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Title: Who Pays for Cooperation in Global Health? A Comparative Analysis of the World Health Organization, the World Bank, the Global Fund to Fight HIV/AIDS, TB and Malaria and the Gavi Alliance

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Abstract:

In this article we examine who pays for cooperation in global health through analyzing the financial flows of the World Health Organization (WHO), the World Bank, the Global Fund to Fight HIV/AIDS, TB and Malaria, and Gavi, the Vaccine Alliance. We find that the past few decades have seen the consolidation of influence in the disproportionate roles the U.S., U.K., and the Bill and Melinda Gates Foundation have played. Current financing flows in all four case study institutions allow donors to finance and deliver assistance in ways that they can more closely control and monitor at every stage. We highlight three major trends in global health governance more broadly that relate to this development: towards more discretionary funding and away from core or longer-term funding; towards defined multi-stakeholder governance and away from traditional government-centered representation and decision-making; towards narrower mandates or problem-focused "vertical" initiatives and away from broader systemic goals.

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Key Messages:

1. Three major trends in global health governance over the past two decades are: towards more discretionary funding and away from core or longer-term funding; towards multi-stakeholder governance and away from traditional government-centered representation and decision-making; towards narrower mandates or problem-focused "vertical" initiatives and away from broader systemic goals sought through multilateral cooperation.
2. The shifts described above are reflected in the creation of partnerships such as the Global Fund to Fight HIV/AIDS, TB and Malaria and Gavi, the Vaccine Alliance as well as in the increased voluntary contributions to the World Health Organization and World Bank. These mechanisms allow donors to

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finance and deliver assistance in ways that they can more closely control and monitor at every stage.

3. WHO's volatile financial state is a reflection of a lack of donors' trust in the agency. Reform should focus on improving the agency's relationship to monitoring and accountability through addressing membership, including voting rights for non-state actors, and transparency to the public and member states.
4. The past few decades have seen the consolidation of influence across all four of our case study institutions in the roles the United States, the United Kingdom, and the Bill & Melinda Gates Foundation have all played. Despite a proliferation of initiatives in global health, much of the financing comes from a few powerful donors.

Introduction:

Whether it is confronting and containing an Ebola outbreak originating in Guinea or a Zika outbreak originating in Brazil, deploying vaccines to rural India, or getting insecticide-treated bed nets to Malawi, governance matters. It is through institutions that nations have long organized and focused efforts to protect and improve the health of their citizens. Today, however, health governance has gone global. Global governance is formally conducted by and across national governments and non-state actors through international institutions, underpinned by both financing to enable them to fulfill their missions and rules to structure interaction.

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The essential functions of health governance, which historically have been the purview of the World Health Organization (WHO) and its governing board, and now are stretched across a broader spectrum of actors, include: convening key stakeholders; defining shared values; establishing standards and regulatory frameworks; setting priorities; mobilizing and aligning resources; disease surveillance and health emergency and outbreak response; and promoting research and development (1). All of these are vital to mounting responses to prevent and treat infectious diseases and non-communicable diseases (NCDs) alike.

To understand institutions means delving into how they are governed, how they make decisions, and how they are financed. In this article, we take a closer look at the World Health Organization, the chief coordinator and director of international health within the United Nations, and compare its financing and governance with three of the most important global institutions, as determined by resources commanded and disbursed (Figure 1): the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance.

We focus on three research questions in this article: How are the WHO, World Bank, the Global Fund, and Gavi financed? How does their financing possibly influence their agenda and third, what explains the financing flows and new governance of global health? To answer the first, we rely on data from each institution itself as well as data aggregated by the Institute for Health Metrics and Evaluation at the University of Washington (IHME). For the second, we look for evidence as to how changes in financing flows have influenced the institutions' agenda over time. Finally, we offer our own thoughts and reflections about what explains these various shifts and what this means for the future of the WHO.

Financing the WHO

The WHO was established, as it states in its own words, 'to direct and coordinate' international public health efforts and is primarily a normative and technical agency (2). WHO receives funding from two tranches: assessed contributions from its 194 member states (previously called 'regular budget funds') and voluntary contributions (previously called 'extrabudgetary funds') from its member states, philanthropic foundations, corporations, non-governmental organizations (NGOs), and private individuals (3). The former are the monies WHO has full discretion to use as its leadership determines and the World Health Assembly (WHA), a body comprised of all its member states, approves. In practice, core funds are used to support the administrative costs of running WHO and programs that may not have received funding through other channels. Individual states' membership dues are calculated in conjunction with WHO's biennial budget process and based on the UN's standard scale of ability to pay as determined by a country's gross national product (size of economy) and population.

In 1980, the WHA voted to freeze its membership assessments in real dollar terms; in other words, only inflation and exchange rates would influence membership assessment adjustments (4,5). This took effect with the 1982-1983 budget. Throughout the 1980s and 1990s, the failure of member states to pay even their frozen levels of contributions presented a significant challenge for WHO. The United States in particular withheld funds, a move largely interpreted as expressing dissatisfaction with WHO's list of essential medicines (6), in line with public opposition from U.S. pharmaceutical companies (4, 7). In 2014, the collection rate was 86% (8, 9). The WHO has little leeway to force states to pay even their membership dues; loss of voting rights is the most extreme step it can take, but rarely does until a state is in significant arrears (10).

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A larger challenge for WHO has been the steady rise of extrabugetary funding as a percentage of the WHO overall budget, steadily approaching 80% (Figure 2-webappendix). Over time, the rearrangement of WHO's priorities to align with funds was inevitable with donors earmarking 93% of voluntary funds in the 2014-15 budget (11-13). Influence is heavily concentrated among the top donors (Figure 3) (13). Undeniably then, a direct link exists between financial contributions and WHO focus.

Financing the World Bank

Alongside using voluntary contributions as a mechanism of control over WHO activities, donors also turned to other institutions, first the World Bank and then later Gavi and the Global Fund, to further exert influence in global health and over their use of funds. Over the past 40 years, the World Bank has become increasingly important in health through its lending for health-related projects, and its role as an advisory body, an intellectual research institute and a training centre for developing country civil servants (14). The Bank's legacy in health is controversial given its former support of structural adjustment and user fees, which the current Bank President Jim Kim has recanted (15). Yet, within the Bank, health itself claims a relatively small share of attention. For its 2014 fiscal year, loans in the 'health and other social services' space stood at less than $3.4 billion, out of a total loan pool of more than $40.8 billion (16,17). Health loans accounted for less than 10% of the Bank's portfolio that year, barely edging above 8% of total loan volume.

From 1990 through 2011, the World Bank, according to its own data, disbursed close to $20 billion in grants and loans throughout its health, nutrition, and population (HNP) portfolio, and $33.8 billion over the same time period in loans and grants, plus $2.8 billion of in-kind support, when a broader definition of health (e.g. inclusive of HIV/AIDS) is used (16, 17).

The World Bank generally refers to the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA), the two largest parts of the Bank. The IBRD is funded by capital contributions from its members and is effectively 'owned' by its 188 member states. As votes are allocated based on capital subscription, there is clearly an incentive for member states to meet – and even seek to increase – their capital commitments. This pressure is evident in the recent intransigence of the United States Congress to cede a portion of its current 16.1% voting share (which allows it to effectively block any decision it does not agree with given most of the Bank's key decisions require 85% of all votes outstanding to approve) and in China's efforts to invest more into the Bank to gain a commensurate rise in voting power. However, the majority of IBRD's funding comes from the issuance of World Bank bonds that are sold into capital markets across the world. Yet, given the broad market for such bonds, it is the capital contributors, not the bondholders, who exert more influence over the Bank's agenda.

In contrast, IDA is funded by replenishments, or donor commitments made at specific intervals, generally every three years. Since its launch in 1960, IDA has convened 17 replenishment meetings, securing increasing IDA commitments from World Bank members almost every round. Only Bank members can contribute to IDA – there is no mechanism for the Gates Foundation for example, to contribute to IDA although Gates and others have invested alongside IDA in health related areas, for example in polio eradication (18). IDA's first replenishment raised $750 million, with the U.S. accounting for more than 40% of total funds pledged. In 1984, in advance of IDA's 17th replenishment, the U.S. said it would not account for more than 25% of IDA at any point in time, in line with similar arguments expressed throughout the UN system, including at WHO (19). While the World Bank convenes the replenishments, in practice, they are overseen by donors, not the Bank nor IDA recipients. Looking at the 16th replenishment provides a more complete picture of IDA donors (Figure 4). It is clear a finite number of donors account for the majority of IDA's coffers, and it is a similar list to those most prominent to WHO's budget.

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Yet, unlike is true for WHO, it is hard to see evidence of greater donor control in the patterns of IBRD and IDA funding – or in how the Bank then chose to allocate those funds. In fact, it is only through trust funds that donors can earmark funding for specific uses; in 2012, roughly $5 billion, or more than one-third of donor contributions were earmarked (20). Trust funds are a financial arrangement set up with contributions from one or more donors and in some cases from the World Bank Group itself for a particular purpose. A trust fund can be country-specific, regional, or global in its geographic scope, and it can be free-standing or programmatic.

Financing The Global Fund to Fight AIDS, Tuberculosis and Malaria

A core difference between the 'old' institutions, WHO and the World Bank, and the 'new' ones, the Global Fund and Gavi, is the latters' focused mandates. The Global Fund is a financing mechanism targeting efforts to end HIV/AIDS, tuberculosis and malaria while Gavi also marshals funds toward a goal of equitable access to vaccines for children living in the world's poorest countries. Unlike WHO or the Bank, the Global Fund relies entirely on voluntary contributions. Even for its

de facto permanent Board members, like the U.S., China, and the Gates Foundation, there is no formalized expectation of funds contributed annually. Similar to IDA, the Global Fund relies on replenishment as its principal fundraising mechanism. At replenishment time the donors alone take center stage. Aside from the Gates Foundation, the composition of the Fund's major donors closely resembles IDA's major donors (Figure 5).

In its first 13 years, the Fund received $29.6 billion in financial contributions, with $27.9 billion coming from donor countries, including both Board Members and non-members, and from a small number of implementing countries largely through debt swap arrangements with donor governments. These were not common arrangements, accounting for less than .3% of total funds over the period (21). When swap agreements were struck, donor governments would forgive part of a loan repayment if developing countries would invest a commensurate amount in Global Fund grant arrangements in their countries. Through the end of 2013, the Fund had received $75.8 million from five swap agreements across four implementing countries and two donors. For purposes of our analyses, we include those debt swap arrangements as donor contributions under the relevant donor. As was true for many public health concerns in the early 21st century, the only significant non-bilateral donor to the Fund was the Gates Foundation. The Gates Foundation donated more than $1.1 billion to the Fund in its first 13 years, accounting for two-thirds of all non-bilateral funds the Global Fund received over that time period (21).

From 2000-2013, bilateral donors accounted for 94.3% of the monies the Global Fund raised (21). Unlike the World Bank's IBRD or Gavi, the Global Fund Board never seriously considered and certainly never approved raising funds through the capital markets (22). Neither did the Global Fund Board ever decide, despite significant debates inside the Board and outside the Fund, to introduce expected contributions levels from donor countries (23). In addition, the Board's inability for much of its first decade to determine protocols for accepting in-kind donations due to generic market concerns may also explain why private support never materialized at substantial levels (24). Yet even for WHO, which has long-standing protocols governing in-kind donations, such donations have never proven meaningful as a percentage of budget.

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Regardless, the Global Fund funding base is similar to the WHO and the World Bank's IDA. The United States in particular has strong presence on the Global Fund Board, and in its coffers. Most years, the U.S. has accounted for one-third of the Fund's total received contributions. The U.S. is not a passive nor quiet investor. For years now, following every Global Fund Board meeting, the U.S. publishes its points of view on Board decisions and debates. Analyzing every such document through the first 28 Board meetings, against the Board decision points, yields few disagreements and no significant ones between the decisions of the Global Fund Board and the organization's largest funder (25). The U.S. also maintains a staff presence in Geneva to liaise with the Global Fund. The greater density of interactions that likely result from such an arrangement may help explain the congruence between the Fund and the U.S., a dynamic amplified by the more frequent meetings that Global Fund donors have often held between Board meetings than have implementing countries (the Fund's terminology for recipient countries) or civil society organizations involved with the Fund, including those that serve on its Board (26). Or, the explanation may lie in the dependence of the Fund on U.S. funds. Looking solely through a financing lens, it is clear that donors, and notably the Fund's largest donor the United States,

work hard to ensure their voices are coordinated when possible and heard well beyond the Board room.

Financing Gavi, the Vaccine Alliance

Gavi, and particularly the Global Fund, benefitted from the robust development assistance for health environment coincident with their first years (what IHME termed 'the Golden Age') (27). Although Gavi raised much smaller amounts than the Global Fund, its experience of how it raised those funds contrasts sharply– even if the source of those funds does not differ. Unlike the Fund and World Bank/IDA, Gavi came relatively late to replenishment as a means to marshal donor funds. Prior to its first pledging conference in June 2011, all donor contributions to Gavi were made on an ad hoc basis.

Through December 2013, Gavi received $8.3 billion in direct donor contributions (Figure 6). Its most significant source of funds, by far, was the Gates Foundation, which contributed $2.1 billion. Notably, the Gates Foundation's contributions were effectively synonymous with non-bilateral support. Contributions from the Gates Foundation, both through direct unconditional funds and through matching funds, comprised 97% of non-governmental and non-intergovernmental (e.g., the OPEC Fund and the European Union) support (28). Yet the Gates Foundation's support, and by extension non-bilateral support, became less important on a percentage basis in Gavi's early second decade than had been true in its first ten years.

Additionally, one of Gavi's 'innovative mechanisms' accounted for an additional 15% of the monies raised in its first 13 years. Gavi received $1.24 billion from the International Financing Facility for Innovation mechanism (IFFIm), which effectively securitizes long-term pledges from bilateral donors, converting the pledges into usable cash resources by selling bonds in the capital markets. Through the end of 2013, the United Kingdom, France, Sweden, Norway, the Netherlands, Spain, Italy, and South Africa had provided support to Gavi through the purchase of long-term IFFIm bonds. Collectively they had pledged $6 billion over 20 years that had translated into $4.5 billion of bonds sold (29). Also over the same time horizon, Gavi raised $581.8 million through the Advance Market Commitment (AMC), a mechanism through which donors committed to purchase new pneumococcal vaccines at a price that covers development costs and provides some profit for the drugs' manufacturers with the provision that they only be distributed in low- and middle-income countries (30, 31, 32). The donor composition for the AMC differs a bit from that of Gavi as a whole, with Italy accounting for more than 40% of total AMC-related funds through early 2015 (33-38).

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Still, for all of its mobilization of funds through innovative mechanisms and the strong, even foundational support of the Gates Foundation, Gavi is largely dependent on a conventional bilateral donor list. Moreover, Gavi is even more dependent on the Gates Foundation than the Global Fund is. Gavi and the Fund are hardly alone in continuing to rely on bilateral donors. Even the International AIDS Vaccine Initiative and related HIV/AIDS-vaccine initiatives are largely funded by governments, despite the strong business case for the private sector investing in this work; 83% of aggregate funding for a HIV/AIDS vaccine in 2011 came from the public sector, 13% from the philanthropic/foundations sector, and only 4% from the private sector (39).

It is harder to discern the likely influence at Gavi as neither the Gates Foundation nor the U.K. or U.S., the three largest donors to Gavi, publish their views

on Gavi Board decisions in the way the U.S. does following Global Fund Board meetings. This may be because of the strong influence they exert quietly or because Gavi hews to the vision its donors, principally the Gates Foundation, have for it. Additionally, Gavi has also long provided support to its developing country Board members to meet before Board meetings, investments the Global Fund started only to make relatively more recently. We are unable to discern whether such facilitation may have led to a greater harmonization of interests across diverse constituencies, or convergence to donor preferences.

Why has so much investment been made in the new partnerships, and why are the four institutions financed in this way?

The move towards the partnership model in global health and voluntary contributions to the WHO and World Bank allows donors to finance and deliver assistance in ways that they can more closely control and monitor at every stage. The shift towards partnerships like the Global Fund and Gavi illustrates three major trends in global health governance more broadly: towards more discretionary funding and away from core or longer-term funding; towards multi-stakeholder governance and away from traditional government-centered representation and decision-making; towards narrower mandates or problem-focused "vertical" initiatives and away from broader systemic goals sought through multilateral cooperation (40).

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By using financing and governance mechanisms within the 'old' institutions, as well as by creating new agencies, donors can more likely achieve their goals for a few reasons. First, they have structurally aligned the objectives of global agencies with their own objectives. Individual governments (or small groups of governments and like-minded others) can use new funding mechanisms, agencies, or initiatives as a way to define and pursue a separate mandate. HIV/AIDS, discussed in Box 1, is only one such example.

Second, funders have created and enforced incentives for performance. As seen in the above, governments, as well as other donors, can (and do) use budget as rewards and punishments in their attempts to induce international institutions to achieve particular outcomes. This has taken two forms: an increase in discretionary contributions to conventional multilateral organizations (as seen at WHO) while not increasing core budget support, and the establishment of new organizations funded through a replenishment model (as seen with the Global Fund and Gavi). Additionally, from inception, the Global Fund has linked past grant performance to fundraising. Gavi also has long promised results as proof of concept to its donors.

Third, donors have more directly reduced the technical knowledge gap between themselves and the global health institutions they support. In WHO and the World Bank, it is the senior management of the organization who present proposals to the Board, thus ensuring that the management and staff of the organization retain considerable influence and agenda-setting power (even if they are unable secure the funds for this agenda). By contrast, the decision-making Boards of the Global Fund and Gavi instead take advice from panels composed of independent experts that make recommendations to them directly (at Gavi the Independent Review Committee

recommendations go first to the Chief Executive but then are passed along to the Board).

Fourth, key donors can more closely monitor what global agencies are doing. As technology has enabled closer monitoring (at least in theory), this has become a major preoccupation of donors in recent years, placing emphasis on organizations' demonstrating results through results based management systems, comprehensive results frameworks, an increased use of evaluations (both independent and in-house), and increasing transparency for donors and the public. When contrasted to the Global Fund and Gavi, the World Bank and WHO look particularly difficult to monitor: for starters, their activities are broader and more diffuse, their budgets are more complex and their regional and country offices make complete oversight impossible. In contrast, the Global Fund provides detailed financial information about its grant commitments and disbursements, donor pledges and contributions, and, importantly, grant progress reports. It also discloses the independent Technical Review Panel recommendations and then Board decisions. Additionally, most donors have people on the ground in countries receiving funds from the Global Fund who at times are members of the country coordinating mechanisms charged with overseeing grant implementation. This translates into more real-time monitoring for certain donors than even the Global Fund Secretariat could claim. Gavi has a Transparency and Accountability Policy that governs the management of all cash-based support to Gavi eligible countries and similarly discloses all Independent Review Committee recommendations and Board decisions related to Gavi applications and approved grants. Donors have pushed the World Bank in this direction. For example, in 1993 the Board, driven by the U.S., created the Independent Inspection Panel: an institution investigating Bank decisions and actions and reporting directly to the Board (41, 42). This is similar to what the U.S. pushed for, and achieved, 15 years later with the introduction of the Inspector General at the Global Fund and what we, and others, have recommended, without successful adoption, for WHO (43).

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Influence of Financing Flows on Global Health

The irony that our analysis brings to the fore is that states form and join global institutions such as WHO recognizing the need for collective action that does not always mesh with their own individual national interests. Yet, as the shifts in global governance over the past two decades demonstrate, they largely resist providing the adequate support and investment necessary for the institutions to succeed on delivering against collectively determined priorities.

Three important risks emerge from varied, and unpredictable, financing flows (40). A first concern is normative. Critics allege that global health pursued through coalitions of the willing (either in vertical initiatives or in discretionary special funds in international organizations) impose the priorities of powerful donor states and philanthropic organizations on poorer countries, whose populations have little recourse to demand accountability or to influence these priorities given their inability to contribute funds or affect donor decision-making.

A second concern is efficiency (40). The risk is that the new health funding may be creating mechanisms that encourage donors to favor short-term priorities, even important ones, over longer-term public health goals: the rationale for creating WHO was to ensure that nations would 'compromise their short-term differences in order to attain the long-run advantages of regularized collaboration on health matters' (44).

A third consequence of the shifts in global health financing and governance is the consequent erosion of and underinvestment in important capacities in global public health. For example, the knowledge and information derived from global monitoring today to help plan for and prevent epidemics and other health crises in the future, historically the purview of WHO. The dissipation of donor support for WHO broadly, and in these areas specifically, led to the now well-documented collapse in funding for its pandemic preparedness and response functions (45). Global monitoring may be a casualty of the new health funding if it erodes the capacity of multilaterals effectively to monitor and disseminate information. The impartiality of the international agency pooling information is vital for monitoring. Countries need to trust an international agency in order to give it information and to respect the integrity of the information it, in turn, provides its members.

The chronic underinvestment by donors in health systems relative to other priorities provides our second example here (46). Donors have been reticent to invest significantly in what is broadly known as health systems strengthening, either through traditional multilaterals, vertical funds or their own bilateral mechanisms, despite the broad-based recognition that health systems are vital to achieving durable vertical and horizontal prerogatives alike. This reticence is also there for the monies needed to invest in building core capacities to prevent, detect and respond to new infectious disease outbreaks (47). Not until 2012 did donor funds targeting health systems broadly surpass $2 billion per year, a level it stayed above in the subsequent two years (46). In 2014, the U.S. was the largest provider of development assistance for health in this arena at $425 million. These are not insignificant sums on an absolute basis though they are significantly lower than the almost $36 billion in development assistance for health disbursed in 2014 or the more than $14 billion through bilateral and multilateral channels such as the Global Fund given to fight HIV/AIDS, tuberculosis and malaria. The relative sense of priorities is clear although we acknowledge that some of the rationale for these trends is donor mind-set that countries should finance health systems through domestic sources.

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On the more positive side, the new health funding has filled historic underinvestment in other areas (such as HIV/AIDS throughout the 1980s and 1990s with the Global Fund) or regained recently lost ground (such as with vaccines in the 1990s through Gavi). They have encouraged social mobilization and strong civil society participation at all levels from the Boardroom to the field. Further, new mechanisms have focused attention on how and where more traditional international organizations, such as the World Bank and WHO, might do better, while also maintaining pressure on the Global Fund and Gavi to live up to their founders' expectations, including their nimbleness to reform when necessary. Additionally, it is conceivable that the greater control donors have over their funds and the heightened ability to monitor how those funds are used have led to more funds being contributed, funds that otherwise may not have flowed to global health at all.

The Future of Global Health Governance

We offer final reflections on the future of global health governance related to WHO based on our analysis of the three other institutions.

First, WHO's volatile financial state is a reflection of a lack of trust in the agency. WHO's reform agenda proposes broadening the funding base by attracting donations from foundations, emerging economies, and the private sector. Although worthwhile, these stakeholders are unlikely to behave differently than traditional

donors, and will prefer to control their funds through earmarks, particularly if they are not offered a meaningful say in how their funds will be used. Reliance on philanthropic and corporate funding, moreover, opens the agency to the charge that it is not fully independent. The Global Fund's experience demonstrates that hoping for and even investing in recruiting broad private sector and philanthropic support does not necessarily yield substantial financial support.

Second, rather than simply asking for more money, the agency needs to work toward a 'new deal' with donors. In return for flexibility and predictability, the agency would scale back on activities agreed by the Executive Board so that it focuses on making gains where it has unique comparative advantage in global health today.

Third, membership, including voting rights, and transparency, which both tie into monitoring and accountability, needs to be explicitly addressed. Because non-state actors have not been given a voice within WHO, they have redirected their energies elsewhere. This process has 'hollowed out' WHO, as resources and influence move to partnerships such as the Global Fund and Gavi where non-state actors have more input. The World Bank recognized this problem and launched the Civil Society Forum, convened in advance of its Annual Spring Meetings every year.

Transparency is also key. Stakeholders demand clarity on how their resources will achieve improved health outcomes. Yet, an independent evaluation graded WHO as 'weak' on key parameters, such as cost-consciousness, financial management, public disclosure, and achievement of development objectives (48). The 2011 reform agenda promised to establish independent evaluations of WHO's work (49). This would then be in line with the independent evaluations the Global Fund has periodically both commissioned and participated in, as well as the increasing openness of both Gavi and even the World Bank, around the grants and loans each finances. For example, in 2010, the Bank introduced a formal access to information policy which detailed that information would be disclosed unless it is on the policy's exceptions list (50, 51). Additionally, the Bank publishes extensively on the results of its programmatic investments, certain internal assessments, and through the Bank's Independent Evaluation Group (IEG). WHO has not yet introduced regular independent evaluations nor a public information policy.

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Conclusion

The past few decades have seen the consolidation of influence across all four of our case study institutions in the roles that the U.S., U.K., and the Gates Foundation have all played. This is clearly evident in the creation of Gavi and in the disproportional role each play from a financing perspective in Gavi, the Global Fund, and WHO. Additionally, the Gates Foundation has changed how institutions are held accountable, given that it is a philanthropic body substantively different from government representatives. The significant role the Gates Foundation plays in global health makes it imperative that all four major global health institutions engage with it. It continually puts pressure on performance and results, and when unhappy, pushes for quick reform in whatever ways that it can, including withdrawing or providing funds. The persistence of a small group of funders to the World Bank's IDA raises the specter that the institution is also beholden to a small number of donors.

How institutions maintain autonomy and discretion when relying entirely or predominately on voluntary donor commitments is a key question, particularly as we look to more diagonal interventions complementing developing country governments'

own efforts rather than vertical interventions funded by donors alone. In addition, recent trends indicate that the monies available for global health will become more limited as limited growth has come to characterize development assistance for health (52). In this environment of limited funds and competing priorities, it is now more important than ever for attention to be paid to what institutions in global health donors are willing to pay for, for what reasons and with what consequences.

Author Contributions:
Both authors contributed equally to the design, data collection, analysis, interpretation and writing of the manuscript.

Conflict of Interest Statement:
Chelsea Clinton discloses that the Clinton Health Access Initiative (CHAI) has worked with the Global Fund as well as served on a few Country Coordinating Mechanisms for Global Fund grants and additionally has worked with the World Bank on health systems strengthening and rebuilding, among other areas, and also has had various interactions with WHO and Gavi.

Devi Sridhar has nothing to disclose.

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Box 1: The Response to HIV/AIDS

The case of multilateral cooperation on HIV/AIDS illustrates the dynamic process of donors' realigning objectives. In the early 1980s, after overcoming significant initial reticence to address HIV/AIDS at all, donor governments were reluctant to invest heavily in WHO's core budget: instead they attempted to ring-fence their contribution. In 1986, the US government gave $2 million to WHO, conditioned on half the money spent on global AIDS control and half to fight HIV/AIDS in Africa. In 1987, donors supported the Global AIDS Programme launched by Jonathan Mann within WHO, but with a governance structure somewhat separate from WHO. Unlike other programs, it did not require approval from WHO regional offices for policy guidelines it promoted within their respective jurisdictions and its funding was extrabudgetary. Despite this tight grip on funds, donors became rapidly convinced that they were unable to control where additional AIDS money was being spent. In response to this frustration, WHO created several ways to channel bilateral aid through a new medium-term plan, so that donor governments could give money for the multilateral AIDS program while earmarking for country-specific projects. Yet, in 1990, the US Congress began to question publicly where the extra funds it had given over the last few years to WHO for AIDS had been used, amidst fear that the extra money had led to corruption, not progress in combating the disease.

In 1992, donors conducted an external review of the WHO response to HIV/AIDS, which called for a new effort that could address HIV/AIDS as a development issue. The external review concluded that 'no single agency is capable of responding to the totality of the problems posed by AIDS; and as never before, a cooperative effort, which is broadly based but guided by a shared sense of purpose, is essential (1).' In 1994, G7 donors and U.S. and European HIV/AIDS activists alike agreed that a joint and cosponsored initiative would be established. The initiative would not be an agency in itself but instead leverage the resources of its co-sponsoring UN agencies. The result was the Joint UN Programme on HIV/AIDS (UNAIDS) – a new body launched in 1996 – whose creation was the product of weaknesses within WHO, inter-agency conflict, and donor pressures for more control over a multisectoral approach (2). The momentum for the new agency was led by a group of donor countries, driven by AIDS activists from Europe and North America, and complemented with a desire for accountability of aid for HIV/AIDS, as fashioned by the UN's Economic and Social Council (ECOSOC). In 2015, the UNAIDS Program Coordinating Board includes 22 member states, 11 cosponsoring entities (including WHO and the World Bank), and four regional NGOs working on the epidemic or representing people living with HIV/AIDS (3). Despite the still broad-based engagement, soon after its creation, UNAIDS donors began to view it as being unable to mobilize and spend large amounts of funding to fight the explosion of AIDS in Africa, in part because of its legal status as a UN entity (4). In other words, donors still remained reluctant to trust the UN system with the substantial funds that were increasingly recognized as being needed to combat the HIV/AIDS epidemic.

As HIV/AIDS shifted to the top of the global agenda, the World Bank increased its HIV/AIDS efforts. In December 2000, the World Bank launched its Multi AIDS Program for Africa, better known as its MAP Program, which committed more Bank resources to AIDS in Africa in 2001 – $2 billion over 15 years – than all previous years combined. Yet, donors continued to worry that the Bank's efforts would result in slow, inflexible, and top-down programs that would take too long to respond to countries' needs. There were also worries that the Bank's procurement rules would hinder developing country-ownership of their own HIV/AIDS agenda (5). Additionally, donors such as the U.S. and United Kingdom (U.K.), supported by the

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G7 in Okinawa, felt that the World Bank supported top-down public sector spending, at the cost of supporting more effective NGOs, community groups, or local or international private sector providers. While the Bank may have hoped its financial commitment to the MAP Program would gain donors' trust, it quickly became clear those hopes were not to materialize in substantial donor commitments. Throughout 2000-2001, it was evident that UN Secretary General Kofi Annan clearly believed a new entity was needed to signal a new level of commitment by the world to combat HIV/AIDS, TB, and malaria (6). Pressures mounted for another new agency, and the Global Fund took shape.

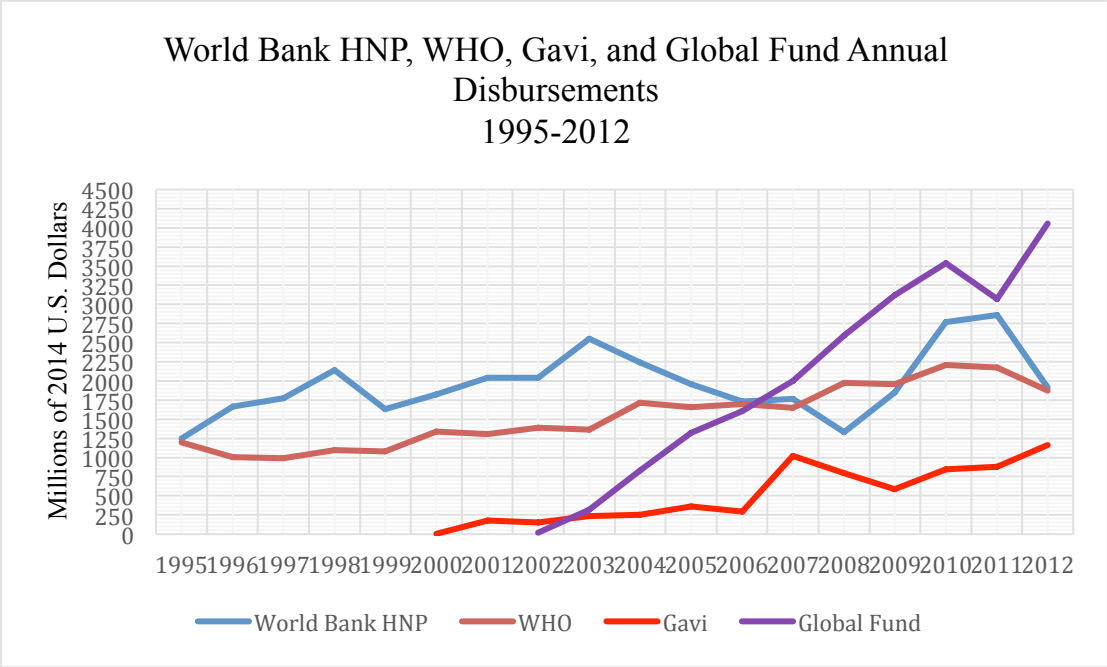
It is difficult to imagine a stronger donor endorsement for the Global Fund than the U.S. government's persistent levels of high funding, in most years accounting for one-third of the Fund's budget. Most of the U.S. contributions come from the President's Emergency Plan For AIDS Relief program, or PEPFAR. Created in 2003 by President George W. Bush, with a strong budget from Congress, and reauthorized every five years since, PEPFAR is now the largest source of funds to combat HIV/AIDS, both bilaterally and through the Global Fund. By 2003, early results from Global Fund grants hinted that more money could make a real difference (even while acknowledging growing pains for the Fund and grantees alike) (7). One could argue that at least in the Global Fund's early years, its greatest achievement was in being a catalyst for PEPFAR. Or, one could argue that PEPFAR catalyzed more giving by other donors to the Global Fund. It also could be argued that PEPFAR enabled the U.S. greater leverage over the Global Fund given its financial importance to the Fund. What is inarguably clear is that the Fund's story is inextricably linked to that of its largest donor, the U.S. What is also true is that PEPFAR influenced, and even constrained, the role of the World Bank's MAP in countries and may have further stymied any HIV/AIDS efforts with WHO (8). Despite the persistent search for new beginnings in the fight against HIV/AIDS, the fates of newer and older efforts alike continue to be intertwined.

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Figure 1:



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Figure 2: (move to webappendix)

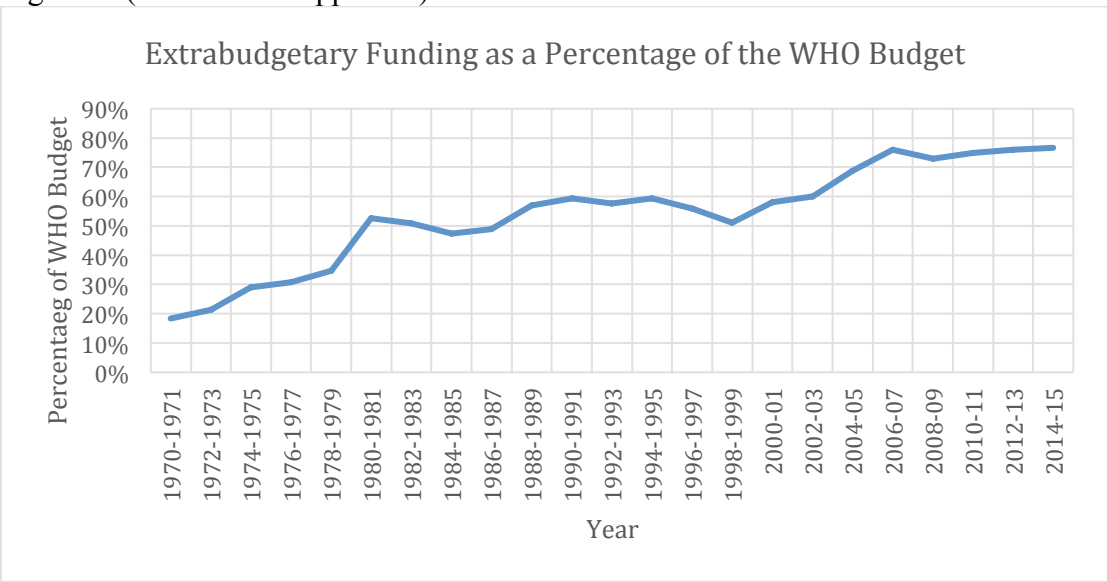


Figure 3

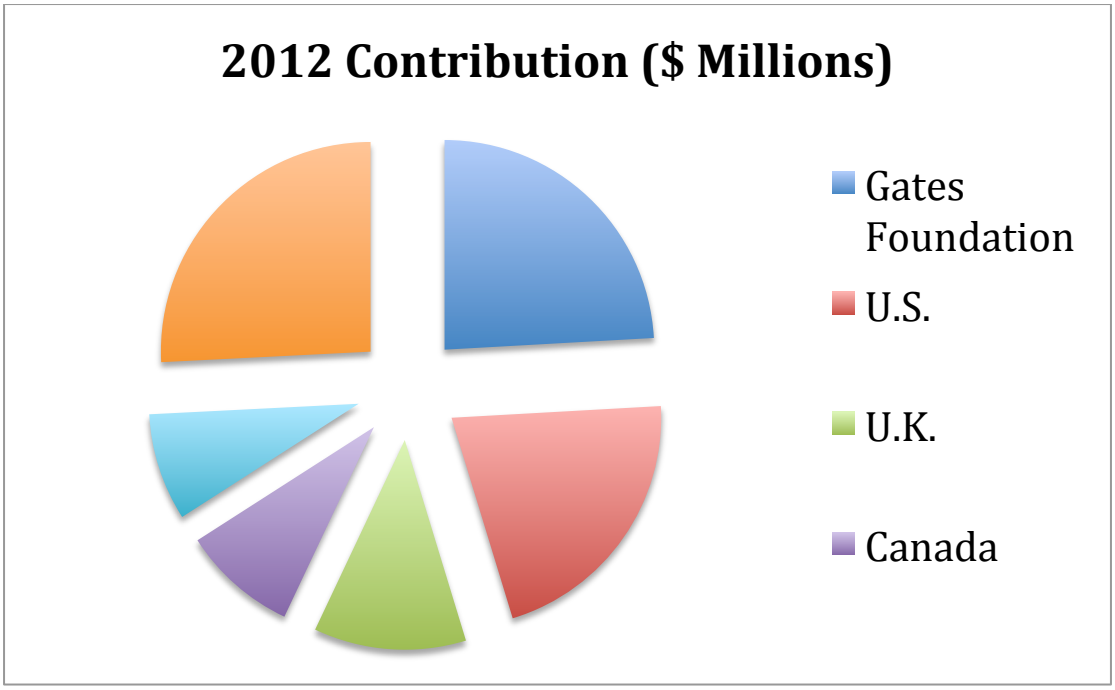


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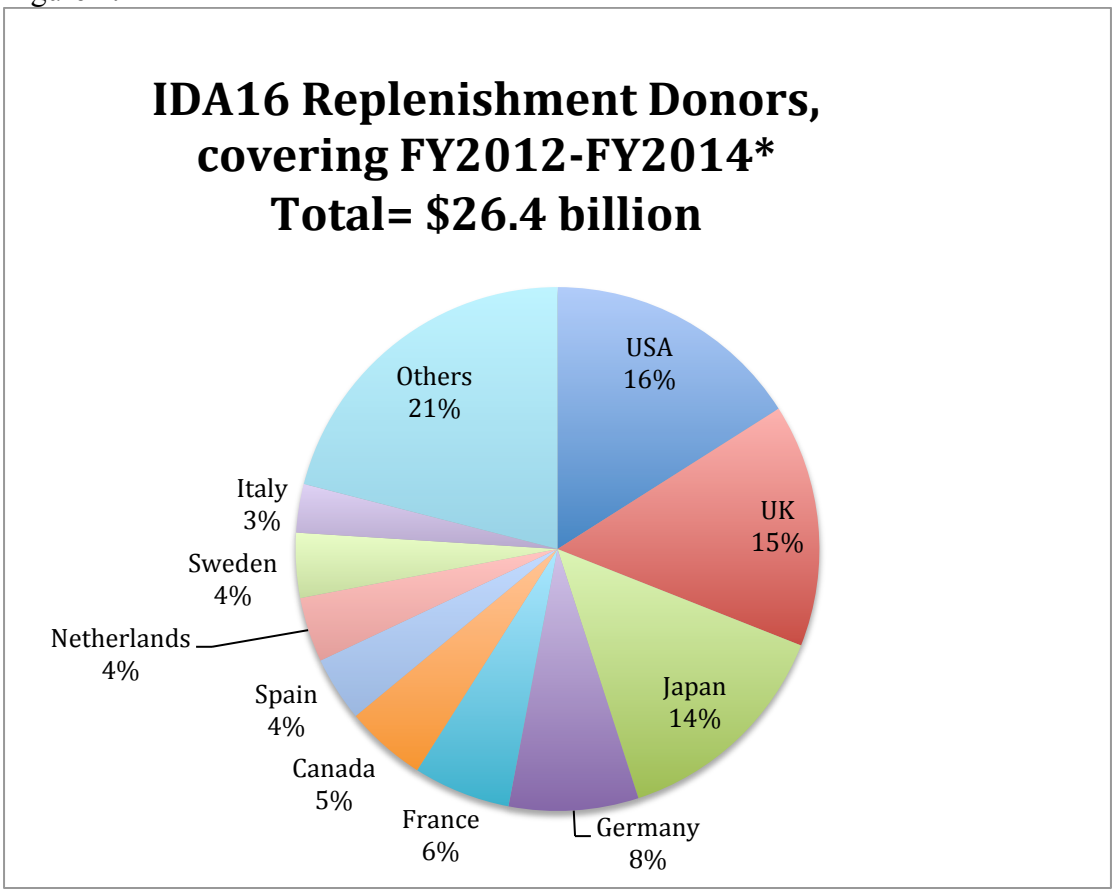
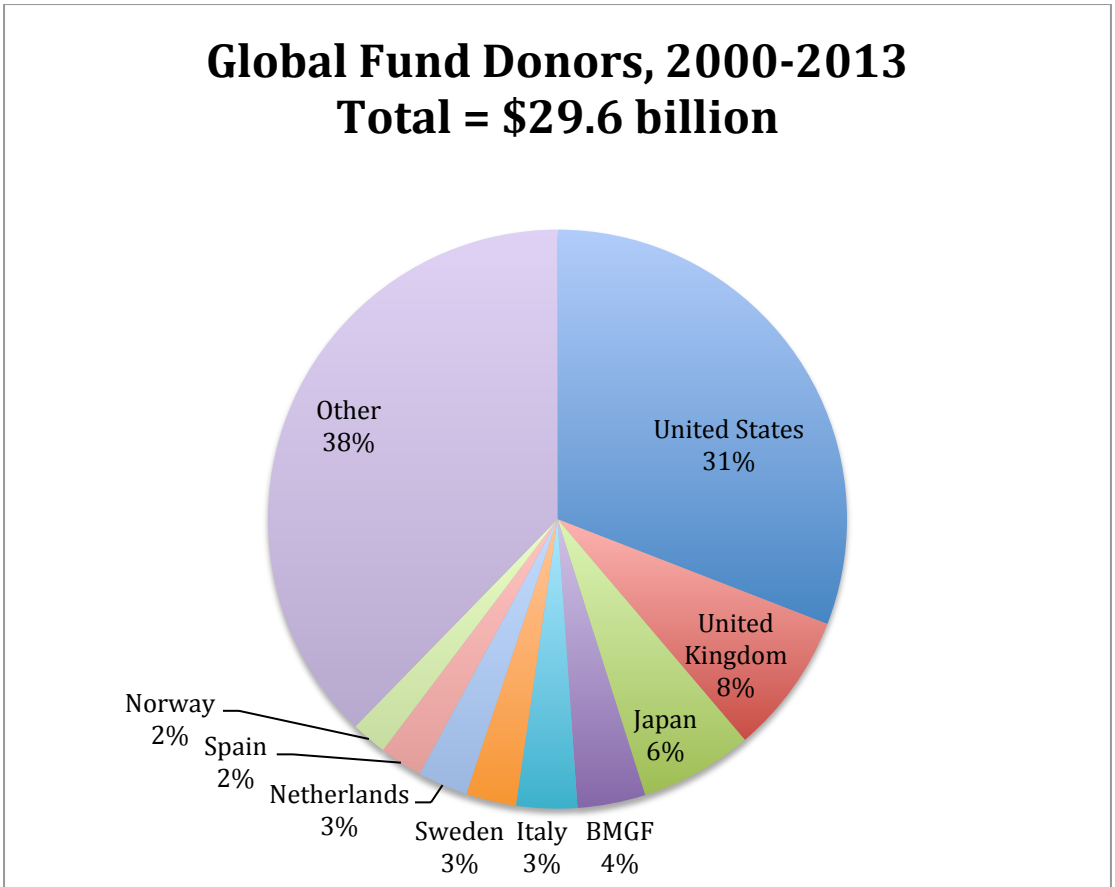


Figure 5:



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Figure 6

