AAI shadow reports reveal pertinent trends in the CCM PR selection processes across the several countries CCMs they evaluated in SubSaharan Africa relating to power asymmetries highlighted in the literature. Most prominently the experience of having a PR that is not always in alignment with the beneficiaries' needs and calls for advocacy. Which in turn impacts the intervention, program implementation, and direction of funding. Focus group discussions conducted by AAI civil society taken from implementing governments and civil society PRs and SRs enabled the perspectives of non-CCM members that also interact with the CCM.

Some of the key areas of discussion highlighted in the FGDs that were critical for this research included the extent to which meaningful participation of key populations in CCM leadership existed, the level of women and KP representatives in the CCM; the extent of significant participation of key populations, informal and ad hoc committees; and the mechanisms in place to translate KP insight, and feedback to the greater constituencies; and lastly the process of selection for civil society members as transparent and open.

The Ghana Civil Society and Communities CCM Shadow Report

In the AAI shadow report for the CCM of Ghana on the development process of a transparent and inclusive conceptual note, CCM and non-CCM members detailed that the development of the conceptual note is consultant driven and driven by the technical capacities of the representative (Arthur et al., 2017). The experiential insight of KPs is not fully represented because not only are they, in large, excluded from the drafting process because of legalities

concerning their status, but they also have limited technical capacity so concerns go silenced (Arthur et al., 2017). As marginalized and most impacted groups of people, they should be the primary persons consulted in understanding the landscape of the problem and needed actions to combat the issues. The larger structural issue of key populations representatives like SWs, IDUs, and MSM, not being considered legitimate voices due to their limited "technical capacity" or lack of official organization because of exogenous legal issues can be combated through advocacy campaigns where the humanization of these peoples groups are invested in and scaled up through health promotion and social behavioral change. These kinds of approaches would have to begin with the active involvement of KPs in the very programs that could combat such inequities (*ibid*). For the results on whether or not an open and transparent Principle Recipient section process exists, in Ghana the AAI report details the transparency of the selection process which is guided by a policy intended to largely counter conflict of interest (COI). With strict observation and little room for contextual flexibility, this guiding work then excludes highly qualified organizations from presenting as PR because of COI. Other non-CCM members detailed their views on the transparency and openness of the PR selection process when they reflected on how CCM-member-led organizations always have the upper hand with project options and funding reception. One CCM member interviewee said that there was an "overuse of the COI '*monster*' " which kept people out of decision-making (*ibid*).

The Tanzania Civil Society and Communities CCM Shadow Report

For the Tanzania AAI shadow report, it was revealed that the Tanzania National Coordinating Mechanism (TNCM) concept note development process was transparent and well documented (Mutashobya, Mangi, & Jonas, 2018). The report found that the TNCM engages a wide range of constituency representatives and members have the space to include and formulate relevant activities in the applications. However, for some one-on-one interviews certain concerns on meaningful participation and whether there is an adequate range of contributors from the multi-stakeholders in the development of the concept note, came up. The report details how one interviewee seemed to have no understanding of the concept note development process (TNCM, 2021) (Mutashobya, Mangi, & Jonas, 2018). For transparency and openness in the PR selection process, the study showed an intense disconnect between beneficiary concerns and the selection of the PR who would represent the CSOs, KPs, and community networks well. After the selection of a PR who did not reveal their conflict of interest until the last minute as a member of the TNCM, interviewees further described the process as being unfair being that the PR of the time (2015-2018) lobbied the process, and had an influence in the decision, revealing that the guidelines were not followed (*ibid.*). In the Tanzania case, it is evident from the shadow reports that there are discrepancies between the conceptual note development and the selection of the PR for the TNCM. The PR should be in alignment with the beneficiaries' and KP's concerns and points of advocacy. If the conceptual note is developed inclusively and transparently but the selection of the individual applying and heading the stated concerns is not, then the work that

was done to center the necessary voices can become futile if the subgrantee does not prioritize these issues (*ibid.*). This issue of having an unfair selection process of a PR who illy represents the populations of concern can be politically driven but political furthermore reflects poor public health practice. A contextually tailored approach that brings in a wide range of contributors for a holistic outcome does it exist when key individuals who are both CCM members and non-CCM members are not consulted, referenced, or involved.

This method of action is reflective of a flawed model of development in which international organizations use a top-down approach that excludes the knowledge, expertise, and experience of the people most impacted. This also then results in ineffective and inefficient work that perpetuates power asymmetries, and the invisibilisation of people who are already marginalized and excluded in programmatic designs that are meant for them.

The Zambia Civil Society and Communities CCM Shadow Report

In Zambia, the funding request conceptual note development process is carried out by the Strategic Planning and Investment Committee part of their technical task team (TTT) which includes the Ministry of Finance (MoF), Ministry of Health (MoH), Churches Health Association of Zambia (CHAZ), and the Zambia National AIDS Network (ZNAN). All of these entities were the country's primary PRs when Zambia first started receiving funds (Phiri, Mwanza, & Mulwanda, 2018). The TTT has a 25-person core writing team wherein all populations are implicated as it is supported by a larger technical reference team. For Zambia's case, the study shows that their process of developing a conceptual note for funding is transparent and inclusive. It was highlighted from the AAI report that during the process of development, the CCM was also actively making consultations in the various provinces to make sure any new and emerging issues that needed to be added to the funding request were taken into account (*ibid*). The program design with these necessary and engaging checkpoints in Zambia resulted in a more inclusive CCM. The Zambian CCM was shown to be open and transparent, however; from the FGDs there was some observed controversy because some CSOs were not pleased with the process. Given that CHAZ, one of the two chairs of the TTT alongside the ZNAN, would take interest in faith-based organizations (FBO) and involve CSOs less (*ibid.*).

The Uganda Civil Society and Communities CCM Shadow report

According to the AAI shadow report for Uganda, the transparency of the CCM was limited at the constituency levels. It was found that most non-CCM members testified to not being consulted or referred back to for feedback and commentary during the conceptual note development process (Byonanebye, Alesi, & Dan, 2017). This revealed how efforts to construct an evidence-based consultation were constrained due to a loss of valuable experiential insight from LGBTI, sex workers (SWs), and injection drug users (IDUs) interviewed but not notified about the Global

fund concept note development process (Byonanebye, Alesi, & Dan, 2017). Similar to the minimal transparency existing in the conceptual note development process, the PR selection also was not straightforward. Two PRs are selected, one by the government and the other by civil society but the criteria for selecting the PRs are not available to the general public. Thus it isn't clear on what basis they are being selected (*ibid.*). The nebulousness of these processes has detrimental implications for the realization of national and local goals in combating the three diseases effectively. When key individuals and beneficiaries are not implicated in the development process of the strategies and programs that will be used to counter the very issues they face, the existing problems will most likely remain (*ibid.*).

The input of KPs in the foundational stages of the CCM is critical for funding to be allocated in alignment with real priorities. The literature reveals at large that a principal concern regarding the ownership notion of CCM is that it is not always inclusive of all the critical voices, of those most impacted by the three diseases (*ibid.*) From the few countries detailed through the AAI Civil Society Shadow reports it is apparent that despite their being variability between country contexts, there are parallels in the limitations concerning transparency and openness. The studies help to further contextualize many of the points that often come up concerning fiduciary agents and funding organizations influencing how resources are applied and utilized (*ibid*). Furthermore, examining the quality of performance through the evaluation of meaningful engagement, and use of documentation resources highlights some easily looked-over dynamics like the relationship between The PR and key population, beneficiaries, and community/ civil society representatives. From interviews and the literature, it is apparent that these kinds of partial engagement engender varied levels of frustration amongst CCM engagers and other beneficiaries. Cecilia Senoo, Executive Director of Hope for Future Generations (HFFG) local NGO in Ghana, Board Member: of Developing Country NGO Delegation to Global Fund (DCNGO), and Technical Advisor of Society for Women and AIDS in Africa pointed out in an interview, that even with major advocacy by key population stakeholders like PLHIV relaying they’re experiences and pushing for what they know is needed, like directing resources to capacity strengthening for preventative care and health promotion, they are often not acknowledged by the PR in leadership because the non-implementing work that is foundational to intervention is not considered as important.

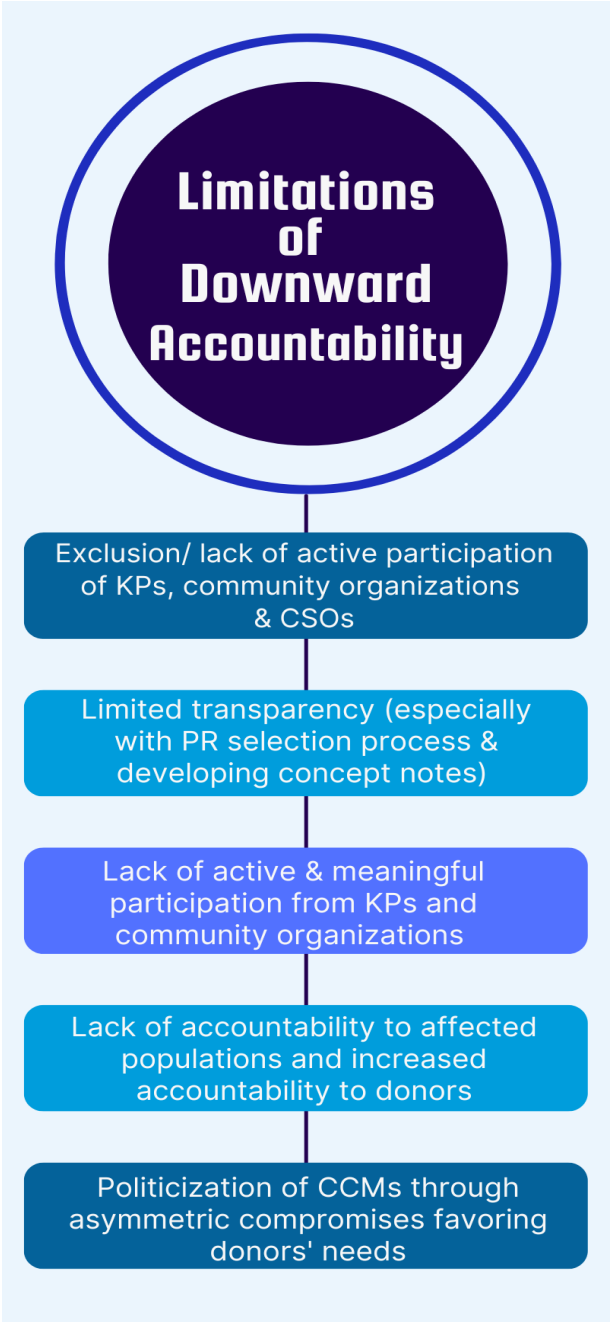
Table II: Cross-country comparison of CCMs

This table summarizes the key features (advantages and disadvantages) of the CCMs across the above-mentioned case studies and highlights the type of accountability prevalent in each case

Country	Key features of the CCM	Type of accountability prevailing within the CCM
Ghana	• **Exclusion** of key populations (KPs) from the drafting of grant proposals • Disregarding the concerns of KP due to their **limited technical capacity** • **Exclusion of highly qualified organizations** from presenting as principal recipients (PR)	Upward accountability (top-down approach to decision-making)
Tanzania	• **Lack of meaningful participation** and contribution from various stakeholders, particularly, CSOs and KPs • **Lack of transparency and openness** with the PR selection process	Upward accountability (top-down approach to decision-making)
Zambia	• **Transparent and inclusive process** of developing funding concept notes • **High level of advocacy and community outreach** across Zambian provinces to ensure all provincial issues are	Downward accountability (bottom-up approach with high inclusion levels of community organizations in the decision-making process)

	addressed in funding requests ● **Bias** towards some faith-based organizations over CSOs	
Uganda	● Transparency of the CCM was **limited at the constituency levels** ● Lack of consultation from non-CCM members ● **Lack of transparency in the PR selection** criteria (was not publicly available)	Upward accountability (top-down approach to decision-making)
Ethiopia	● **Lack of active and meaningful participation of CSOs** ● **Prevalence of consensus-based decision-making** approach rather than respecting voting rights ● **Politicization of the CCM** which disregards collective interests of KPs and prioritizes donor needs	Upward accountability (top-down approach to decision-making)

Figure IV: Limitations of a downward accountability framework: The figure below summarizes the key challenges to adopting a purely upward accountability framework within the CCMs as observed from the previous case studies



As highlighted in **table II** and **figure IV**, we used our accountability framework to situate the different CCM cases, using a purely upward accountability model increases risk of exclusion, limited transparency, a lack of accountability to key populations, and politicization of the CCM. Though this type of vertical approach is the standard within the health-humanitarian development nexus it could likely nurture constructs of power asymmetries from one point to the other. There is a need for an approach to accountability that takes on a more horizontal engagement, that centers meaningful cross collaboration and active dialogue amongst the most impacted stakeholders. The normalized dynamic of the centered and peripheralized entities should be disrupted by viewing this relation as more cyclical.

Based on the five case studies highlighted in our report, it is evident that the CCMs often adopt an upward accountability approach whereby those with more political power and influence have more leverage over decision-making. The most prevailing limitations of the CCMs across our case studies are the lack of transparency, inclusion as well as the active participation of different stakeholders, especially CSOs and KPs. Moreover, the CCMs tend to be highly politicized, as in the case of Ethiopia, making decisions that primarily appeal to donors rather than focusing on addressing the needs of the affected populations. In this case, transparency and accountability within the CCM framework become merely buzzwords with no practical application on the ground. Since Western donor countries wield significant influence on the GF board, at the same time they fail to grasp the local complexity of cultural and political circumstances. For that, CCMs tend to tailor their grant proposals in a way that appeals to donors instead of addressing the needs of KPs. This, in turn, jeopardizes the accountability of the CCMs and renders donors powerful actors in the accountability relationship. Wafula et al. (2014) identify this process as "onward accountability" to donors whereby withholding financial assistance is used as a strategy to influence the decision-making of CCM members to meet the demand of the donors. In this case, the inclusion of beneficiaries, community organizations, and CSOs within the CCM mechanism does not necessarily entail their effective representation and active participation in the decision-making process. The CCMs represent the national bodies, encompassing multi-stakeholders, who submit and oversee GF's grants on behalf of their countries. They are based on two key principles: transparency and inclusiveness (GF, 2022). Thus, when examining the efficiency of the CCMs, we must unpack the concept of inclusion to determine whether it merely entails the presence of actors or also their active participation in the negotiation process by embracing their voices, ideas, and proposals. When the enforcement of CCM decisions heavily relies on a top-down approach whereby, funders and state agencies become at the center of decision-making while local communities and KPs become peripheralized. Therefore, using a purely upward accountability model, as in the majority of the case studies examined in our report, renders the CCMs less inclusive, transparent, and representative of the voices of all stakeholders it encompasses.

Moreover, ensuring transparency and representation within the CCMs requires representing the voices of all communities, especially those on the margins like sex workers, injection drug users, trans, and gender non-conforming people, men who have sex with men, and people in prisons. The representation of these marginalized communities is hindered by social and cultural stigmatization which is then translated into how the exogenous bodies like the CCM operate and function. In our interview with Kate Thompson, head of the Community Rights and Gender department at the GF, she highlighted the need to have safe spaces within CCMs for marginalized communities to freely and openly express their opinions and concerns. Kate detailed that often the difficulty that she sees in her work with key population civil society engagement is ensuring the creation of space because of the time and effort it takes. She touched on the notion of a long-term approach to community engagement that actively brings in those most impacted by considering their concerns with regard to programmatic design, funding allocation, and core activities. Otherwise, as Kate explained, and as mentioned in the prior discussions too often than not this pushes communities to focus on donor interest rather than the advocating engagement that is central to combatting the three diseases. for engagement When investment is not diffused throughout the community. Kate's comments speak to the idea of not only valuing community perspectives but also centering the lived experiences and cultural expertise as a basis for knowledge production similar to the theories expressed in Dutta's Culture-Centered Approach.

Gavin Reid, the Community Engagement Lead at the GF, added that different CCMs need to adapt their community engagement strategies to account for the various contextual and cultural factors in the countries where they operate. Both interviewees emphasized the persistent lack of understanding of the concept of "community engagement" within the CCMs. Community engagement is often regarded as a one-off or a tick-box exercise rather than a long-term approach to ensure true inclusivity and representation within the CCMs. Gavin and Kate's commentaries were insightful compliments to the prior research gathered as they contextualized the different issues highlighted with regard to imbalances in engagement and outcome. While Gavin underscored the complexities within a community and the many different configurations it exists in impacting how a human rights-based approach manifests, Kate expressed that Community engagement that is meaningful requires an understanding that community is not a uniform body and there needs to be an embrace of discomfort and disagreements where difference is valued and assumptions are challenged. This way, communities play a principal role in holding the GF accountable. Community engagement should be an ongoing process framed within a context of trust and respect whereby diverse and underrepresented communities are involved at every step of the decision-making. Only then can CCMs truly encompass the values of transparency and representation and become an impactful mechanism for increasing meaningful community engagement and dialogue amongst often silenced groups.

Coloniality of Knowledge Production in the Context of CCM community Engagement

The notion of coloniality details the elastic and structural existence of power asymmetries and mechanisms of dispossession through hegemony and power imposition. The global health funding institutions that exist today are mostly dominated by and concentrated administratively in the Global North often disconnected from the lived experiences and ground realities of the impacted beneficiaries. Though the CCM is a mechanism that the GF implemented to combat the limitations in community involvement, there still exist major gaps in this mediation as regulatory aspects that ensure communicative infrastructures that consider, receive, and embrace the ideas and concerns of the communities most impacted are missing.

Inferiorizing the work, expertise, and approaches from Africa by Africans as seen in the case studies detailed above, in global health approaches to solutionizing positive change in Africa is reflective of white supremacy, which is not only well documented in the literature to be a systemic issue but also a structural one. When local perspectives of key populations are dismissed during processes of CCM mechanisms because of reasons like limited technical competence or capacity, all while neglecting the lived validity of their lived experience, the larger structural issue of embedded coloniality reveals itself. White supremacy in knowledge management is what allows for the distrust of work coming from Africa as a generalized and subaltern space at the margin In global health, this looks like key populations are not being involved in the development and decision-making processes of the CCM in meaningful ways. In Abdisalan Noor's paper on country ownership in global health, he writes about "Confusion of control over resources with a value of ideas" where ethical partners know their role as one of support (Noor, 2022). The longstanding practice of dismissing knowledge and practices from people working on the ground is detrimental to positive change-making. . To expand on the critiques made by Catherine Kyobutungi, Executive Director of the African Population and Health Research Center in Kenya Agnes Binagwaho, Vice Chancellor of the University of Global Health Equity in Rwanda in Global Health Matter podcast on *Actions for decolonizing global health*, in the humanitarian development health nexus space of work, the role of knowledge productions must be considered very strongly as the current mode of approach alongside the research and knowledge ecosystem is intensely supportive of savior complexes and supremacy (Aslanyan, 2022).

The normative and standard approach of solutionizing for global health through the existing knowledge system usually consists of disconnected methods of defining a problem through literature reviews made up of knowledge produced and maintained by similar expertise and positionalities. From this dis-attached analysis of the problem, solutions are then conceptualized based on the problem that the research or expert has essentially defined and not the real

problem(s) that exists. As mentioned by Ms. Kyobutungi and Ms. Binagwho, this self-perpetuating cycle of exclusion and control where some knowledge is legitimized and considered valuable whilst other knowledge is not solidifies a hierarchized polarity between those who have access to and work within spaces of legitimized knowledge/knowledge production and those who do not. In Anibal Quijano's work on the coloniality of power he determines that power is based on the racialized social classifications of the world under euro-centered power; but it goes beyond the problem of racism in social relations as it shaped the foundations of "capitalist colonial/modern world power" (Quijano, 2007). The colonial matrix of power obfuscates experiences that exist in the parts of the world relegated to the Global South or otherwise understood as the *periphery*. Though subtle, the work of systematically removing the voices of concern that are already "othered" in decisions impacting their humanity is an example of the coloniality of power working epistemically, through knowledge management, and production.

In Gene Richardson's book *Epidemic Illusions on the Coloniality of Global Public Health*, he uses the example of epidemiological research methods in Public health to demonstrate how the locus of knowledge productions impact interventions and health outcomes. Richardson's analysis implies that there is a certain level of ideological work produced through the use of contemporary science or the universally accepted norm of knowledge productions coming from the locus of the Global North which he describes as inherently promotive of neoliberal agendas that can also perpetuate systems of oppression(Richardson, 2020). The universalization of western neoliberal approaches in the field of global public health and development work often manifests as disconnected corporatized interventions that fail to engage those most concerned in a meaningful manner as is the case for the GF and the CCMs. The harm in solely applying one lens of understanding is that the bigger picture is often missed. There is value in consulting, engaging, and collaborating to solutionize. Often the normative, legitimized, and accepted approaches to research and development work takes on a technical and very practice-oriented approach to the human experience. The researcher or expert, who finds solutions for problems that they have defined through a limited scope of understanding often lacking in experiential insight, is justified in their individualized sense of savior-ism. Richardson describes a kind of systematic obscuring that occurs with the use of mechanistic approaches to peoples and places through his contextualization of epidemiology in the field of public health where quantifiable indices are core to the narrative generated for and about populations (Richardson, 2020). There is no objective way of approaching the human experience, as everything is impacted by multifaceted realities and changing dynamics. Inevitably, even with the western scientific legitimized and normative ways of perceiving, the perception of an issue coming from a single site of conformity will have the political ideals and experiences of a specific context and positionality which can be detrimental when universalized and diffused to other spaces where experiences, values, and world approaches differ. In this respect, Richardson uses epidemiology

to illustrate how within public health, its use, can inescapably exist as a political tool that projects certain ideals and fosters cycles of exclusion.

As mentioned before, within global health development work, there is a certain level of corporatization embedded in mechanisms for change where levels of bureaucratic arrangements within the administrative bodies strongly align with vertical top-down exchanges and upward accountability mechanisms. The corporatization of change within the humanitarian-global health-development nexus is highly reflected through the technical approaches to meaningful engagement of the community and individuals most impacted by that de-center their human experience through a practice oriented, technical, and legitimized analysis of the people and places that likely does not consider real lives of the ones concerned. This again comes from an approach where "the expert" defines the problem and then creates a solution despite it being reflective of what the true issue(s) are. This idea that there should be consultation from only the deemed expert and a sort of hierarchical differentiation between their knowledge as well as equipped to *save* the persons they have studied under "scientific methodology" versus the concerned and most impacted person on the margins with lived experience and culturally rooted expertise is seen in the CCMs when resource allocation is not put towards behavioral change mechanism for combating health disparities like advocacy work and the centering the narratives of the key population but rather towards technical project intervention and work that is lacking in this people-centered approach. is. This paradox is again reflective of a bureaucratic corporate agenda that exists in spaces of accumulation and neoliberal capitalism. A programmatic and conceptual design intended for sustainable and structural change should exhibit a people-centered and community-oriented approach that takes on a hybridized form of upward and downward accountability and is resistant towards corporate models of work that have the strong potential to decenter the human experience.

These types of adventures embody realities of epistemic violence that Gayatri Spivak highlights in her text *"Can the Subaltern Speak"* (Spivak. 1988). Spivak's discourse on the subaltern provides a critical realm of analysis when evaluating how work is done on people in global health rather than in support and collaboration. The *subaltern* represents the wholly marginalized who when they speak are not listened to (Brunner, 2021) Subalternity relates to the racialized, classed, gendered, and othered subject who is invisibilized and unheard. The *subaltern* condition refers to one removed from dominant discursive spaces and pathways of movement into hegemony."(Dutta 2018) (Spivak 1988). Applying the concept of subalternity to the civil society/key population communities and CCM body highlights the level of difference embedded in infrastructures that do not emphasize centering community voice and cultural expertise.

Culture Centered Approach

Mohan Dutta's theoretical framework of the culture- centered approach (CCA) is a helpful stage through which one can conceptualize the process of structural change by centering the voices of

the typically silenced and historically marginalized. Dutta refers to the CCA as an intentional and methodological strategy that not only includes the voices of those on the margins but actively centers the "subaltern" experience in knowledge production and formulation of interventions. The notion of cocreating is integral to the CCA as it emphasizes the need to… "co-create infrastructures of listening to knowledge claims that are rooted in the lived experiences of communities at the global margins (Dutta, 2008, 2011)" The CCA theorizes that a principal reason for structural disparities in health and wellbeing are likely rooted in inequalities in "opportunities for community voices to be heard."(Dutta). Co-creation of spaces that situate community knowledge, lived experience, and "othered" expertise can give way to the transformative socio-cultural and political change needed to positively impact country ownership and accountability, especially in the context of Global Health.

The culture-centered approach posits that through culture and community-driven problem identification and subsequent solutionizing there can be sustainable impact on combating the typical erasures of people historically marginalized and positioned at the lower end of the vertical approach. Though the CCA finds its roots of inclusivity within the realm of the academic-community partnerships Community based participatory research (CBPR), it expands on it this by emphasizing the community as the primary resource for knowledge generation and the….." *academic partner* facilitates bringing into hegemony subaltern knowledge claims."(Dutta 2008) Dutta's work considers the role of power asymmetries for those relegated to spaces of *subalternity* in developing equitable communicative structures that allow for meaningful exchange and reception by centering the silenced first. He describes a methodological process of disrupting the reproduction of erasures within structures in positions of dominance or power. The *subaltern* oftentimes is imposed as a sort of mediator in order to be acknowledged or heard. With mediation or having someone speak for you, distance from the truth of the *subaltern*'s experience increases each time their story is told, used, hailed, and (or) examined for them. The mediator then becomes the driver of epistemic violence where they play a key role in further silencing the typically silenced person. As Dutta asserts through the CCA, and as emphasized through a number of the interviews conducted, where there is an unleveled dynamic of reception, recognition, and embrace of ideas and knowledge from communities on the margins there is also the inevitable reproduction of power asymmetries. Inequalities in communicative structures for dialogue foster aspects of hegemony, power imposition, and coloniality which shape the relationship in favor of the more powerful actor and perpetuate systems of silencing.

The CCA invites us to methodologically interrogate hegemonic power systems that silence people through active listening and meaningful engagement. Participation, partnerships, communication dialogue, and reflexivity are tools that can be used to methodologically implement culture-center projects with a culturally centered approach, The CCM is an inherently biased mechanism for change wherein aspects of coloniality exist given the bureaucratic and

institutional nature of its foundation. Despite being an added element to the Global Fund to combat the lacking community voice, bolster engagement of key populations in decisions that concern them, and increase country ownership, it exhibits a more top-down vertical approach that leaves many people out.

Through an understanding at the conception of an intervention for change, those structural disparities in health are linked to communicative inequities, approaches to meaningful engagement can be fostered in spaces where populations on the margins are not silenced and are actively participating. The ways that truths are conveyed through stories and knowledge production impacts our understanding of translated experiences. The truth conveyed by the story being told differs from author to author. The researcher or expert as the mediator or storyteller, considers themselves to know the situation based on their reading and analysis of the problem but the reality of the situation wherein exists the real problem and consequently, the real solutions are with the individuals most impacted structurally, sociopolitically, contextually, and physiologically. Allowing entry points where the subaltern can enter hegemony presents the beginning of ruptures in power asymmetries that put forward downward accountability mechanisms for change that can be more holistically inclusive. Challenging the hierarchization within social structures that sustain power asymmetries by approaching structural inequities in a way that accommodates people's varied levels of powerlessness is essential to resisting silencing systems, by upholding infrastructures of listening that Dutta asserts.

X. Recommendations and Conclusions

Based on the findings and results of our research project, we developed a set of recommendations focused on addressing issues of accountability and power asymmetries within the Global Fund, especially pertaining to CCMs. Our recommendations are as follows:

- **Enhancing the flow of the hybridized accountability within the CCMs:** CCMs need to shift towards a hybrid mode of accountability that ensures that KPs and beneficiaries are truly included at every step of the decision making process by ensuring their representation and active participation at the table. All KPs and community organizations should be actively engaged in the process of developing funding concept notes to ensure that all their concerns are addressed in the grant proposals. This could be done by increasing advocacy and community outreach initiatives within countries to ensure that issues across different communities at the local level are addressed as in the case of Zambia where community engagement across provinces guaranteed that all provincial issues are addressed in funding proposals. The findings show that the creation of dialogic spaces that are safe and foster meaningful engagement by concerned beneficiaries are

needed to combat disparities in health and achieve sustainable ownership. Strong infrastructures of communicative engagement should be co created to disrupt existing power asymmetries of dominant structures. We should actively interrogate hegemonic power structures in order to foster a more hybridized existence of accountability. When there's engagement from the very beginning and creation is happening collaboratively, upward downward accountability can exist more cyclically.

- **Tackling cultural and technical barriers to increase community engagement:** To increase accountability and transparency within the CCMs and the GF's funding projects, there is a need to increase meaningful community engagement and dialogue amongst often silenced groups. To ensure that CCMs are indeed multi-sectorial, we need to ensure that the most impacted and marginalized KPs have a seat and a voice at the decision-making table. For that, we need to take into account the cultural and technical barriers that could hinder their participation. Countries need to acknowledge and address the significant power dynamics that persist within the various stakeholders involved within the CCMs. For instance, many KPs, especially sex workers, drug users, and transgender and gender non-conforming individuals are stigmatized and excluded from the decision-making process. Thus, we need to develop strategies and initiatives that promote their active engagement and participation within the CCMs. This could be done through peer-to-peer technical assistance and support as well as investing time and resources to make CCMs meetings become a safe space for all KPs. Also, establishing communication channels to engage global and regional networks of KPs can provide support for longer-term sustainable community engagement. Furthermore, some individuals face technical barriers to attending CCM meetings. Often, the community engagement representative lacks the capacity and funds to reach the meeting location. For that, national governments need to invest resources to ensure that all stakeholders have an equal opportunity to participate in the meeting. By tackling these technical and structural barriers, we can place the beneficiaries with all their diversity at the center of decision-making while promoting cross-fertilization of ideas
- P**ower differentials that should be considered for meaningful community engagement:** There is a rooted essence of coloniality existent in the global health apparatus but most especially amongst global health financing institutions in the way that decision-making takes place for the allocation of resources in a disconnected and disengaged manner. Even with extensive stipulations detailing the systematic approach to funding distribution, political agendas, biased perceptions, and differences in positionalities of the decision-making body impact the way beneficiaries request funds and seek out needed resources. It is understood that if they do not align their proposal with the agendas of the agency they likely will not be allocated the resources they need even if it deprioritizes their principal concerns. This generates a dynamic of control where the fiduciary agent, in this instance the Global Fund, essentially decides how the beneficiary shall use the funds they distribute even if it is not impactful or meaningful to

the beneficiary and their concerns. Addressing cycles of dominance should be integral in efforts to solve health disparities anchored in decoloniality.

- **Implementing tools that interrogate and thus disrupt the reproduction of erasures in global health:** Discursive spaces of knowledge production, expertise, and development work are necessary for an approach to structural change anchored in decoloniality. Dutta conveys the idea of situating participation as a means of interrogating power differentials by way of engaging processes that build communicative resources for community voices to be heard in the dominant structures that have historically silenced them (Dutta 2008). This can be actively implemented by working to achieve spaces where the concerned community members not only identify the core problems but also provide the narratives and theoretical understanding of the problem(s) and the different ways in which they exist. The promotion of more holistic understandings in the conceptualization of solutions through collaboration and Co-création can result in sustainable outcomes that take on the hybridized cynical framework of upward downward accountability that we developed and resist erasures of key populations through cycles of dominance.

The evidence gathered in this report enunciates the lack of meaningful engagement happening at the CCM level between key populations, civil society actors, and community networks who actively mobilize for change. Often little dialogue occurs with the most impacted individual and the PR who is closer to the GF despite both being involved in the CCM. Limited communication with beneficiaries at the margins and the representative global fund entities affects the fiduciary dynamic in a way where the funding agencies influence how beneficiaries request and use funds in alignment with the funding agencies ideals as opposed to what the beneficiary needs. We found that CCMs tend to be predominated by an upward accountability framework whereby donors and governments are at the center, while KPs and community organizations remain peripheralized with limited voice and agency in the decision making process. Narratives of sociocultural stakeholders in communities at the margins , or the subaltern voice should have the capacity to evaluate how best resources should be used to combat the disparities they live and experience most closely. There should be an incorporation of a hybrid form of accountability to ensure that all stakeholders, particularly KPs and marginalized communities, within the CCMs have voice and agency in the decision making process that concern them. A system of solution that has the tendency to overlook certain community concerns despite it existing for the betterment of community ownership and engaged well being is empty when the work is detailed in theory but not in practice. The GF CCM varies by context and the level of ownership and engagement differs by population and socio-cultural/political apparatus. Despite this, a base level of consultation from the concerned beneficiaries must exist in a way that grounds their lived experience(s) as key to knowledge generation and intervention conception to center meaningful engagement and resist disconnections expanding overtime.

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