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It is time to increase Africa's governmental representation on the governing board of the global fund to fight AIDS, tuberculosis and malaria

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INTRODUCTION

The response to COVID-19 exposed a lack of African capacity to influence global health decision-making and policy. A more general recognition of limited African voice has also been reflected in reform debates within Global Health Initiatives (GHIs) as well as in more traditional sites of geopolitical power, such as the United Nations Security Council. Yet, whereas the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was once heralded as the innovative partnerships for health, its governance structure has not kept pace with emerging global norms that advocate for greater African representation, national ownership, sustainable development and greater aid effectiveness.

Drawing on insights from a larger GFATM research report,[1] we focus on only one reform pathway of many to address this shortfall. Namely, we argue that the GFATM should add at least one additional voting seat for African governments on its Governing Board. This would not only bring the GFATM in line with global norms and institutions that advocate for increased African representation, but also, by doing so, increase the performance and aid effectiveness of the GFATM, helping address longstanding challenges in how we finance and promote global health.

GFATM AT AN INFLEXION POINT IN GLOBAL HEALTH POLICY

The GFATM was established in 2002 as a public-private partnership to raise and distribute financial resources to confront HIV/AIDS, Tuberculosis and Malaria. As an innovative partnership, the GFATM Board was specifically designed as a multistakeholder/multisectoral decision-making body, which is currently made up of 20 voting members (10 donor constituencies and 10 implementing constituencies) and eight non-voting development partners. The GFATM has two voting members from Sub-Saharan Africa on the Board representing governments, one representing West and Central Africa (WCA) and one representing East and Southern African countries (ESA). Combined, these two African constituencies cover 47 countries and 74 principal recipients.

The idea of increasing African government representation on the GFATM is not new and has been internally debated on at least two occasions. The first, in 2014, raised the issue, but was quickly dropped with requests for African partners to better articulate their

SUMMARY BOX

⇒ There is increasing attention in global health governance to increase African representation within decision-making bodies.
⇒ Although the African national constituencies represent 71% of all Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) allocations, the largest disease burden and 75% of all 'challenging operating environments', they represent only 10% of the voting members on the GFATM Governing Board, suggesting under-representation.
⇒ Increasing African governmental representation by at least one voting seat on the GFATM Board would better align the institution with global norms advocating increased African representation.
⇒ Evidence further suggests that increasing governmental representation would provide greater opportunities to create better contextualised, integrated and sustainable GFATM programmes, thus helping to address longstanding challenges in how we finance and promote global health.

position and provide evidence to support their case. A second debate took place outside formal Board discussions between October 2023 and July 2024. On this occasion, the proposal for an additional African seat was never tabled for official Board deliberations, receiving lukewarm and mixed views from Board members, particularly donor countries and civil society constituencies that called for better articulation of the need. Here, political interests played the key role in scuppering the reform, with many members reluctant to make reforms too close to GFATM replenishment, while donors and civil society voiced concerns about Board 'balance', suggesting that African constituencies needed to do more with what they already had.[1]

This was a missed opportunity, since calls for increased African representation come at a critical inflexion point in our thinking about the role, scope and sustainability of GHIs. A condition made more acute by recent reductions in development assistance for health. In terms of GFATM, lasting critiques include claims that conditional funding often distorts country health priorities, undermining health system strengthening,[2] while imposing external agendas resulting from asymmetrical power between global health funders on the GFATM Board and country implementors.[3 4] This can result in policies that are misaligned with national priorities, creating duplicated human resources, disjointed monitoring and evaluation systems, with increased transactional, opportunity and direct costs to implementors.[5]

Regarding sustainability, the GFATM has been accused of inadvertently creating an overreliance on foreign aid, with an associated shifting of responsibility for health to funders and non-governmental organisations (NGOs).[6] The lack of self-reliance is compounded in Africa by a lack of government direction and weak regional governance, diluted power and financial uncertainty,[1] escalated by limited GFATM support to improve local financial management or capacity building within implementing countries. Consequently, a reliance on external expertise rather than leading from within impacts on sustainability. GFATM continues to operate in a vertical manner, creating 'siloes of excellence' while competing for limited human and financial resources within implementing countries.[7] This reduces country ownership of policy[8] with many key programme decisions made away from where problems and localised solutions reside.[1]

PROPORTIONAL REPRESENTATION

An important foundation of democratic representation is that individuals should have reasonable opportunities to be self-lawgivers in concert with others. Political legitimacy emerges from deliberative processes where those affected by a policy can have opportunities to affect decisions that greatly affect their lives. Proportional representation is often used to guarantee that key groups affected by a specific policy are sufficiently represented within a governing process. Proportionality

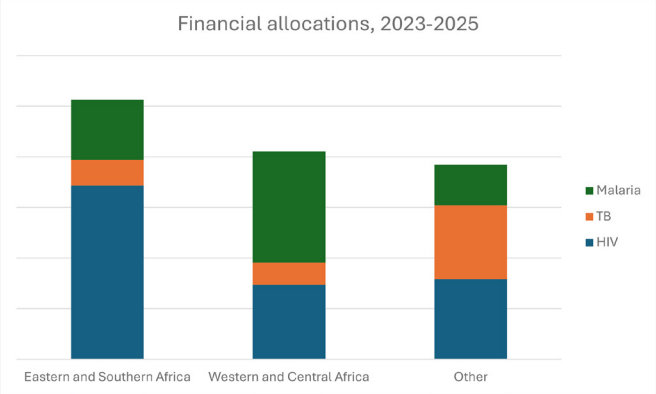

Figure 1 Global Fund to Fight AIDS, Tuberculosis and Malaria funding allocations. TB, tuberculosis.

can be assigned based on important constituency characteristics such as those 'most affected' by a policy or on 'recognised need'. If done right, proportional allocations can better capture constituency contexts and ownership within social policy, thus increasing legitimacy, accountability and policy outcomes.[9]

Yet, in terms of proportional representation on the GFATM Board, the WCA and ESA make up only 10% of its voting members. This is disproportionate in terms of 'recognised need', since in 2023 the WCA and ESA combined to represent 71% of all funding allocations (figure 1), which is more than all other implementing countries combined.

In terms of disease burden and 'most affected', the two African constituencies account for 81% of Global Fund allocations for malaria, 76% for HIV/AIDS and 39% for tuberculos. Moreover, the mortality statistics for the two African constituencies demonstrate that they combine to embody 95% of all deaths associated with global malaria, 60% of global HIV and 33% of global tuberculosis, which are each accompanied by high social and economic impacts.

These basic statistics suggest that African constituencies are woefully under-represented when measured against allocative models concerned with 'most affected' and 'needs-based' policymaking. One by-product of this underrepresentation is that it greatly limits how local insights can help steer GFATM policies and the resulting performance of its programmes. If this basic subsidiarity is a 'good', then the current distribution of seats on the GFATM Board undervalues this principle, thus reducing context-based policy, ownership, legitimacy and, as argued below, GFATM effectiveness.

NATIONAL OWNERSHIP AND AID EFFECTIVENESS

Evidence suggests that nationally owned programmes result in greater aid effectiveness.[10] Moreover, enhanced local and national ownership improves needs-based indicator selection and performance, as well as better system alignment and health prioritisation,[11] which also reduces fragmentation.[12] Well-designed local programmes with

high levels of national ownership improve country capacities and resiliency in addition to improved accountability and leadership.[13 14]

In terms of the effectiveness of financial results, programmes that have high perceptions of national ownership result in improved additionality toward national health and financial targets,[5 15] increased value for money and return on investment, while also improving partnership and perceptions of legitimacy.[16] Finally, national ownership supports a decolonisation agenda,[17] while improving the sustainability of programmes.[6 18] What this indicates is that national ownership is crucial to aid effectiveness, which GHIs must advance. Yet, with ownership comes responsibility and African governments should seek to reduce dependency through meeting the 2001 Abuja Declaration to allocate 15% of national budgets to health.

CONTEXT, CO-FINANCING, SUSTAINABILITY AND WHY INCREASED AFRICAN VOICE MATTERS

Decisions of the GFATM Board and how its funding is provided to countries can greatly impact health outcomes.[10] Yet, the GFATM Board currently maintains a disconnect between country-driven, locally based solutions to global health problems and GFATM decision-making and generalised operational considerations.[19] As argued by others, the 'long arm' of GFATM policy can greatly impact local policy choices, pervert incentives and undermine equity and effectiveness.[20] This suggests that greater African representation is not only needed to capture localised insight, but to also promote African country capacity-building, since this is under-used within GFATM operational considerations.[14]

First, the WCA and ESA constituencies represent 75% of all challenging operating environments (COEs) in which GFATM programmes are implemented. COEs create several contextually specific challenges that affect not only how specific GFATM programmes operate incountry, but also how African representatives on the Board can effectively act as a regional delegate across such a large and disparate region (across 47 countries). If the 'long-arm' of GFATM policy significantly affects local policy,[20] and if those policies require specific and tailored considerations for programme success, then this supports the argument for 'needs-based' proportional representation and adding at least one African government voting seat on the Board.

Second, the evidence maintains that sustainable health financing is improved by increased national ownership and the associated co-financing that comes with it.[5 15] Thus, government 'buy-in' and co-financing is necessary for programme success and sustainability, an element that can only come from, and in concert with, African governments. Yet, in the case of GFATM programmes, only 57% of the funding allocated between 2023 and 2025 is channelled through African public financial systems (figure 2). This lack of public channelling undermines

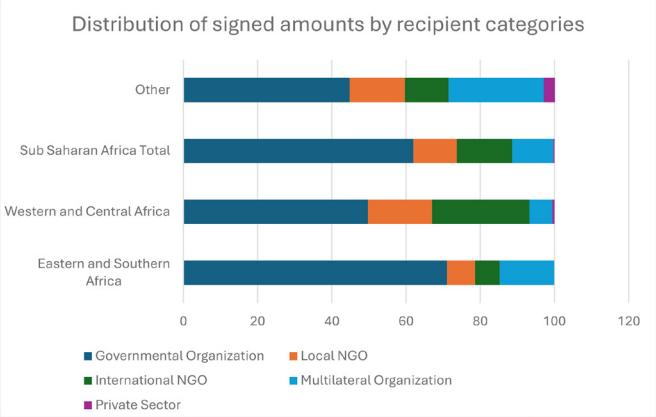

Figure 2 Distributions of allocations by categories.

country ownership, capacity-building and co-financing, which in turn perpetuates overreliance on International non-governmental organisations s (INGOs) and other multilateral organisations.[14]

IN THE END, IT WILL BE POLITICS AND NOT EVIDENCE THAT CREATES CHANGE.

Emerging global covenants like the 2005 Paris Declaration on Aid Effectiveness, the 2022 Accra Declaration on Universal Health Coverage and the 2023 Lusaka Agenda advocate for national ownership, better aligned health programmes, meaningful collaboration between stakeholders, greater mutual accountability and the need to focus on sustainable health financing. In the case of the Lusaka Agenda, it proposed a specific action plan for a shared, long-term vision of nationally funded health-care systems, as well as Universal Health Coverage that leaves no one behind.[5] Contemporarily, the global health lexicon also now reflects a more serious ideational effort to decolonise global health, with emphasis on local resiliency and global health equity.[1]

Yet, as outlined elsewhere in detail,[1] there remains resistance within the GFATM to adopt additional African government voting seats on its Board. This resistance relies on the argument that the African constituencies do not effectively use the seats they already have. What is needed, some suggest, is better African voice not more, advocating to strengthen the African Constituency Bureau (ACB), which is an NGO designed in 2012 to act as a technical and governance resource for WCA and ESA.

Nevertheless, this is fallacious, which exposes a wider problem about power, since strengthening the ACB and adding an additional African governmental seat are not mutually exclusive. Moreover, the role of the African Union within GHIs and within GFATM governance is worthy of further thought.[1] Combined, they would be mutually reinforcing in relation to the democratic and aid effectiveness arguments presented above, while also reflecting recent global norms in health. As outlined elsewhere,[1] the resistance is symbolic of entrenched interest promotion underwriting GFATM governance,

where GFATM donors wish to maintain stricter control of finances and the agenda, while INGOs and civil society have vested interests in how and to whom those finances flow.

In the case of the GFATM and Africa, power will need to be won through a persistence of common and coordinated African voice, via multiple national, regional and international forums, which leverage Africa's resource wealth and market potential. It will be won through the type of 'quality' African representation argued to be lacking by others. Although there is a strong ethical and empirical case for adding at least one African government seat on the Board, it will only be through hard-won diplomacy that what is known to be good for global public health will also become what is politically possible.

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