



Global Funds: Lessons from a not-too-distant past?

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Abstract

This paper suggests parallels between earlier attempts to address poverty through integrated rural development and current institutional arrangements for combating HIV/AIDS through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The paper suggests that there are a number of lessons that can be learned from the integrated rural development (IRD) debacle if the current initiatives are to avoid some of the problems that plagued the IRD. The errors included top-down management, application of a standardised institutional template in different contexts, overburdened local institutions, internal brain drain and non-sustainability of initiatives.

Résumé

Cet article effectue une comparaison entre les premières tentatives de lutte contre la pauvreté à travers un développement rural intégré, et les dispositions institutionnelles actuelles permettant de combattre le VIH/SIDA à travers les *Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)*. Cet article affirme qu'un certain nombre d'enseignements peuvent être tirés de l'échec de l'IRD, afin d'éviter que le même sort n'advienne aux initiatives actuelles. Parmi les erreurs notées figurent un système de gestion par le haut, l'application à différents contextes d'un modèle institutionnel standardisé, des institutions locales surchargées, la fuite interne de cerveaux ainsi que la non pérennisation des initiatives.

Introduction

The 1990s witnessed the establishment of global funds to address specific issues such as environment and health. Many factors accounted for these

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initiatives: globalisation and a growing awareness of interdependence and the existence of 'local public goods' solidarity informed by political and moral values and driven by transnational civil societies; the emergence of private foundations with a global reach; and changes in the perception of the efficacy of existing international organisations as agents in the pursuit of global agendas. The new initiatives have often produced new institutional arrangements at both global and national levels that have had far-reaching consequences for both global and national governance. Perhaps the most prominent of these new institutions is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which is an independent organisation governed by an international board that consists of representatives from donor and recipient governments, non-governmental organisations (NGOs), the private sector (including businesses and philanthropic foundations) and affected communities. The focus on GFATM is neither intended to suggest that the institutional model is its brainchild nor that it is the only global fund that exhibits the kinds of problems touched upon in this paper. The focus is justified by the much greater institutional footprint that the GFATM seems to have.

Partly because such initiatives are dealing with new issues such as HIV/AIDS or the environment, they have tended to be isolated from wider developmental debates and institutions despite the general recognition that both the factors driving them and the capacities to deal with them are closely intertwined with the complex social, political and cultural environments underpinning poverty and development. I will illustrate my arguments with the historical experience of integrated rural development (henceforth IRD), which, while different in some significant aspects, may have important lessons for the current practice. I recognise the changed international and national circumstances within which new initiatives are taking place, but I will suggest that there are enough parallels to justify drawing lessons from earlier IRD initiatives, and that unless some of the lessons of the past are learned, there is the danger of repeating some of the earlier errors. I also cite some preliminary evidence suggesting that my fears are not merely alarmist.

The IRD was largely introduced in the 1970s in response to the realisation that the 'trickle down' of growth in gross domestic product (GDP) had done little to alleviate poverty. While the 1960s and 1970s were decades of rapid growth in a large number of countries, poverty remained stubbornly prevalent. There were thus calls for new strategies that would meet the 'basic needs' of the poor or that would ensure 'growth with equity'. One factor driving the new style project was the sense of urgency about poverty that Robert McNamara brought to the World Bank, and his ability to convince the donor world that something could be done. Under McNamara, the World Bank was to initiate a direct 'assault on poverty' without waiting for

growth to 'trickle down'. One instrument pushed by the World Bank and adopted by several bilateral donors was the so-called area development programmes. With the adoption of IRD, donors shifted attention from earlier functional projects, such as national agricultural credit or extension projects, to vertical projects involving the promotion of agricultural production as well as social services. Between 1974 and 1982, 59 per cent of all projects in East Africa and 63 per cent in West Africa were in area development. Many other donors were bought in as well, so that in Tanzania, for example, four donors were involved in four integrated rural development schemes. In total \$136.5 million was committed to these projects (Stein 2003).

IRD lasted only a decade, and by the early 1980s its projects were abandoned as policy reverted first to national agricultural policy and later to structural adjustment programmes in which agricultural policy was largely reduced to liberalisation of product and input markets. By the World Bank's own measurement, undertaken by its operation evaluation department, the IRD projects were a failure. In East and Southern Africa, twelve out of fifteen projects failed; in West Africa, 43 per cent did so.¹ A number of studies were commissioned by the World Bank and bilateral donors to find out what went wrong.² These studies brought out a number of lessons, some of which I will highlight.

The technocratic fix

One of the reasons given for the failure of IRD was insufficient attention to building political coalitions in support of a continuing commitment to rural development (De Janvry and Sadoulet 1999). Although IRD was driven by political imperatives to address what was perceived as an issue of great social and political urgency – poverty – and for all the perfunctory recognition of the importance of 'political will', the actual institutional arrangements set in place were technocratically driven and somehow sought to circumvent politics. This penchant for technocratic solutions seems to plague the fights against HIV/AIDS today, even though in this case there has been a more pronounced recognition of the importance of political will. Here, too, the technocratic imperatives seem to overwhelm the political dimensions. Thus, although it is widely recognised that in the two most touted 'success' stories in Africa (Senegal and Uganda) the institutional arrangements set up sought to exploit the political clout of the presidency in combating HIV/AIDS, and the leaders of the central state took initiatives to rally the nation behind the fight against the pandemic, there have been attempts to replace these institutional arrangements with the new model. The consequence is, as Putzel concludes in his study, that '... the establishment of supra-ministerial bodies effectively ends up in inadequate attempts to reinvent government

and to replace what is essentially a political challenge of prioritizing HIV/AIDS in government and non-government sectors with an organizational fix' (Putzel 2003: 28).

A number of factors have accounted for the propensity towards a 'technocratic fix' to both IRD and GFATM. First have been the huge amounts of money involved for both initiatives. At the World Bank, McNamara presided over a huge increase in the volume of lending to rural development, which put pressure on country and project staff to get enough projects approved. As Carl Eicher observes, the 1970s turned out to be a 'Golden Age' of donor aid to agriculture (Eicher 2003). Interestingly, for all their insistence on technical efficiency and cost-benefit analysis to developing countries, the donors themselves ignored these analytical tools, as pressures to spend the money simply overwhelmed the rationale for economic calculus, making demands for more complex analysis unwelcome (Little and Mirrlees 1990). In addition, there was an enormous temptation for donors to use programme aid budgets to protect their own project lending activities. To ensure success, some donors poured millions of dollars into a particular rural development project in order to turn it into a 'successful project'. Thus in the case of Malawi, the World Bank insisted that there was recurrent under-funding of its IRD, although alternative evidence suggested that the social sectors suffered even more from recurrent under-funding than the agricultural sector (Harrigan 2001). Many 'successful' projects were so loaded with vehicles and experts that they could not be replicated on a regional or national basis without a continuous infusion of foreign aid (Eicher 2003). Throwing money at flawed projects came to be known as the 'McNamara Effect', and the outcome in many cases was 'rusting tractors'. There are some indications that the funding of HIV/AIDS may suffer from the same 'bang for buck' syndrome that vitiated IRD. The GFATM is one of the best financed global health initiatives and faces enormous pressure to disburse its funds. The motto of the Global Fund, says Executive Director Richard Feachem, is 'Raise it, Spend it, Prove it' (cited in Scalway 2003).

A second factor contributing to the technocratic thrust of both initiatives was the major technological breakthroughs that not only provided the wherewithal for doing something but also accounted for the sense of optimism and euphoria. In the case of IRD, the core instrument was the technology of the Green Revolution which was welcomed as 'the missing piece' in the failed community development movement of the 1950–1965 period (De Janvry and Sadoulet 1999). The 'roaring success' of the Green Revolution in Asia added to the lustre of the new technology and the sense of urgency in bringing it to other parts of the world, especially Africa (Eicher 2003). Similarly,

in the case of HIV/AIDS, the dramatic fall in the cost of antiretroviral therapy has played the role of technological stimulus.

In both cases the ‘bang for the buck’ attitude and the technological breakthroughs conspired with the sense of urgency to nourish ‘short-termism’. Too much emphasis on ‘proving it’ creates pressures to perform in the short term, possibly at the expense of a longer-term vision. Scalway, in a Panos report, notes ‘As a result, short-term planning and rushed processes of strategic development have so far typified the Fund’s work’ (Scalway 2003). This is despite the fact that both in the fight against poverty and HIV/AIDS, it is widely recognised that policy must take on a long-term perspective since results only emerge over long periods of time.

‘Institutional monocropping’

One practice that is now widely recognised as having vitiated aid has been the ‘one-size-fits-all’ institutional model or what Peter Evans calls ‘institutional monocropping’ (Evans 2003), which often involves the imposition of an idealised version of whatever is considered ‘best practice’, stripped of its historical origins and context specificity. One argument for the institutional arrangements behind IRD was that rural development was multifaceted, involving not only increases in agricultural production, but also improved access to other social services such as health, education and infrastructure. As a World Bank report summarised the argument:

The basic idea underlying the integrated development programme was simple. Agricultural development requires not only investment in particular projects but also a series of complementary investment in other areas to enhance the projects effects. Moreover administering these projects as entities separate from the formal government apparatus could avoid difficulties in coordinating the activities of different ministries (Pryor 1990).

National bureaucracies and ministries of agriculture were deemed too specialised to handle a multifaceted problem, and too slow and rigid to act rapidly and flexibly. In addition there was the belief that, given both the magnitude of the problem and the urgency of its resolution, it was necessary to act quickly. Rather than waste time reforming existing institutions and engaging political actors, it was better to start from scratch with new institutions that were shielded from local politics and bureaucratic traditions (Van de Laar 1980). Thus it was deemed necessary to set up separate entities that would cut across ministries, circumvent national bureaucracies, provide more flexible and autonomous ways of using donor funds, and allow for a more focused approach that would bring together the various aspects of IRD that went beyond the brief of individual ministries.

These arguments were even more compelling in contexts where local capacity was deemed inadequate. In the case of IRD, this produced the paradoxical situation in which the complexity of donor programmes was greater in Africa than in Asia, for example, precisely because Africa had poor capacity to implement complex projects (Lele 1987) What was ignored in all this was that weaker domestic capacity would make it difficult to deal with 'imported' complex arrangements, which, in some cases, simply drowned all national initiatives. One outcome of IRD was that it often destroyed or weakened existing agricultural development systems by undermining the principal role of national ministries of agriculture.

In a similar vein, the GFATM has found it necessary to set up new institutions. The arguments given for these new arrangements are reminiscent of earlier ones about IRD. Furthermore, by the time the GFATM was set up, many governments and international organisations had succumbed to the fashion of New Public Management (NPM), which sought to change traditional bureaucracies into result-oriented and transparent structures by bringing private management styles to the public sector. Indeed, a number of programmes from which the GFATM learned or flowed had already experimented with NPM. Attempts at setting up institutions that would handle multisectoral or cross-cutting problems had already been made by other international organisations; thus the GFATM cannot be blamed for inventing this particular form of organisational set-up.

Although the GFATM insists that the framework it proposes is not a requirement but a recommendation, given its financial leverage and the hurry to get approval, most governments are unlikely to depart too far from its explicit or implicit preferences. Although the GFATM eschews conditionality and avoids being prescriptive, its guidelines have become increasingly detailed. One immediate effect is that, because of the funds involved, governments have felt it wiser to simply copy whatever the GFATM has accepted or indicated as 'best practice'.³ Brugha and associates cite a Zambian official saying 'The CCM (Country Coordination Mechanism) was formed in response to the dangling of dollars' (Brugha et al. 2004). And not surprisingly, the emerging institutions are uncannily alike. In addition, the nature of the GFATM itself has dictated its institutional preferences. At the national level, partly as a reflection of its own institutional hybridity, it insists on new institutional arrangements that bring in new actors other than the ministry of health. It is thus not surprising that the GFATM has given birth to local institutional arrangements that mirror its own structure. In each country, funding applications are coordinated through the Country Coordination Mechanism (CCM), country-level partnerships formed to develop and submit grant proposals to the GFATM and designed to include broad representation from

governments, NGOs, civil society, multilateral and bilateral agencies and the private sector.

Just as IRD tended to reduce the role of the ministry of agriculture, under the new 'organisation template', to use Putzel's expression (Putzel 2003, 2004), the ministry of health is undergoing the same experience as the new arrangements challenge its position in relation to national initiatives on health. This has been true even in countries, such as Senegal and Uganda, where locally devised institutions had played a successful role. As Putzel observes:

In reaction to over-reliance on the health sector in the past, the model has tended to secondarise medical expertise, by treating ministries of health as just one among many co-equal (bureaucratic and incompetent) government ministries and the medical dimension of the fight against the epidemic as just one among many co-equal aspects of what must be a multi-dimensional effort (Putzel 2003: 28).

The problem of the imposed organisational template was not limited to Uganda and Senegal. The *tabula rasa* approach to national initiatives has basically meant riding roughshod over national institutions. While the Ugandan ministry's programme was strong enough to survive the imposition of a revived Uganda Aids Commission in 1999, the AIDS control programmes of other ministries of health, like that in Malawi, had virtually collapsed due to the establishment of a similar commission.

One source of failure of IRD projects was that they fostered conflicts between donors and local authorities. This tension may have contributed eventually have to their failure, as they were unable to leverage capacities in other public institutions. By treating them as corrupt or incompetent, the new institutional arrangements often merely produced sworn enemies who would actively or passively resist the incursion of their turf. One of the ironies of the attitude towards new bureaucracies is that it has tended to be self-fulfilling, in part because the shortcuts adopted have deprived aid funding of the protection provided by local bureaucracies and attracted individuals of dubious professional integrity. It is common knowledge that aid funding transferred outside regular government channels is the easiest to target for corruption. Such funding is a 'sitting duck' unshielded by national administrative systems that, while cumbersome, have often served as a brake on corruption and that donors have sought to circumvent.

Overburdening national institutions

One effect of IRD was to tie up national resources in servicing special projects. This was done by (a) demanding costly counterpart services from the government in terms of oversight and reporting; (b) attracting local skilled

personnel from the government to these new projects; and (c) compounding coordination problems among national institutions and between these and external institutions. The incorporation of non-agricultural components into the projects overloaded management, and implementation suffered as a result. As van de Laar notes, all this is well documented and fully acknowledged in donor circles: what was not always fully acknowledged was that this could lead to institutional sclerosis or outright destruction of national capacities (van de Laar 1980). Writing about IRD, Uma Lele notes: 'The multisectoralness of these projects has added enormously to the difficulty of administration, diverting attention from the most basic agricultural development problems, such as the inadequacy of profitable technical packages or the unavailability of the right package'. The World Bank itself noted, in the case of Malawi, that the intense attention focused on its four projects led to the neglect of other areas.

Based on precisely the same logic, the GFATM has led to new institutional arrangements which involve a 'multisectoral approach' taken to mean both 'mainstreaming' HIV/AIDS in all government activity – for example, all departments incorporate an assessment of the impact of the epidemic on their work and design mitigating measures as well as action to combat the epidemic in their domains – and 'full involvement of non-governmental sectors' – religious, voluntary and private – in planning and implementing HIV/AIDS campaigns.

One point made in a DFID evaluation of IRD was that the approach appeared to be:

based on the misconceived assumption that it was necessary to have all the components in the development of a particular area not only under one particular project but also under one management umbrella. While non-agricultural components should be planned and implemented concurrently if inter-related, this need not be under a single project management, or indeed within a single project (DFID 2004).

Similar concerns have been expressed about the 'multi-scaleness' of GFATM and it has been suggested that some of the elements included in the model are excess baggage that reflects the zeitgeist and global institutional arrangements more than other real needs of combating HIV/AIDS. Tying down medical staff in matters of 'good governance', 'partnerships', and so forth may actually be counterproductive, as the real work of combating HIV/AIDS is overwhelmed by a cumbersome model that insists on having everything in place before moving on. Serious problems have already emerged as already overstretched government staff in recipient countries have to respond to myriad expectations from donors, and both donors and recipients are

being overwhelmed by the massive paperwork and reporting that come with these institutional arrangements (Brugha et al. 2004; Heimans 2002).

Recurrent costs and reintegration

One lasting effect of IRD was the financial burden that failed projects left behind, partly because of the failure to recognise that projects not only entailed high recurrent costs but also tended to tie up an inordinate share of national government funds as counterpart funds. Under IRD, national governments were urged to increase their headquarter capacity in order to interact efficiently with donors, or to use their own counterpart funds more efficiently. This led to a dramatic extension of staff at headquarters to provide 'counterpart' services to IRD projects, and later to absorb some of the people who had been attached to the projects. When the projects were abandoned, countries were saddled with costly administrative structures. In some cases operation and maintenance problems of particular non-agricultural components were so severe as to lead to their partial abandonment after being handed back to the ministries (Pryor 1990: 75). And in many cases, top bureaucrats chose to reduce the number of field workers rather than downsize the bloated bureaucracy that had been created in response to the exigencies of donors. All too often, the result was a drastic reduction of extension services at the end of IRD projects.

The problem of recurrent costs with respect to GFATM is widely recognised and has been highlighted by attempts to reconcile the additional assumption of GFATM (i.e. its funding must be additional to the current health budget) and the budget ceilings that are part of stabilisation measures, under which any foreign grant for health would be accompanied by a corresponding reduction in the amount of money that the sector receives from the government. This conflict is well illustrated by the case of Uganda where the government first announced that GFATM money would not lead to an increase in health expenditure in line with its commitment to budget ceilings to the Bretton Woods Institutions. The ministry of finance had predetermined a budget ceiling for the health sector and to maintain the ceiling. Finance officials argued that lifting the ceiling would destabilise the economy (Wendo 2002b). Some of the NGOs placed the blame squarely on the IMF. Thus a report published by four NGOs categorically stated:

Despite the fact that the global community stands ready to significantly scale-up levels of foreign aid to help poorer countries finance greater public spending to fight HIV/AIDS, many countries may be deterred from doing so due to either direct or indirect pressure from the IMF. The IMF fears that increased public spending will lead to higher rates of inflation, but there is an open

question in the economics profession about how high is too high, and what is an appropriate level of inflation (Rowden 2004).

The IMF denied putting pressure on Uganda. After standing 'firm' on this position, the government was compelled to yield to GFTAM threats to withdraw its funding (Wendo 2003).⁴

Coordination failures

Integrated Rural Development (IRD) was characterised by serious coordination failures among government agencies in the delivery of expected complex packages of 'integrated services' because most IRD projects required inputs from numerous central ministries (agriculture, health and education), which often did not delegate implementation authority to local ministry representatives (De Janvry 1982; Eicher 1986, 2003). World Bank officials tended to place the blame on poor state policies and institutions rather than design problems (Stein 2003). The case of Malawi illustrates the point when World Bank states:

In retrospect, the government underestimated the administrative and coordination difficulties inherent in the basic concept of the complementarity of agricultural investment (which is closely related to the 'big push' in development). The administrative separation from the ministerial structure of the government did not prove to be the expected cure-all for such coordination problems; indeed such gimmicks can seldom overcome administrative constraints on government. In addition, turning completed projects back to particular ministries was difficult (Pryor 1990: 75).

GFATM seems to be witnessing the same problems with respect to coordination. And given the diversity of actors, we are likely to witness more serious coordination problems than was the case under IRD. At a meeting of the Commonwealth Ministries of Health in Africa in Entebbe at the end of 2002, there was heated discussion about the problems all ministries had encountered. In summing up priorities for action at the end of the meeting, the first priority was set as follows: 'There is need for clarification of roles, functions, coordination and implementation mechanisms of National AIDS Councils and MoH AIDS Control Programmes'. The first resolution noted 'the need for distinction between the implementation and coordination roles' of commissions and ministries of health, saying, 'the arising ambiguity could reverse progress of national responses to HIV/AIDS', and called for consultations between the national commissions, ministries of health and donors to 're-examine and further clarify roles and functions and redefine mechanisms for co-ordination and implementation' (cited in Putzel 2004: 13).

The literature on health systems is replete with arguments for embedding disease-specific initiatives into national health systems at the pinnacle of which

is the ministry of health. Indeed, this has attained the status of a mantra in international policy statements as most donors recognise that developing countries' health systems are fragile yet central to the delivery of drugs and vaccines (Brugha and Walt 2001). The GFATM's policy documents suggest an awareness that the success of its programmes will depend on the effectiveness of the entire health system, and on the need for mechanisms to avoid distortion of health-sector funding potentially created by substantial new money for the three diseases (Global Fund To Fight Against Aids 2004). The GFATM's stated intention is to 'address the three diseases in ways that will contribute to strengthening health systems'. It aims to support proposals which 'build on, complement and coordinate with existing national policies, priorities and partnerships, including Poverty Reduction Strategies and sector-wide approaches'. It will thus have to tackle the question of balancing vertical, disease-specific 'product support' against horizontal health systems support.

However this is more easily said than done. For one, embedding the GFATM into these Sector-Wide Approaches has not been an easy political and administrative task as the 'verticalisation imperative' has proved overriding (Brugha et al. 2004). GFATM is already caught between conflicting perspectives among donors – on one hand a preference for vertical programmes with a specific disease focus and run centrally (on grounds that such structures ensure efficiency and accountability), and on the other, adhesion to more horizontal approaches to health as expressed in Sector-Wide Approaches (Brugha et al. 2004). New financing mechanisms have made the integration of programmes with each other more difficult, because the funding and rationale of such programmes have brought pressures to establish vertical management structures, and monitoring and evaluation systems, to satisfy donors for 'evidence of impact'.

Internal 'brain drain'

One consequence of IRD was 'internal brain drain'. This often took two forms: directly hiring experts away from the government; and, less conspicuously, either through the secondment of local staff or simply by tying them to an IRD project, as the state had to provide counterpart support and was thus compelled to concentrate its best human resources at headquarters, a factor which often leads to a crowding out of any of other crucial tasks.

The new HIV/AIDS funding initiatives are already producing similar effects. In Uganda, the new structure came along with salaries that far exceeded those in any national institution. The leadership of the Uganda AIDS Council was initially formed of expatriate Ugandans who earned foreign-level salaries.

And according to a *New York Times* report (Dugger 2003), the president of Botswana and Ernest Darkoh, operational manager for Botswana's effort to expand treatment with antiretroviral drugs, have both complained that the non-profit groups, foreign governments and international organisations that have come to help Botswana cope with its AIDS crisis have hired away many skilled health professionals in the country's public health system, offering salaries of five to ten times those of the government. And this is a country with fairly decent wages for its public sector. In Zambia, the proposed salary of the donor-funded HIV/AIDS secretariat was set at \$6,000 per month – this in a country where the president's salary was reported as \$700 a month (Dale 2003) and that of a civil servant with university education at \$206 a month.

HIV/Secretariat – Selected Salaries from the Proposed Staffing and Staff Emoluments (in US \$)

Position	Monthly Salary	Annual Total
Director	6,000	72,000
Head of Programmes	4,000	48,000
Various Officers	2,000	24,000
Manager of Information systems	2,500	30,000
Driver	150	1,800
Office messenger	100	1,200

Source: Mwikisa (2002).

Important differences

All comparisons always run the risk of either exaggerating or downplaying similarities and differences. So far I have stressed the similarities between the two initiatives. However, there are a number of differences in both content and context that need to be highlighted if the lessons of the past are to be relevant to the current situation.

Weakened states

The first difference is the greater economic muscle of donors in the recipient countries, especially those in Africa. In the era of IRD, donors were mostly focused on their projects and did not demand wide-ranging reforms as conditionalities. Not as deeply indebted as they are today, nation states had much more room for policy choice. In addition, concerns over national sovereignty were a constitutive part of the dominant ideologies of the time.

The situation today is quite different, as the state's role is circumscribed by a wide range of conditionalities regarding 'good governance', 'accountability', etc. The new institutional arrangements reflect the weakening of state structures at the national level, the emergence of new actors in the service delivery sector, including NGOs and the private sector providers, and donors' mistrust of the state. They also reflect a jaundiced view of local elites as 'partners'. The rationale given for these new arrangement was often oblivious to the sensitivities of local bureaucracies. Not surprisingly, the proposed institutions are often aimed at circumventing states through creation of 'autonomous' bodies for the managements of projects.

Second, the problems of imported institutional arrangements have been compounded by the fact that the new initiatives emerged after 'decades of under-funding that have taken their toll in terms of derelict infrastructures, poorly motivated staff, chronic shortages of drugs, etc., and when the national health systems in most countries had been subject to severe and often chaotic reduction under pressures of structural adjustment' (Lambert and Stuyf 2002: 558).

Third, there has been a re-ordering of power and influence among ministries within government, with ministries of finance playing a decisive role in a wide range of policy issues, essentially by bringing the voice of donors to bear in any national deliberations.

Democratisation

The second significant difference is the greater democratisation of many recipient countries today. As a consequence there are more open debates about HIV/AIDS and heightened political pressure on governments to do something than there ever was on government policies with regard to IRD. Unfortunately, this has occurred at a time when there has been the trend to remove as many institutions as possible from the oversight of elected governments in the name of giving greater 'autonomy' to these institutions (UNRISD 2004). And for all the talk of participation and democracy, the conventional view is that 'good governance' involves insulation of policies from the demands of politics and acceptance of 'external agents of restraint'. A preference for technocratic forms of governance has thus spilled over to the fight against HIV/AIDS. Conversely, civil society is often viewed in a much more positive light in the donor world; more resources are channelled through them as a result which exacerbates the tensions between representative and participatory governance. Central governments have had constantly to assert their pre-eminent position in the country against attempts by donors to deal directly with lower levels of government or NGOs. In the context of democratisation, elected bodies may find it difficult to accept that

unelected partners have the same political legitimacy and moral position when discussing long-term national goals such as development. A dramatic example of such conflicts is provided by South Africa, where Health Minister Manto Tshabalala-Msimang criticised the GFATM for bypassing the national government when it allocated R600 million (\$60 million) directly to Kwa-Zulu Natal, the worst hit of the country's nine provinces.

'The Global Fund was trying to bypass the democratically elected government and put it (the money) in the hands of civil authorities', she told the youth gathering in Johannesburg, adding: 'Perhaps this is because the Fund does not trust governments elected by the people' (Agence France-Presse 2002).

In an earlier statement, GFATM Executive Director Richard Feachem told South African media that 'it's intolerable that the money gets stuck in Pretoria and if Pretoria can't move it for any reason, we will simply withdraw it and establish direct relationships with the people actually doing the work'.⁵ This statement has angered the South African government and provoked bitter remarks from the South African president.⁶ Mr Feachem had to issue an apology for the misunderstanding his remarks may have produced (News24 2004).

The private sector and NGOs

The third significant difference is the greater involvement of non-state actors in HIV/AIDS programmes. Based as it was on the view of pervasive market failures for smallholders, IRD accepted a central role for the state which was to coordinate and usually subsidise the delivery to smallholders of services complementary to the new technologies, particularly credit, technical assistance, access to markets and crop insurance (De Janvry and Sadoulet 1999). In contrast, the GFATM was born in the context of a more jaundiced view of both the intentions of political actors and state capacity in the developing countries.

The GFATM has emerged during a period of active civil society engagement at both global and national levels. Indeed, there is in the new institutional template 'an implicit assessment of the inability of organizations within the state, or public authority, to implement HIV/AIDS programmes and an implicit, virtually ideological belief, that NGOs, religious organizations and private sector organizations will be able to do better' (Putzel 2004: 21). This has influenced the inclusiveness of management structures and the process of selecting who is to be included. The GFATM was conceived in the spirit of 'partnership' between the public and private sectors. This was inevitable. Contributions by the private sector have dwarfed those of many states and have earned it a seat in decision-making organisms of the fund. This is not to

suggest that the private sector and NGOs were absent from earlier initiatives. IRD relied on agribusiness to provide some of the critical inputs, and there is a considerable amount of literature on the relationship between IRD and agribusiness. The big difference seems to be that while there was an arm's length relationship between national governments and donors on one hand and agribusiness on the other, the new relationship is more intimate, based on notions of 'partnership', 'stakeholder accountability' and corporate social responsibility.

In addition, although 'popular participation' was one of the cornerstones of IRD it never attained the iconic status of NGOs today. In most cases 'community participation' in IRD was largely manipulative and meant to help the management of the projects (for example, in debt collection). IRD was unsuccessful in part because of the failure to decentralise decision making to the community level and to enlist the participation of beneficiaries in project definition and implementation (De Janvry and Sadoulet 1999). HIV/AIDS has had the unique quality of mobilising a well-organised constituency.⁷ The GFATM is more aware of the importance of participation by various stakeholders, including local communities. It has insisted on NGO participation in governance structures, but in most cases this has not faced up to the complex issues of capacity and representativeness of NGOs. That NGOs should be represented is not as simple as it is made out to be: For example, who decides what NGOs should be represented, and how is their legitimacy and representativeness determined? In the case of Senegal, for instance, the list has excluded NGOs who have played a major role in the combat against AIDS (ENDA Tiers Monde, Sida-Services, Synergie pour l'Enfance, Africa Consultants International [ACI]). Indeed, given the huge amounts of money at stake, there is evidence that the GFATM has driven the emergence of a certain type of NGO. NGOs often serve three roles: representative, advocacy or service delivery roles. External funding has increasingly tended to reinforce the last function, often at the expense of the other two.⁸ As a result, the view that civil society consists of autonomous actors able to speak truth to power is compromised by their dense linkages to those who hold power. Similar fears have been expressed in countries such as Brazil where NGOs clearly played a major role in raising awareness of HIV/AIDS and in eliciting a response from the government. The older, more activist, NGOs feel their autonomy threatened by the emergence of new NGOs around the funding for HIV/AIDS which are more inclined towards service delivery than activism and compromise their relationships with their clientele.⁹ In many cases the older NGOs have had to 'partially relinquish their autonomy to maintain their doors open and sustain activism, abiding by funding norms and submitting to government rules' (see, for instance Ingles 2004).

More complex international links

The final significant difference is the emergence of major new non-interstate institutions of 'global governance' with which governments have to interact. More significantly, there has been a tendency to reduce the authority of institutions based on state membership and on the 'one country, one vote' principle that has driven policy-making in many international organisations.¹⁰ Global health funds have been created partly in response to the perceived inefficiencies and wastefulness of large global and national donor agencies (Heimans 2002). One of the decisions made about the GFATM has been about its institutional location and its relationship with other institutions whose global mandate within the UN system is health. This location has enormous implications on how funds are managed and disbursed at both the global and national level. It also has implications for the channels through which national governments relate to the outside world.

Re-ordering of chairs at the global level seems to have not paid attention to existing linkages. National-level institutions tend over time to develop special relationships with international organisations, and a kind of division of labour – formal or informal – emerges in which certain parts of the state are delegated with certain tasks for dealing with the outside world. Over the years, skills are developed in dealing and responding to international institutions. In the case of health, ministries of health have developed relationship with the World Health Organisation (WHO), and over the years these ministries have cooperated on a wide range of health issues and campaigns. Now governments are having to learn how to deal with and to make the necessary institutional arrangements to access the resources of the GFATM.

Conclusion

There are some striking parallels between the earlier experience of integrated rural development and the present fight against HIV/AIDS, malaria and tuberculosis. One feature of IRD projects was that they introduced ambitious and complex institutional arrangements, often with scant regard to local circumstances and few links to local government structures. The institutions pushed by donors are more a reflection of their own organisational proclivities, their view of partner states and perceptions of local politics, rather than of the institutional needs of the recipient countries. Not only did IRD projects fail in terms of output, let alone poverty alleviation, they also undermined state capacity to promote agricultural development. Although there is much greater awareness of the dangers of isolated and vertical systems, the danger remains that the fencing off of HIV/AIDS institutions will militate against the much-touted principles of country ownership and keeping decision-making close to developing countries. Conversations with local officials and other

anecdotal evidence suggest resentment against these schemes and genuine concerns that GFATM projects will run in parallel to existing health systems and will divert scarce human resources and simply compound existing problems.

The HIV/AIDS pandemic poses serious challenges for the international community, and there can be no doubt that increased resources and innovative institutional arrangements are urgently needed. Huge projects such as the IRD and GFATM, by the sheer magnitude of the resources they mobilise, have huge system-wide effects, many of which have unintended consequences. Although again there is an awareness of the potential impact and the need to ensure a good fit between the disease-specific focus and health care systems, the GFATM emphasis on efficient and rapid disbursement and the institutional options chosen are already showing signs that if care is not taken, the GFATM could produce similar results to those of the IRD.

Finally, the fight against HIV/AIDS in the developing countries will have to pay close attention to the experiences and lessons from development efforts in general if it is to avoid reinventing the proverbial wheel and mindlessly borrowing problematic concepts and practices from other fields of development. Because of its isolation from the larger developmental debates and experiences, there is the risk that 'solutions' that have either been discarded or are known to be unfeasible, and ideas whose organisational efficacy has been debunked elsewhere, will circulate in these circles, unencumbered by all the battering inflicted upon them elsewhere. To avoid such areas, the campaign against HIV/AIDS will have to draw liberally from the vast knowledge on managing projects in the developing countries.

Notes

1. In Malawi, one of the most showcased experiments with IRD, which had 'attracted worldwide attention and emulation' (Duncan 1997), the projects proved to be costly flops:

They obviously had little effect on gross crop production of the smallholder sector as a whole, which at best has grown slightly faster than the growth of the population. An evaluation of the Lilongwe project shows no sustained increase in maize yields and perhaps a decrease in groundnut yields. In the Shire Valley project, the hectare productivity in cotton (the major crop) fell; for other crops it rose only slightly. The scattered data for Karonga also show no remarkable results. No evaluation of the lakeshore project is readily available (Pryor 1990: 73).

2. These were the MADIA (Managing Agricultural Development in Africa) studies, the major findings of which were summarised by Uma Lele (Lele 1990).
3. This problem of 'pre-emptive compliance' is not particular to HIV/AIDS. As one African minister stated, 'We do not want to second guess the Fund. We

prefer to pre-empt them by giving them what they want before they start lecturing us about this and that' (cited in Cheru 2001).

4. The apprehension that choices are being forced on poor countries has also been expressed by government officials. Thus speaking at the World Bank in November 2003, UNAIDS Executive Director Peter Piot stated, 'When I hear that countries are choosing to comply with the budget ceilings at the expense of adequately funding AIDS programs, it strikes me that someone isn't looking hard enough for sound alternatives' (cited in Results 2004). Head of the UK's Department for International Development (DFID) office in Uganda, Michael Hamond said Uganda should be given an opportunity to make decisions, and is quoted as saying 'If we come and change their priorities then it becomes a dictatorship, not a partnership' (cited in Wendo 2002a).
5. What compounds matters is that the GFATM has itself taken what are obviously political positions in the funding of individual countries. Richard Feachem said Zimbabwe's application was turned down for many reasons, among them concerns about government accountability – 'Yes, the politics of a nation plays a role when we determine the country's application'; 'It does not help the people of Zimbabwe to pass money through channels which are not well worked out' (Mafundikwa 2004).
6. The South African President weighed in, stating that while South Africa might depend on goodwill to fight diseases such as AIDS, this must not be an excuse to condemn the nation to 'perpetual subservience' because of its poverty. Mbeki said:

Our country faces many challenges whose resolution requires large resources, among other things. We deeply appreciate the assistance extended to us by many governments and non-governmental organizations to enlarge our capacity to respond to these challenges ... It is true that we are poor and need the support of people of goodwill ... It is, however, also true that we would betray those who sacrificed for our liberation, and corrupt our freedom, if we succumbed to the expectation of some of those more richly endowed than ourselves, that our poverty should condemn us to perpetual subservience. This we will not do (Mbeki Speaks Out on AIDS Funds', News24, 28 May 2004).

7. The Gay Movements have made enormous contributions to this fight.
8. As noted by Scalway in a Panos paper (Scalway 2003),

Most of these organizations (64 per cent of NGOs we surveyed) get their funding from a Northern source or from governments whose health budgets are derived from the donor community. More NGOs and Community Based Organisations (CBOs) that Panos surveyed said their work was determined by their donors than by the communities most affected by HIV/AIDS ... The donors these NGOs were referring to were mostly Northern based. A quarter of all these organisations reported that they were not sufficiently accountable to the communities they served. And in a separate question,

those same NGOs were asked to what extent they felt that their activities were led and 'owned' by those most affected: 28 per cent answered 'a small amount', 'a very small amount' or 'not at all'. Only one in five NGOs surveyed thought that communities affected by HIV/AIDS were adequately represented in general decision-making.

9. One of the unfortunate new features of NGO activities is the introduction of what, in Malawi at least, is referred to as 'sitting allowances' whereby people are paid a fee for attending meetings. A GFATM report on Ghana found that, overall, the CCM had been working not only because of the commitment of officials and development partners, but also because of the 'somewhat controversial and ... not particularly effective' payment of an attendance fee of \$23 per member for each meeting (Global Fund To Fight Against Aids 2004). In Senegal some organisations received 'indemnité de représentation', apparently without the knowledge of other members of the committee. In Malawi, the president has condemned the proliferation of 'workshops' around HIV/AIDS and the 'per diem culture' it has spawned. In addition, since GFATM activities have become the locus for important resource allocation decisions, they could jeopardise the collaboration and coordination among parties contending for the funds.
10. The case of the World Health Organisation is discussed in Horton (2002).

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