



Generating evidence of aid effectiveness in global health: the case of the Global Fund

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Abstract

Global health has been identified as a ‘tracer-sector’ for advancement in regards to aid-effectiveness. This paper interrogates how evidence of aid effectiveness has been generated within one of the central, most resource-rich global health actors: The Global Fund to fight Tuberculosis, Aids and Malaria. Key terms are defined, processes for generating evidence of aid-effectiveness within both the public and global health arenas examined, and conclusions around the predominance of vertical interventions in the global health arena proposed. Ultimately, it is argued that the need for strategic and financial legitimacy has driven the Global Fund to generate very specific kinds of evidence of AE and that the Global Fund only generates the kind of evidence it can take.

Generating Evidence of Aid Effectiveness in Global Health: The case of the Global Fund

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Introduction

In his seminal work on aid and development in Lesotho, Ferguson suggested that for the most part, the actors engaged in this highly diversified, multi-billion dollar ‘development’ undertaking “only sought the kind of advice they could take” (1994, p. 284). This comment reveals a quandary at the center of many contemporary debates around aid and development, largely – how can evidence of “aid effectiveness” (hereafter AE) be generated? In order to answer this question, it is necessary to interrogate not only how, but also why and for what purposes evidence is generated. The pivotal word in this phrase is ‘generated,’ for it reveals that evidence is, in and of itself, fundamentally constructed (Mosse, 2004; Justice, 1987).

This essay will examine the interface of evidence production and AE in the field of global health. Global health is a particularly relevant field for this examination: not only was health identified as a ‘tracer sector’ for global attempts to improve AE in the 2005 Paris Principles on Aid Effectiveness (Gebhard et al., 2008, p. 3), but also because global health undertakings comprise a very significant proportion of all development work occurring today (OECD, 2011, p. 7). As many key scholars have demonstrated, substantial insights can be garnered through ethnographic evaluations of development institutions (Mosse, 2011; Gellner & Hirsch, 2001; Harper, 1998). Recognising the value of this approach, this paper will interrogate how evidence of AE has been generated within one of the most resource-rich global health actors (Lisk, 2010) – the Global Fund to fight Tuberculosis, Aids and Malaria (hereafter Global Fund). Ultimately, the paper suggests that the need for strategic and financial legitimacy has necessitated that the Global Fund generate very specific kinds of evidence of AE. To echo Ferguson’s sentiment, the paper concludes that the Global Fund only generates the kind of evidence whose advice it can take (Webb, 2011; Sridhar, 2009).

Foundation for analysis: defining the key terms

In order to assess how evidence of AE can be generated, it is first necessary to establish what is meant by ‘aid’, ‘evidence’, and ‘effectiveness’. The meanings of each of these terms are contested, but the following discussion attempts to present some widely accepted definitions as a baseline.

Aid, in this paper, is defined as “relief and assistance” which is transferred from one party to another (Kilby, 1999, p. 6). As Barder suggests, “governments give aid for many reasons,” and in turn, entities receive aid for an equally vast number of complex and varied reasons (2011, p.3).



Evidence is defined as “...the available body of factors or information indicating whether a belief or proposition is true or valid” (Brownson et al., 2009, p. 176). Informed by the medical and public health traditions, evidence in the context of global health is defined as, “... data – including epidemiological (quantitative) data, results of program or policy evaluations, and qualitative data – for use in making judgments or decisions” (Brownson et al., 2009, p.176). Lambert suggests that “evidence is always evidence ‘of’ or ‘for’ something,” (2009, p. 18).

At the most basic level, *effectiveness* can be defined as achieving an established goal; this concept can be unpacked by asking to what extent an undertaking will have the desired outcome (Cartwright, 2009). For the current discussion, the complexity of the seemingly straightforward term ‘effectiveness’ becomes evident when we situate it within the multifaceted interface of aid and evidence, and attempt to decipher how these three entities are employed within the field of global health.

Constructing aid effectiveness

In his 2004 ethnographic examination of aid, Mosse suggested that the critical ethnographic question is not whether, but “how development projects work; not whether a project succeeds, but how success is produced,” (p. 646). The purpose of this section is to suggest that evidence of AE, or ‘success,’ is the product of a number of complex processes that are fundamentally informed by the dominant concepts of knowledge and power as filtered through the bureaucratic context of specific global health institutions. Evidence of AE can therefore be seen as the confluence of these three factors – power, knowledge and bureaucracy – resulting in highly constructed lines of thought that institutions use to justify certain actions and discredit others.

Within the field of global health there has been a resounding call for an expansion of the evidence-based approach (Buekens et al., 2004). Evidence-based approaches, it is suggested, are grounded in effective interventions that have been proven to affect the desired goals (Buekens et al. 2004, p. 2639). However, Lambert suggests that evidence-based medicine “is a slippery and amorphous creature, variously identifiable as a movement, a practice, a paradigm, a methodology, and a regulatory system...” (2009, p. 17). The push towards incorporating evidence-based approaches into broader social policies can therefore not be “seen as scientific enterprise, so much as a pedagogical movement” where the language of evidence and effectiveness is used to streamline action across a wide spectrum of actors (Lambert, 2009, p.17).

In this way, evidence-based policy is an example of the “audit culture now found throughout public sector institutions,” where information is delivered in an “effective, reliable means” which can then be used by individuals within any given institution to confidently inform their decision making process – thereby shifting the burden away from the decision-maker and onto the evidence itself. However apt Lambert’s (2009) analysis may be, it is necessary to recognise that evidence can have considerable utility depending upon the context within which it is employed; in medicine, for example, evidence of drug potency is critical to determining appropriate treatment regimens (Buekens et al., 2004). The argument for



evidence-based policy in global health is an extension of this line of thought, suggesting that the best global health interventions would be those that most effectively reach their targets; how effectiveness is constructed and targets chosen then becomes of critical importance. Cartwright suggests that within the movement towards evidence-based policy there has been an over-emphasis on the importance of efficacy, which ultimately "...is only a small part of the story when it comes to deciding what results will occur when the treatment is introduced on the ground" (2009, p. 128). This observation reveals two key points: that a focus on effectiveness distorts the ability to recognise the wider processes involved in the construction of evidence, and that there is an entity that is both constructing and evaluating effectiveness. In the context of global health, processes of evidence construction occur within highly bureaucratised institutions (Ebyen, 2010; Ferguson, 1994). And while the significance of bureaucracy has been debated since the turn of the 20th century (Weber, 1978), for the current discussion it is sufficient to note that institutional arrangements and orderings have a substantial influence on not only how evidence is produced, but also why and to what ends this process is undertaken.

Lewis and Mosse propose "that within the critical deconstructionist framework... anthropologists understand the techno-managerial discourse or 'order' of development itself as an instrument of cognitive control, social regulation or exploitation. This form of order is also viewed as a rationalising discourse that conceals development's real political relations" (2006, p. 3). 'Evidence' – as put forward by many institutions – can be seen as a manifestation of this 'rationalising discourse.' The discursive employment of the term 'evidence' generally suggests that something has been proven, conveying a substantial degree of authority (Lambert, 2009).

Furthermore, "power lies in the narratives that maintain an organisation's definition of the problem – that is, success... depends on the stabilization of a particular interpretation, a policy model" (Mosse, 2004, p. 646); it therefore is necessary to recognise that both policy itself, as well as the evidence used in its formulation, are socially produced. The interests of a wide variety of institutional actors – as well as the interests of actors from the wider networks within which institutions operate – are embedded in the process of evidence generation and policy formulation (Eyben, 2010). And as will be revealed through the case study of the Global Fund, "the more interests tied up with particular interpretations, the more stable and dominant development's policy models become" (Mosse, 2004, p. 646).

Before turning our discussion towards how evidence of AE can be generated in global health, it will be useful to briefly touch upon one more foundational concept – knowledge – and specifically, how knowledge becomes evidence (Seckinelgin, 2007, p. 1221). As Escobar pointed out nearly two decades ago, "there are different kinds of producers of knowledge" but only a limited range of these are able to make their voice heard in the policy arena (1995, p. xii). When looking at the "politics of whose knowledge counts," (Seckinelgin, 2007, p. 1221) in the process of evidence generation, only the knowledge of a small group is generally accounted for.

Through what Seckinelgin has termed 'epistemological violence' evidence generation in global health has become predicated on external definitions of 'success' and more



importantly, on external definitions of objectives; these external definitions are often determined by those outside of the affected community, representing only the top of the decision making pyramid. Both Seckinelgin (2007) and Cartwright (2009) suggest that the fundamental question in regards to these produced lines of knowledge is contextual relevancy. The question of central importance becomes addressing how relevant a given line of knowledge is for the contexts within which it is employed.

Despite attempts to answer this question by promoting participatory methods (Chambers, 1994; Agrawal, 1995), within global health institutions there is such a limited conceptualisation of ‘what counts’ that the value of these broader participatory, and community-based approaches are often lost (Seckinelgin, 2007). As the forthcoming examination of the Global Fund will illustrate, the window of ‘what counts’ in global health can be seen as narrowly defined precisely because of the bureaucratisation of knowledge within large institutions, which has resulted in a highly utilitarian and socially constructed version of evidence.

Generating Evidence – from Public to Global Health

Much as the randomised clinical trial is widely considered to be the ‘gold standard’ for evidence generation in medicine (Buekens et al., 2004, p. 2639), economic evaluations predicated on the logic of cost-effectiveness have long-dominated in global health (Dodd & Lane, 2010). Brownson et al. (2009) identify *economic evaluations* as the first way that evidence of AE can be generated in public health. Applying the theory of cost-effectiveness to aid dispersal is a reasonable undertaking, and Emmanuel suggests that it is morally wrong not to analyse the cost-effectiveness of a chosen approach (2012, p. 2097). However, the pre-eminence of cost-effectiveness evaluations in global health decision-making has fundamentally distorted not only how evidence of AE is measured, but also how targets are set. In both public and global health, AE is often measured in terms of how much “bang for the buck,” is achieved (Emmanuel 2012, p. 2097). The focus on generating evidence of cost-effectiveness in global health has compressed much of the multifaceted, and often emotionally loaded, work undertaken in the name of ‘aid’ to mere numbers and figures, as this type of economic analysis does not account for the complexity of those actions (Dougouliagos & Paldman, 2009).

The *Health Impact Assessment* (HIA) can be identified as the second way that evidence of AE can be generated in this field. HIAs analyse “the probable impact of a policy or intervention in health and non-health sectors, such as agriculture, transportation and economic development on population health” (Brownson et al., 2009, p. 185). This kind of evaluation attempts to engage relevant stakeholders in the process, and subsequently expand the scope of voices engaged in deciding what should be counted (Brownson et al., 2009). However, HIAs have their limitations as, “it is illusory to believe that all interventions can be subject to impact evaluation, and that evaluations will permit the flow of aid exclusively to what works” (Bourguignon & Sundberg, 2007, p. 316). Significant ‘spill-over’ and ‘equilibrium’ effects resulting from much work undertaken in the name of ‘aid’ are not comprehensively captured by HIAs (Bourguignon & Sundberg, 2007, p. 317), and critics suggest that HIAs only capture a slightly broadened scope of voices than cost-effectiveness assessments.



In conjuncture with the move towards HIA, there was a suggestion that if the process of generating evidence of AE was to become more inclusive, the gaze must be shifted away from the institution and towards the impacted community (Brownson et al., 2009). This recognition resulted in the emergence of *participatory analysis methods* as what will be classified here as the third way of generating evidence of AE. In participatory, evidence-based public health, the involvement of community members is necessitated and there is a focus on the collective definition and evaluation of outcomes (Brownson et al., 2009, 186). Various stakeholders are engaged not only in evaluating if aid has been effective, but also in defining how aid should be used (Chambers, 1998, p. 249). As Chambers suggested nearly 20 years ago, the recognition of the value of participatory approaches does not negate the need to “make normal bureaucracies more participatory” (Chambers, 1998, p. 250), which if acted upon, could fundamentally alter the process of evidence generation within a wide range of global health institutions.

One of the three main recommendations emerging from the 2005 Paris Declaration on Aid Effectiveness was that aid should be allocated “...on the basis of performance, measured by the strength of country policies and the monitorable (intermediate indicators) they deliver,” (Bourguignon & Sundberg, 2007: 316). And so in addition to the three means of generating evidence outlined above, within global health it is pertinent to add a fourth category – *results-based assessment* (RBA) (OECD, 2011, p. 35). RBA generates evidence of AE by measuring if an intervention reaches its desired target(s), but how targets are defined largely depends on the institution and actors involved (Pearson, 2011).

While quite similar, it is nonetheless useful to distinguish between RBA and results-based financing (RBF) (OECD, 2011). RBF necessitates that funds are only released once targets have been reached (Pearson, 2011). Some see employing RBF to “link aid to results,” as vital to enabling actors to “send more aid to where it has the greatest impact” (Barder, 2011, p. 4), whereas others have suggested that this approach is reminiscent of aid conditionality, as funds are only released once evidence of ‘success’ has been generated (OECD, 2011; Webb, 2011). In contrast to RBF, RBA analyses whether or not targets are achieved by assessing progress across indicators such as changes in life expectancy, or disease prevalence (Emmanuel, 2012). Assessment is still based on results, but unlike with RBF, funding is ‘for’ results not ‘by’ results (Pearson, 2011). Many large global health institutions including the Global Fund have adopted a results-based approach, and it is towards this institution that we now shift our focus.

The Global Fund

The Global Fund was established in 2002 as an “inclusive partnership,” which brought together “governments of developing and developed countries, the private sector, civil society, and affected communities,” (Lisk, 2010, p. 99) for the explicit purpose of providing financial assistance to low- and middle-income countries in their fight against tuberculosis, AIDS and malaria (Atun & Kazatchkine, 2009). As of 2012, the Global Fund had received more than 19 billion USD in pledged contributions from bilateral donors including the United States, Germany, United Kingdom and Japan (94%) as well as from private foundations such as the Gates Foundation (3.5%) (Schwank, 2012, p. 10). Headquartered in Geneva, the Global



Fund is overseen by a “24-member international board of directors,” that seeks to represent its diverse range of stakeholders (Lisk, 2010, p.100).

Although explicitly established as a “selective, vertical and disease-based funding agency,” (McCoy et al., 2010, p. 14), since its formation the Global Fund has professed a commitment to both country ownership and results-based financing (GF, 2013). The Global Fund’s focus on results emerged in a period when “cost-effectiveness analysis [formed the] basis for international health priority-setting,” (McCoy et al., 2012, p. 7). Within the Global Fund, RBF necessitates that once an initial grant is won and the first allocation of funds dispersed, “subsequent disbursements are made... on the basis of evidence of progress achieved and the flow of funds over the initial two-year program period is linked to continual progress” (McCoy et al., 2012, p. 7). The Fund’s “conditionality of additionality” has necessitated that country-level staff adapt their practices to produce sufficient evidence of effectiveness in order to receive the full allocation of funds (Cruz & McPake, 2011).

Evidence of AE within the Global Fund is predicated on the process of RBA and success is measured by the funding of disease-specific input/output programs run largely by in-country staff (GF, 2013). And while the execution of Global Fund programs is in the hands of in-country staff, the accountability mechanisms are centralised in Geneva, as the Switzerland-based staff are responsible for assessing results (Lisk, 2010). In the Global Fund’s own words, “development efforts are based on the achievement of quantifiable results,” and therefore ‘success’ is assessed by the degree to which the desired results are realised (GF, 2013). In turn, the performance of the Global Fund and its perception in the global network is “mainly measured against its impact on disease-related health outputs and outcomes,” (McCoy et al., 2012, p. 5).

Some have criticised the Global Fund for being first-world centric due to its lack of “institutional representation or direct presence in the countries where it operates” (Lisk, 2010, p. 100). The Global Fund justifies this institutional ordering by insisting that its reliance on in-country actors is a critical aspect of country-ownership and that its’ employment of results-based approaches facilitates more responsive and adequate approaches (GF, 2013). While there may be some validity to this point of view, it has also been suggested that, “simply using results-based approaches to support more of the same may simply help us deliver the wrong results more efficiently,” (OECD, 2011: 36). It is therefore necessary to question if the Global Fund is asking the right questions in its search for evidence of aid effectiveness.

Critics suggest that the Global Fund addresses only a very narrow range of questions, as it only funds projects with “short term and visible achievements... thus leading them to prioritise visible and uncontroversial forms of assistance with short run payoffs...” (Cruz and McPake, 2011, p. 28). This contrasts with endeavours to strengthen the health system as a whole through, for example, infrastructure or institutional reform, which is aimed at producing “... longer-run returns...”(Cruz and McPake, 2011, p. 28). By predominantly financing vertical, disease-specific projects the Global Fund largely sidesteps country health systems, thereby contributing to the creation of parallel health care structures that may weaken already overburdened and underfunded health systems (Lane & Glassman, 2009).



The Global Fund has acknowledged the mounting criticisms around vertical programming and the growing popularity of horizontal, system-wide approaches (GF, 2013). Demonstrating a certain degree of reflexivity, in 2009/2010 the Global Fund “began to ‘bolt on’ HSS support” to many of its projects and sought to “progressively de-verticalise its operations and disease, based structure” (McCoy et al., 2012, p. 13), while maintaining the focus on results-based assessment and country-ownership (GF, 2013). However, over the past three years, the Global Fund has gone through what McCoy et al. (2012) have coined a “triple crisis – fiduciary, financial and managerial,” (p. 4), which has halted progress towards integrating horizontal approaches into the Global Fund’s approach; instead, this crisis has reinforced the Global Fund’s vertical, disease-specific approach (McCoy et al., 2012).

In 2012 the Global Fund released a new “five-year strategy detail[ing] the steps needed to invest for impact” in order to get better “value for money,” (Morrison & Summers, 2012, pp. 10-11). As the Global Fund attempts to pacify funders in an attempt to mitigate the ‘triple crisis,’ the Fund has become even more focused on “being able to attribute results back to itself,” thereby reinforcing the earlier reliance on vertical programming (McCoy et al., 2012, p. 14). This focus on vertical programs is endemic in global health and as Sridhar elucidates, “the imperative for donors to fund programmes that demonstrate measurable results in a short time-frame demonstrates a preference for vertical health funding” (2009: 1369).

Vertical programs produce metric-based evidence that can then be easily employed as a measure of AE (Sridhar 2009). In this way, Global Fund engagement - which professes to prioritise country-ownership (GF, 2013) – may be “distorting partner country priorities by drawing resources away from basic health sector reforms,” and is also engaging in the discursive practice of defining what results are ‘desired’ by these countries (Webb, 2011, p. 12). Furthermore, their recently reaffirmed focus on vertical programming allows for the definition of ‘problems’ and the assessment of success or failure to occur outside of the ‘target’ country, reinforcing the idea that “donor knows best” (ROA, 2008, p. 7).

Conclusion

To return to Justice’s 1984 comments around political and financial considerations dominating decision-making processes in international health, the need to produce evidence of ‘success’ to donors has fundamentally informed how the Global Fund generates evidence of AE. The drive to financially substantiate their existence and win support from various bilateral donors has resulted in the Global Fund approaching global health in a vertical, disease-specific manner, despite the cacophony of voices advocating for broader horizontal, system-wide approaches (Sridhar, 2009; Cruz & McPake, 2011; McCoy, 2012). The process of generating evidence of AE is fundamentally informed by the agencies rationale for engaging with international assistance in the first place (Ferguson, 1994), the need for funders to be able to explain to their constituents where their money has gone, as well as the need for policy makers to be able to prove the validity of their own policies (Seckinelgin, 2007). Even the World Health Organization has suggested that it is “often politically advantageous for donors to raise and spend aid ‘vertically’ in order to show a direct link between their tax monies and results” (WHO, 2007, p. 3). The so-called ‘reluctance hypothesis’ within academia further confounds the process of evidence generation as “researchers are reluctant to



publish negative results...creating a truncated distribution of empirical results,” which in turn, “distorts the process of convergence towards ‘truth’ perhaps impeding it entirely” (Dougouliagos & Padman, 2009, p. 436).

The Global Fund can be seen to have “not generat[ed] events, but help[ed] stabilise the interpretation of events” – in this case ‘events’ being global health priorities and methods of generating evidence of AE (Mosse, 2004, p. 655). This examination of how evidence of AE is generated within one of the key global health actors has revealed that highly-bureaucratized institutions such as the Global Fund must construct easily quantifiable evidence in order to justify their continued presence on the global stage and ensure sustained financial support. As the Global Fund’s own financial crisis has demonstrated, funding considerations are central to an organisation run on voluntary contributions; however, it is critical to question whether or not the production of the type of evidence necessary to exist within this global ordering has truly resulted in advancement towards the much lauded concept of aid effectiveness.



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